Bundle Public Trust Board 7 December 2022

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

Lead: Prof. Steve Field, Chair
Apologies Received:
Ms Ofrah Muflahi
In attendance: Prof. Patrick Vernon, Chair, Walsall Together
Quoracy: Meeting is quorate

2 09:35 - Declarations of Interest

Lead: Prof. Steve Field
Action: Board members to advise of any conflicts of interest pertaining to any item on the agenda which are not declared on the attached register.

Declarations of Interest Front Sheet Sept 2022.pdf

Declarations of Interest - Nov 22.pdf

3 09:40 - Minutes of the last meeting

Lead: Prof. Steve Field
Action: To Receive and Approve as an accurate record

Draft Final Public Board Minutes - 05102022.docx

4 09:45 - Matters Arising

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

5 09:50 - Action Log

Lead: Prof. Steve Field
Action: To update actions and close actions as relevant.

Action items.docx

6 09:55 - Trust Values and Nolan Principles

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

Nolan Principles of Public Life.pdf

7 10:00 - Chair's Report - Verbal

Lead: Prof. Steve Field
Action; To Inform

8 10:05 - Chief Executive's Report

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

Chief Executive report, 07.12.22.docx

8.1 10:10 - Chair's Trust Management Committee Report (October & November 2022)

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

TMC 07.12.22, Report for Trust Board, 25.10.22.docx

TMC 07.12.22, Report for Trust Board, 22.11.22.docx

9 10:15 - Patient Story - Please see link to the youtube video in the description box below.

Lead: Lisa Carroll, Director of Nursing
Action: To Inform
Please copy and paste the link below into your chrome browser to watch the youtube video.
The video will not be played in the meeting, so please watch this prior to the meeting:
++https://www.youtube.com/watch?v=Wyn_zFMaonU ++

10 Integrated Quality and Performance (IQPR) - (Section Heading)

The Executive Summary will follow as Item 10.4

10.1 10:25 - Performance & Finance Committee - Chair's Report (October and November 2022)

Lead: Paul Assinder, Chair, PFC
Action: To Inform and Assure

PFC Chair's Report October 22.docx

PFC Chair's Report November 22.docx

10.1.1 IQPR - Performance & Finance (Detailed Reference Pack for Information)

TB_IQPR_PFC.pdf

10.2 10:30 - Quality, Patient Experience and Safety - Chair's Report (October and November 2022)

Lead: Dr Julian Parkes, QPES Chair
Action: To Inform

Chairs Board report 28_10_22.pdf

Board report 25_11_22.docx

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

TB_IQPR_QPES.pdf

10.3 10:35 - People and Organisation Development - Chair's Report (October and November 2022)

Lead: Junior Hemans, Chair, PODC
Action: To Inform

PODC Highlight Report - TB December 2022.docx

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

TB_IQPR_PODC.pdf

10.4 10:40 - IQPR Executive Summary

Lead - Finance: Dan Mortiboys, Interim Director for Finance
Lead - Performance: Ned Hobbs, Chief Operating Officer and Dan Mortiboys, Interim Director for Finance
Lead - Quality: Dr Manjeet Shehmar, Chief Medical Officer & Lisa Carroll, Director of Nursing
Lead - Workforce: Catherine Griffiths, Director of People and Culture & Alan Duffell, Group Chief Officer for People and Culture
Action: To Inform and Assure

TB_IQPR_ExecutiveSummary.docx

10.5 10:45 - COMFORT BREAK

11 Provide Safe, High Quality Care (section heading)

11.1 10:55 - Director of Nursing Report

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

DoN report to Public Trust Board December 2022 Final.docx

11.2 11:00 - Hospital Mortality Report (September - October 2022)

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To Approve and Assure

Mortality Report Nov 2022.docx

11.3 11:05 - Patient Experience (& Complaints Report) - Quarter 2 report

Lead: Lisa Carroll, Director of Nursing
Presented by: Andrew Rice (apologies received from Garry Perry)
Action: To Approve

Quarter 2 2022 (002) Patient Voice report (002).docx

11.4 11:10 - Continuous Quality Improvement (CQI)

Lead: Simon Evans, Group Officer for Strategy
Action: To Inform and Assure

QI Team quarterly report Trust Board Dec 2022.docx

11.5 11:15 - Director of Midwifery Report

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

Director of Midwifery Report.docx

Appendix 1 WHT Ockenden Insight Visit Template 13_09_22 V1.pptx

11.5.1 11:20 - Clinical Negligence Scheme for Trusts (Report for Information Only)

Lead: Lisa Carroll, Director of Nursing
Action: For Information

CNST Incentive Scheme Board Report - December 2022 (2) (002).docx

Appendix 1 - Saving Babies Lives Element 1.docx

Appendix 2 - Action plan in reseponse to CNST CO reporting.docx

11.6 11:25 - Safeguarding Adults and Children - Q2 Report

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

Q2 Safeguarding Report.docx

11.7 11:30 - Trust Risk Register Report

Lead: Kevin Bostock, Director of Assurance
Action: To Inform and Assure

Public Trust Board Risk Register Report December 2022.docx

11.8 11:35 - Director of Infection Prevention and Control Report

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

IPC BAF update report Trust Board December 2022.docx

11.9 11:40 - Pharmacy and Medicines Optimisation Report

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To Inform and Assure

Medicines Management Report.docx

11.10 11:45 - Health Inequalities Strategy

Lead: Matthew Dodd, Director of Integration
Action: To Inform and Assure

TB Cover sheet Dec 2022.docx

Joint WHT Strategy Final 28.11.22.docx

Appendix 1 Walsall Health Inequalities.pdf

Appendix 2 WHT Strategy Implementation.pptx

12 Care at Home, Work Closely with Partners (section heading)

Section Heading

12.1 11:50 - Walsall Together - Chair's Report

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

WTPB Report Nov 22 v2.docx

12.2 11:55 - Care at Home Executive Report

Lead: Matthew Dodd, Director of Transformation
Action: To Inform

Care at Home Report Nov 22 v3.docx

Appendix 1 Partnership Operational Performance Pack November 2022.pptx

12.3 12:00 - Trust Board Delegation to Charitable Funds Committee

Lead: Dan Mortiboys, Interim Director for Finance
Action: To Inform and Approve

Trust Board Delegation to CF Committee.docx

12.4 12:05 - Digital Strategy

Lead: Kevin Stringer, Group Chief Finance Officer & Director of IT and SIRO
Action: To Approve

Trust board - Digital Strategy 20221130.docx

WHT Digital Strategy v0.5.docx

12.5 12:10 - Black Country Integrated Care System Update

Lead: Simon Evans, Group Chief Strategy Officer
Action: To Inform

WHT ICS Update December 2022.pdf

12.6 12:15 - Black Country Partnership Collaboration

Lead: Simon Evans, Group Chief Strategy Officer
Action: To Inform

WHT TB BC Provider Collaboration Update Dec 2022.pdf

12.7 12:20 - Sustainability Report including Green Plan Update

Lead: Simon Evans, Group Chief Strategy Officer
Action: To Approve

WHT TB Sustainability Update Dec 2022.pdf

12.7.1 Additional Reading Material for Information

Sustainability - Reading Room Pack - WHT Adaptation Plan V0.03 18.11.22.pdf

13 Use Resources Well (Section Heading)

13.1 12:25 - Audit Committee - Chair's Report

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

WHT Audit Committee Chairs Reports 02.09.22.docx

14	Value our Colleagues (Section Heading)
14.1	12:30 - Staff Voice - Acute and Emergency Services - Verbal Update *Lead: Ned Hobbs, Chief Operational Officer* *Action: To Discuss* *In attendance: Ms Ruchi Joshi (Clinical Director) and Ms O'Callaghan, Acute and Emergency Services*
14.2	12:40 - Schwartz Rounds Annual Update *Lead: Catherine Griffiths, Director for People and Culture* Schwartz Round Front Sheet - Dec 2022.docx schwartz round feedback from story tellers.odt WHT Schwartz Round Apr-21 to Mar-22.pdf
15	12:45 - Reports for Information - Minutes of Committee Meetings (Section Heading)
15.1	Quality, Patient Experience and Safety Committee - October 22 Minutes of QPES Committee Oct APPROVED.docx
15.2	Performance & Finance Committee - October 22 Minutes of the PFC 26.10.2022 RC MM.docx
15.3	People and Organisational Development Committee Meeting - September 22 & October 22 *Action: For Information Only* 3. Minutes - People and Organisational Development Committee, September 2022.docx 3. Signed and Approved Minutes - People and Organisational Development Committee, October 2022.pdf
16	12:50 - Any Other Business
17	Date and Time of Next Meeting *Date of Next Meeting: Wednesday 8 February 2023*
18	12:55 - Questions from the Public/Commissioners
19	Resolution *Lead: Chair* *Action: The Board to resolve to invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960.* *Resolved: that the resolution be approved.*

MEETING OF THE PUBLIC TRUST BOARD			
Declarations of Interest			
Report Author and Job Title:	Keith Wilshere Group Company Secretary	**Responsible Director:**	Prof. Steve Field Chair of the Trust Board
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 ☒		

Employee		Interest Type	Interest Description (Abbreviated)	Provider
Professor Stephen Field	Chairman	Loyalty Interests	Trustee	Nishkam Healthcare Trust Birmingham
Professor Stephen Field	Chairman	Outside Employment	Appointed as an unpaid Trustee for the Charity	Pathway Healthcare for Homeless People (ended April 2022)
Professor Stephen Field	Chairman	Loyalty Interests	Director	EJC Associates
Professor Stephen Field	Chairman	Loyalty Interests	Chair	Royal Wolverhampton NHS Trust
Professor Stephen Field	Chairman	Loyalty Interests	Honorary Professor	University of Warwick
Professor Stephen Field	Chairman	Loyalty Interests	Honorary Professor	University of Birmingham
Professor Stephen Field	Chairman	Outside Employment	Advisor to Health Holding Company and Board Member of Makkah Health Cluster, Kingdom of Saudi Arabia	Makkah Health Cluster, Kingdom of Saudi Arabia
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Outside Employment	Professor of Nursing Sciences	Birmingham City University
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Visiting Professor (Unpaid assignment)	Staffordshire University
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Teaching (Fellow)	Higher Education Academy
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Member	Royal College of Nursing
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Shareholdings and other ownership interests	Director	Ann-Marie Cannaby Ltd
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Outside Employment	Principal Clinical Advisor	British Telecom
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Outside Employment (ended)	Honorary Fellow (unpaid assignment)	La Trobe University, Victoria, Australia
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Member of the Advisory Panel - Volunteer role	Cavell (Charity) Advisory Panel
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Group Chief Nurse Officer	The Royal Wolverhampton NHS Trust
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Outside Employment	Advisory Board Member	Charkos Global Ltd
Ms Catherine Griffiths	Director of People and Culture	Shareholdings and other ownership interests	Director	Catherine Griffiths Consultancy ltd
Ms Catherine Griffiths	Director of People and Culture	Loyalty Interests	Member	Chartered Institute of Personnel (CIPD)
Professor David Loughton	Chief Executive	Outside Employment	Chair	West Midlands Cancer Alliance
Professor David Loughton	Chief Executive	Loyalty Interests	Member of Advisory Board	National Institute for Health Research
Professor David Loughton	Chief Executive	Loyalty Interests	Chief Executive	Royal Wolverhampton NHS Trust
Ms Dawn Brathwaite	Non-Executive Director	Outside Employment	Consultant/Former Partner	Mills & Reeve LLP
Mr Edward Hobbs	Chief Operating Officer	Loyalty Interests	Father – Governor Oxford Health FT	Father
Mr Edward Hobbs	Chief Operating Officer	Loyalty Interests	Sister in Law – Head of Specialist Services St Giles Hospice	Sister in Law
Dr Julian Parkes	Non-Executive Director	Loyalty Interests	Daughter – Nurse in ED at Royal Wolverhampton NHS Trust	The Royal Wolverhampton NHS Trust
Dr Julian Parkes	Non-Executive Director	Loyalty Interests	Trustee	Windmill Community Church in Wolverhampton
Mr Junior Hemans	Non-Executive Director	Outside Employment	Visiting Lecturer	Wolverhampton University
Mr Junior Hemans	Non-Executive Director	Outside Employment	Company Secretary	Kairos Experience Limited
Mr Junior Hemans	Non-Executive Director	Outside Employment	Chair of the Board	Wolverhampton Cultural Resource Centre
Mr Junior Hemans	Non-Executive Director	Outside Employment	Chair of the Board	Tuntum Housing Assiciation (Nottingham)
Mr Junior Hemans	Non-Executive Director	Outside Employment	Director	Libran Enterprises (2011) Ltd
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Member	Labour Party
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Business Mentor	Prince's Trust
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Non-Executive Director	The Royal Wolverhampton NHS Trust
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Wife works as a Therapist at The Royal Wolverhampton NHS Trust	The Royal Wolverhampton NHS Trust
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Second Cousin works as a Pharmacist at The Royal Wolverhampton NHS Trust	The Royal Wolverhampton NHS Trust
Mr Keith Wilshere	Group Company Secretary	Shareholdings and other ownership interests	Sole owner, sole trader	Keith Wilshere Associates
Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Secretary of the Club which is a registered Co-operative with the Financial Conduct Authority.	The Royal British Legion (Beeston) Social Club Ltd

Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Trustee, Director and Managing Committee member of this registered Charity and Limited Company since May 1988.	Foundation for Professional in Services for Adolescents (FPSA)
Mr Keith Wilshere	Group Company Secretary	Shareholdings and other ownership interests	Sole owner, sole trader	Keith Wilshere Associates
Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Company Secretary	Royal Wolverhampton NHS Trust
Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Committee member of registered Charity and Limited Company – Foundation for Professional in Services for Adolescents (FPSA)	Foundation for Professional in Services for Adolescents (FPSA)
Mr Kevin Bostock	Group Director of Assurance	Shareholdings and other ownership interests	Sole director	Sole director of 2 limited companies Libra Healthcare Management Limited trading as Governance, Risk, Compliance Solutions and Libra Property Development Limited
Mr Kevin Bostock	Group Director of Assurance	Loyalty Interests	Group Director of Assurance	The Royal Wolverhampton NHS Trust
Mr Kevin Bostock	Group Director of Assurance	Outside Employment	Trustee of a Health and Social Care Charity	Close Care Charity No 512473
Mr Kevin Stringer	Director of IT and SIRO	Outside Employment	Treasurer West Midlands Branch	Healthcare Financial Management Association
Mr Kevin Stringer	Director of IT and SIRO	Loyalty Interests	Brother-in-law is the Managing Director	Midlands and Lancashire Commissioning Support Unit
Mr Kevin Stringer	Director of IT and SIRO	Loyalty Interests	Member	CIMA (Chartered Institute of Management Accounts)
Mr Kevin Stringer	Director of IT and SIRO	Gifts	Spade used for 'sod cutting'.	Veolia
Mr Kevin Stringer	Director of IT and SIRO	Loyalty Interests	Chief Financial Officer and Deputy Chief Executive	Royal Wolverhampton NHS Trust
Mr Kevin Stringer	Director of IT and SIRO	Outside Employment	Interim Director of Finance	The Dudley Group NHS Foundation Trust
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Royal College of Paediatrics and Child Health (RCPCH) Officer for Research	RCPCH
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - RCPCH Assistant Officer for exams	RCPCH
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Chair of NHS England/Improvement Children and Young People's Asthma Effective Preventative Medicines Group	NHSE/I
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Consultant Paediatrician and Clinical Lead for Respiratory Paediatrics at University Hospitals of North Midlands NHS Trust (UHNM)	University Hospitals of North Midlands NHS Trust
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Guardian of Safe Working and Deputy Clinical Tutor UHNM (ends 1st October 22)	University Hospitals of North Midlands NHS Trust
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - West Midlands National Institute for Health Research (NIHR) Clinical Research Scholar	West Midlands Institute for Health and Clinical Research
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Director of Medical Education at UHNM (commenced 1st Sept 22)	University Hospitals of North Midlands NHS Trust
Ms Louise Toner	Non-Executive Director	Outside Employment	Associate Dean Faculty of Health, Education and Life Sciences at Birmingham City University	Birmingham City University
Ms Louise Toner	Non-Executive Director	Outside Employment	Visiting Professor/Advisory Board Member	Lovely Professional University India
Ms Louise Toner	Non-Executive Director	Outside Employment	Chair - Education Focus Group	Birmingham Commonwealth Association
Ms Louise Toner	Non-Executive Director	Loyalty Interests	Member	Royal College of Nursing - UK
Ms Louise Toner	Non-Executive Director	Loyalty Interests	Member	Greater Birmingham Chamber of Commerce Commonwealth Group
Ms Louise Toner	Non-Executive Director	Loyalty Interests	Member	Birmingham and Solihull Local Workforce Action Board and Education Reform Workforce Group
Ms Louise Toner	Non-Executive Director	Outside Employment	Teaching Fellow	Higher Education Academy
Ms Louise Toner	Non-Executive Director	Outside Employment	Non-Executive Director	Royal Wolverhampton NHS Trust
Ms Louise Toner	Non-Executive Director	Outside Employment	Associate Dean Faculty of Health, Education and Life	Birmingham City University
Dr Manjeet Shehmar	Chief Medical Officer	Shareholdings and other ownership interests	Company Director Association of Early Pregnancy Units UK Non paying, no profit UK speciality Society for Early Pregnancy. Executive Board Member Secretary Board Member	Association of Early Pregnancy Units UK
Dr Manjeet Shehmar	Chief Medical Officer	Loyalty Interests	Executive Member Association	Early Pregnancy Units UK
Dr Manjeet Shehmar	Chief Medical Officer	Loyalty Interests	Company Director	Company Director Association of Early Pregnancies Units UK
Ms Mary Martin	Non-Executive Director	Outside Employment	Trustee/Director, Non Executive Member of the Board for the Charity	Midlands Art Centre
Ms Mary Martin	Non-Executive Director	Outside Employment	Trustee/Director, Non Executive	B:Music Limited
Ms Mary Martin	Non-Executive Director	Outside Employment	Director/Owner of Business	Martin Consulting (West Midlands) Ltd
Ms Mary Martin	Non-Executive Director	Outside Employment	Residential property management company	Friday Bridge Management Company Limited (residential property management company)

Mr Matthew Dodd	Interim Director of Integration	Loyalty Interests	Wife working as a Physiotherapy Assistant at Birmingham Community Health Care	Wife
Ms Ofrah Muflahi	Associate Non-Executive Director	Outside Employment	UK Professional Lead	Royal College of Nursing
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	Royal College of Nursing
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Mentor	The Catalyst Collective
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Husband an employee of the Royal College of Nursing UK	Husband
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	Q Community at Health Foundation
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Husband Director of OBD Consultants, Limited Company	Husband
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	UK Oncology Nursing Society
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	The Seacole Group
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member of Health Inequalities Task Group	Coalition for Personalised Care
Mr Paul Assinder	Non-Executive Director	Outside Employment	Honorary Lecturer	University of Wolverhampton
Mr Paul Assinder	Non-Executive Director	Loyalty Interests	Governor	Solihull College & University Centre
Mr Paul Assinder	Non-Executive Director	Loyalty Interests	Director	Rodborough Consultancy Ltd.
Mr Paul Assinder	Non-Executive Director	Loyalty Interests	Voluntary Role as Treasurer (unpaid)	Parkinson's UK Midlands Branch
Mr Rajpal Virdee	Associate Non-Executive Director	Loyalty Interests	Lay Member	Employment Tribunal Birmingham
Mr Rajpal Virdee	Associate Non-Executive Director	Loyalty Interests	Vice President of Pelsall Branch Conservative Party Association (from 19th June 2021)	Conservative Party Association
Mr Rajpal Virdee	Associate Non-Executive Director	Loyalty Interests	Deputy Chair	Aldridge-Brownhills Conservative Association
Mr Russell Caldicott	Chief Finance Officer	Loyalty Interests	Member of the Executive	West Midlands Healthcare Financial Management Association (HFMA)
Mr Russell Caldicott	Chief Finance Officer	Loyalty Interests	Director	Plan 4 E-Health
Ms Sally Evans	Group Director of Communications and Stakeholder Engagements	Outside Employment	Director of Communications and Stakeholder Engagement	Royal Wolverhampton NHS Trust
Ms Sally Rowe	Associate Non-Executive Director	Loyalty Interests	Executive Director Children's Services	Walsall MBC
Ms Sally Rowe	Associate Non-Executive Director	Loyalty Interests	Trustee	Association of Directors of Children's Services
Mr Simon Evans	Interim Chief Strategy Officer	Loyalty Interests	Chief Strategy Officer	Royal Wolverhampton NHS Trust
Ms Glenda Augustine	Director of Planning and Improvement	No interests to declare		
Mr Mike Sharon		Interim Strategic Advisor to the Board	Strategic Advisor to the Trust Board - RWT	The Royal Wolverhampton NHS Trust
Mr Mike Sharon		Interim Strategic Advisor to the Board	Member of the Liberal Democrat Party	Liberal Democrat Party
Mr Mike Sharon		Interim Strategic Advisor to the Board	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.	Various NHS Bodies

MEETING OF THE PUBLIC TRUST BOARD
HELD ON WEDNESDAY, 5TH OCTOBER 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 J Hemans	Non-Executive Director
Prof. L Toner	Non-Executive Director
Dr J Parkes	Non-Executive Director
Ms S Rowe	Associate Non-Executive Director
Ms O Muflahi	Associate Non-Executive Director
Mr P Vernon	Chair, Walsall Together
Prof. D Loughton CBE	Chief Executive
Prof. A-M Cannaby	Deputy Chief Executive/Group Chief Nursing Officer
Mr R Caldicott	Chief Financial Officer
Mr N Hobbs	Chief Operating Officer
Ms L Carroll	Director of Nursing
Ms C Griffiths	Director of People and Culture
Mr K Bostock	Director of Assurance
Mr M Dodd	Interim Director of Integration
Mr S Evans	Interim Group Chief Strategy Officer
Ms S Evans	Group Director of Communications and Engagement

In attendance

Mr K Stringer	Director for SIRO and IT
Mr K Wilshere	Group Company Secretary
Mr S Mirza	Deputy Chief Medical Officer
Ms J Wright	Divisional Director of Midwifery, Gynaecology and Sexual Health
Ms S Stevenson	Deloitte
Mr F Ghazal	Divisional Director, Women's, Children's and Clinical Support Services
Ms D Ohai	Divisional Operations Director, Women's, Children's and Clinical Support Services
Mr M Ncube	Clinical Support Services
Mr C Lemord	UNISON representative
Ms A Downward	The Royal Wolverhampton NHS Trust
Ms L Nickell	Director of Education and Learning RWT/WHT
Ms P Boyle	Head of R&D, RWT/WHT
Mr C Bailey	External
Mr J Vukmirovic	External
Ms S Killian	Community General Manager
Ms S Dhallu	Professional Lead – Palliative & End of Life Care
Ms M Kaur	Occupational Health
Ms C Dawes	Business Support Officer (Minutes)
Ms J Toor	Senior Operational Coordinator
Ms E Stokes	Senior Administrator

Apologies

Ms G Augustine	Director of Planning and Improvement
Mr R Virdee	Associate Non-Executive Director
Dr M Shehmar	Chief Medical Officer
Ms C Jones-Charles	Director of Midwifery

362/22	**Welcome and Apologies**
	Prof. Field welcomed all to the meeting and noted the apologies received. He advised that Mr Mirza was in attendance for Dr Shehmar, Ms Wright for Ms Jones-Charles and Ms Stevenson from Deloitte had attended to observe. He confirmed that the meeting was quorate.
363/22	**Declarations of Interest**
	Prof. Field confirmed that no further interests had been declared in addition to those published.
364/22	**Minutes of Last Meeting**
	Prof. Field confirmed the minutes of the meeting held on 3 August 2022 as received and approved as an accurate record. **Resolved: that the minutes of the last meeting be received and approved.**
365/22	**Matters Arising and Action Log**
	Prof. Field noted the action log and updates were received : **Action 418** -– Mr Evans said that the discussions about how fines could be avoided in relation to the sustainability agenda were taking place with the Environment Agency to potentially agree a trade deal at both WHT and RWT. He said he would keep the Board advised via future Sustainability reports and it was agreed that the action be closed. **ACTION: Action 418 be closed**
366/22	**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. He reiterated the importance of the principles to the conduct and business of the Board. **Resolved: that the Trust Values and Nolan Principles be received and noted.**
367/22	**Chair's Report**
	Prof. Field reported on the recent publicity regarding an orthopaedic surgeon at the Trust. Prof. Field advised that he had recently participated in the Black Country discussions regarding future collaborations and that this would be discussed in the meeting later. **Resolved: that the Chair's verbal Report be received and noted.**
368/22	**Chief Executive's Report**
	Prof. Loughton advised of the appointment of five Consultants, three of these were high calibre Accident & Emergency (A&E) consultants, which he said reflected the reputation of the A&E service in Walsall. Prof. Loughton reported on concerns that had been raised by the Freedom to Speak Up (FTSU) Guardians in relation to the poor working environment for staff within the Medical Records department. He said that rapid improvements to the environment were needed and that Walsall were behind in digitising their medical records. He said that a review of off-site storage space for records was being undertaken for both Walsall and Wolverhampton Trusts. Prof. Loughton reported that students from Aston Medical School had now been fully integrated into both Walsall and Wolverhampton Trusts and said there were no issues running the two syllabuses side by side. He gave credit to the clinical academics as the feedback from student experience had been positive. Prof. Loughton briefly reported on the issues regarding the Trauma and Orthopaedic surgeon in Walsall and advised that this would be discussed further in the meeting. Prof. Loughton reported on the high calibre of consultant appointments, nursing recruitment

	and clinical and nursing fellowship programmes. He said the Trust was working with colleagues to ensure the health and wellbeing of staff and that cost-of-living issues were being reviewed by the Trust so as to provide further support for staff. Prof. Loughton asked colleagues to encourage staff to take up the flu vaccination programme. Ms Martin referred to Prof. Loughton's visit to medical records and said that she was aware of the concerns with paper-based records as this had been a recurrent theme in the internal audit reports. She said there were areas of the hospital where digitalisation had not yet happened, and the Trust needed to have a digitalisation and IT road map in place. She asked Prof. Loughton for assurance on how prioritisation and resource would be provided to undertake this. Prof. Loughton said that as an interim solution, a team was being put in place to review the health and safety issues for the department. He advised that he and Mr Stringer would report back at the next TMC meeting on how to speedily improve the situation with medical records. **ACTION: Prof. Loughton and Mr Stringer to report back at the next Trust Management Committee (TMC) on the situation with medical records, following the review being undertaken in respect of health and safety within the department.** Mr Hemans said he was pleased to hear about the health and wellbeing aspects being put in place to support staff during these difficult times and asked whether the Trust's digitalisation agenda should be part of the wider collaboration with the Black Country. Prof. Loughton agreed that this could be considered in the future, however, he said his current priority was to address the issues within the Trust's health records. Ms Rowe advised that Walsall Council were holders of several medical records and were looking for premises for storage of older records and asked if there was an opportunity for joint working with other public sectors across the Borough. Prof. Loughton agreed it would be helpful to work with Walsall Council to find a short-term solution. **ACTION: Mr Stringer to liaise with Ms Rowe to discuss a short-term solution for joint working with other public sectors across the Borough for the storage of medical record archives.** **Resolved: that the Chief Executive's Report be received and noted.**
PATIENT STORY	
369/22	**Patient Story – Michelle's story**
	Ms Carroll provided the patient story of Michelle whose partner Tim had been a patient admitted to Walsall Hospital in January 2022. She said the story clearly outlined the Hospital's lack of communication, compassion and care to Tim, who suffered from dementia and had been vulnerable. She said that the Hospital should have allowed compassionate visiting from the onset and allowed for Michelle to be with Tim and communicated clearly with Michelle when she had been unable to visit. Ms Carroll said that failure to communicate led to Tim being in hospital, being deconditioned and not returning home in a timely manner. She said that Michelle had reported that if she had been advised about Tim's baseline on the day he had been admitted then conversations that had followed would not have needed to. Ms Carroll said the division involved in Tim's care had since met with Michelle and that their patient story had been shared with all areas involved and their experiences were being used to support work with Acute Medical Care (AMU) and relevant teams.

	Ms Carroll advised the story had been shared at the Quality and Patient Experience Committee and she had committed to sharing it more widely across the organisation. She said that she would be writing to Michelle to explain what actions she would be taking. She explained a Task and Finish Group would be piloting a "eat, drink, dress, move to improve" initiative to prevent deconditioning of patients and enabling them to maintain their independence. Mr Hemans said he was pleased to hear the actions that had been put in place and the learning that had been shared with, individuals and also across the wider organisation. He asked if there was an opportunity for wider learning across both Walsall and Wolverhampton Trusts and Ms Carroll agreed the learning be shared more widely as the benefits of the collaboration were evidence. She reported quality away days with ward managers from both organisations were scheduled over the coming months with the focus on quality of care. Ms Martin asked for assurance on the actions that had been put in place across the teams in AMU and other wards. Ms Carroll advised that several external experts were working across various services and confirmed that the AMU Improvement Programme continues, with monthly AMU Improvement Board meetings co-chaired by herself and Dr Shehmar to review the progress of the AMU improvement. Prof. Cannaby advised she was looking at Walsall and Wolverhampton Trusts to recognise good practice and specialists were working with teams to assist with the collaboration and improvement. She reported that there were specialist nurses currently working in paediatrics, midwifery, oncology, haematology, and emergency department. Mr Dodd reported the patient story had been shared with teams in community services and they had started to use this as an opportunity to think about the implications for out of hospital care and what could be differently. **Resolved: that the Patient Story be received and noted.**
370/22	**Joint Trust Strategy**
	Mr Evans reported on the final stage of the process in the development of the Joint Strategy across Walsall and Wolverhampton and said a sub-group of the joint Committee had been established to oversee developments, and there had been engagement across both Walsall and Wolverhampton Trusts involving relevant user groups, patients and stakeholders. Mr Evans said the new vision had been agreed across both organisations *"to deliver exceptional care together to improve the health and wellbeing of our communities"*. He added that the individual organisational values would be maintained and over the next two years a revised set of values would be developed for both organisations. He said the new strategic aims were the 4Cs (Care, Colleagues, Collaboration and Communities) and advised that the strategic objectives aligned to the four strategic aims over the next 5 years with strategic delivery plans managed by the individual sub-committees chaired by identified Non-Executive Directors and with identified Executive Directors. Ms Evans reported on the proposed communications plan to launch the new Joint Strategy. She said the campaign identified how to communicate the 4Cs to staff, patients, communities and stakeholders and said that all communications would link back to the 4Cs. She said that as the communications would include a host of printed material made available to support both sites, including press releases for communicating with patients and public. She thanked the clinical illustration team for their support in developing the document and printed materials. Prof. Field advised that the Joint Strategy had been approved at the Royal Wolverhampton

	Trust Board the previous day. Mr Assinder said that he was pleased with the collaboration between Walsall and Wolverhampton Trusts and said there were tangible examples of the value of collaboration and what could be achieved. He said as both organisations were operating with financial deficits, consistent with the NHS across the Country, it was important that they recognise the financial context was recognised. **Resolved: that the Joint Trust Strategy be received and APPROVED.**
371/22	**Integrated Performance and Quality Report (IPQR) Executive Summary**
	Mr Caldicott advised that the summary included the four quadrants (quality, workforce, performance, and finance). He highlighted the workforce aspects in relation to overseas recruitment to improve quality standards, a drive to improve attendance, levels of temporary workforce to compensate for the shortfalls, and the high relative position in performance. He advised that finance would be reported in the first quadrant in the next report as per previous Board discussions. **Resolved: that the Integrated Performance and Quality Report (IPQR) Executive Summary be received and noted.**
372/22	**Quality, Patient Experience and Safety Chair's Report**
	Dr Parkes highlighted the breast cancer and symptomatic breast pathway waiting times above the two-week standard at three weeks. He reported that there remained a nationwide problem with health visiting and health visitor recruitment availability and that Walsall currently had a 50% vacancy rate. Dr Parkes reported that stage 2 Mental Capacity Act compliance rates had fallen. He said that a new appointment had been made to undertake the audits and the Director of Nursing had requested an urgent investigation to understand why compliance rates had decreased. He reported that VTE compliance had improved considerably though was not yet at target. Ms Martin noted that the sepsis rates were below target for receiving antibiotics within one hour and asked for assurance on what mitigations had been put in place. Ms Carroll confirmed the sepsis team had been alerted to every patient flagged as having sepsis and reviewed by the out of hours facility by the outreach team to ensure a timely review of patients. She reported that training had been undertaken with focussed work by nurses and practice facilitators as well as the medical workforce to ensure the timely prescription of antibiotics. She said this was now part of all junior doctors' induction, including sessions with microbiologists and wider medical teams. Ms Martin asked what were measures were in place to ensure that patients were being reviewed for sepsis whilst the training and inductions were taking place. Ms Carroll confirmed that every patient flagged was reviewed by the Sepsis Team and alerted to the consultant responsible for their care. Prof. Field highlighted that sepsis was not a separate nursing issue and that it was included as part of the nursing report and would continue to be addressed in the future reports. Prof. Toner referred to the detailed work on VTE and sepsis and asked that further reports would be presented at the Quality and Patient Experience and Safety Committee (QPES). Prof. Toner queried why the 2-week breast wait had reduced so significantly and Dr Parkes said his understanding was that the Trust had been reporting a 3 week wait time, therefore the percentage had dropped out of the 2-week wait time. Mr Hobbs confirmed that this was correct and said that reporting remained in the quality section and was triangulated in the performance section. He said that he recognised that

	this was one of the areas requiring improvement. He assured the Board that women were now being booked at day 16, slightly over the 2-week standard. He said there had been a suite of different interventions with breast services to try and increase capacity, including mutual aid from colleagues across the Black Country and he thanked partner trusts for assisting. He reported on the changes within the service including the appointment of a further breast care practitioner. **Resolved: that the Quality, Patient Experience and Safety Chair's Report be received and noted.**
373/22	**Performance and Finance Committee Chair's Report**
	Mr Assinder said that following the review of the in-year financial position, there was concern for the deficit position to the end of August 22 at £2.5m, £4.6m adverse to plan. He said that this financial position was similar to other trusts across the country and that the key drivers were temporary staffing costs which continued to be higher than plan. Mr Assinder said that despite the successful recruitment of additional nursing staff, the Trust had spent £2.3m on temporary staffing more than anticipated. He reported on the expanding clinical establishment and the lag between recruiting, training, and staff inducted for on the wards. Mr Assinder reported that all trusts were required to deliver efficiency targets and said that the target for Walsall was £6.3m. He said that the issues being reported at the Committee were difficulties in identifying sufficient efficiency opportunities. He said the non-pay inflation across the public and private sector was an increasing cost pressure and the Trust had not had opportunity, due to pressures on emergency and urgent streams, to make headway in the elective backlog of patients. Mr Assinder advised that the Black Country system had posted a deficit position of just under £28m for the 5 month period. He said that the Integrated Care Board were undertaking a project to review the detail of that position and to look at opportunities for collaborative working to address the underlying position. He said that the Committee would take particular attention to how the plan for the Black Country was developed and Walsall and Wolverhampton's part in delivering the plan. Mr Assinder reported on the continued excellent performance of the Care Navigation Centre and Community Hub. He reported that the Committee had shared their concerns in the community sector in relation to Health Visiting services 50% vacancy rate, consistent with others trusts in the country and the resulting prioritisation of workload. He said the Committee would be monitoring the increased number of medically fit for discharge (MFFD) patients emanating from outside of Walsall. Mr Assinder said that urgent and emergency care streams continue to work well with performance the best in the Country in many areas despite receiving 155 out of area ambulance conveyances during August 22. He reported on improvements in breast cancer services and said that Mr Hobbs had flagged to the Committee, two areas relating to diagnostics in cardiac physiology and endoscopy services where staff sickness and shortages had been causing an impact. He said that the divisions were looking at mitigations to mitigate these challenges. Mr Assinder referred to earlier discussions regarding the need for digitisation and said the Committee had considered an early iteration of an updated digital road map and had requested more detail. He reported that the Trust had already submitted bids to the ICB for £7m of additional funding for digitisation work. Mr Assinder advised that the new proposed handover date for the Emergency Department

	and Acute Medical Care Unit (ED&AMU) would be 16 January 2023 with services transferring to the new facility from February 2023 onwards. Prof. Field said that the building would be an asset for the Trust and its patients. Ms Martin said whilst the Trust was achieving higher performance targets in comparison to other trusts in the Country, some targets had not been met and were below levels achieved historically. She said that this suggested that the Trust had not fully recovered from the effects of Covid-19 and asked how the impact of this on patients was being monitored . Mr Hobbs agreed that access to care across the Country had deteriorated over the last few years and said that the Trust would be reporting back at future meetings. Mr Caldicott reported on the work being undertaken with operational teams and divisions in the Trust to provide them with the forecast finance positions. He said that he was working with executive colleagues and the Committee to deliver a financial plan at the December 2022 Board meeting. Mr Caldicott said that the Trust had a healthy cash position, but should it move into a deficit model or risk of a deficit model, the Committee would need to seek assurance for the sustainability of cash holding. Mr Caldicott reported on the ongoing work around the expenditure plans moving into 2023/24 financial year to understand the priorities. **Resolved that the Performance and Finance Committee Chair's Report be received and noted.**
374/22	**People and Organisational Development Chair's Report**
	Mr Assinder introduced the Chair's report on behalf of Mr Hemans and highlighted plans to expand the nursing and midwifery establishments. He said the People and Organisational Development Committee (PODC) had been concerned about the retention rate which had decreased to 78%, the lowest reported in 3 years. He said that people were either leaving for other jobs or opting to retire from the NHS and PODC had asked for a more detailed report on what could be done to improve retention and stem the flow of leavers. Mr Assinder reported the sickness rate at the end August 22 was 5% and said there had been discussion regarding the hot spots of staff sickness and how they were being proactively managed on a case-by-case basis. He reported on positive work in relation to the management of Long-term Sickness (LTS) and said that discussions had taken place with colleagues from Occupational Health about managing LTS. He reported on the Deep Dive into the occupational health and wellbeing service and said that the department had received national recognition and accreditation which was celebrated as an external validation of the department's excellent work in supporting staff and the health and wellbeing of colleagues. Mr Assinder said that PODC had received reports on medical revalidation, the nursing and midwifery recruitment plan, the plan to reduce dependency on temporary staff and the work undertaken to recruit more substantive nurses, midwives and professions allied to health. He reported that the Committee had received a presentation on the "healthy attendance project" which looked at how individuals can be supported better to come to work and remain in work. Ms Griffiths reported that the work and the interventions undertaken, working in partnership with the divisions, illustrated the differences that had been made as absence rates had decreased further. She said the Committee had asked to look at the people's relationship with work post pandemic and those wanting to retire. She said the Committee had commissioned highlight reports on hot spot areas and solutions for those areas.

	Ms Muflahi referred to the workforce trends and correlation with culture and inclusivity, especially considering the continued international recruitment and asked for additional assurance on the strategies being implemented, particularly around the cultural ambassadors' programme and how this was used in recruitment and disciplinary processes. Ms Griffiths said the Trust have a strong team of cultural ambassadors and the next Committee and Board meetings would receive a report on annual equalities, inclusion, and diversity. She agreed that further work on culture was required but advised that the cultural ambassadors as well as the Freedom to Speak Up guardians (FTSU) who had made a difference. Ms Martin asked for guidance for assurance on the efficiency of bank and locum staff being inducted into working at the Trust. Ms Griffiths reported that recruitment activity had increased year on year causing delays in the system. She said that an investment case had been approved for additional recruitment staff and said that the Trust now had the capacity to undertake appropriate compliance and processes and that they were also reviewing the replacement of agency staff with substantive staff. **Resolved: that the People and Organisational Development Chair's Report be received and noted.**
PROVIDE SAFE, HIGH QUALITY CARE	
375/22	**Director of Nursing Report**
	Ms Carroll reported that 79 falls had been reported in July 22 and 65 in August 22 and that all falls were reported at the Falls Accountability and Review weekly meetings. She said that 4 falls had been reported as causing harm and were currently going through the Root Cause Analysis (RCA) investigation process and had been reported to the Serious Incident Group. She said these would be included in her next report to Board. Ms Carroll reported that pressure ulcer incident had reduced, and the new hybrid mattresses contract had been awarded. She reported the in-patient risk assessment document on pressure ulcers had been revised along with all nursing documentation, an education programme with staff with the aim to rolled out across the Organisation in early November 22. She said the Venous thromboembolism (VTE) compliance for August 22 was 93% an increase in compliance compared to July 22 at 89%, although an increase from the previous months it continued below the 95% target. She reported that 2 weekly audits were in place with decisions reported to the Patient Safety Group. Ms Carroll reported on two surgical site infections in August 22 and said that there had been good engagement with the wider multi-disciplinary team (MDT) at RCA meetings. She said there had been some immediate lessons in relation to documentation and processes with an action plan monitored by the Patient Safety Group. Ms Carroll reported 3 cases of Clostridium Difficile toxin ('*C-Difficile'*) reported in July and August 22 and that a review had identified that antibiotics were justified in all cases. She said that overall performance year to date remained below trajectory. Ms Carroll said that she had previously advised that the target for timely observations had increased from 85% to 90% and that prevalence of timely observations for July 22 was 77% which had continued to improve in August 22 to 80%. Ms Carroll reported that the decrease in the Mental Capacity Act (MCA) compliance was of concern as this had been a focus in education and part of junior doctor induction. She said there had been change in the personnel undertaking the audits. She advised that the previous personnel who had retired had agreed to come back to support the new staff to ensure the same methodology was being applied. Ms Carroll said that she would provide

	an update at the next Trust Board meeting. Ms Carroll reported that Tier 2 bookings during August 22 were at the lowest levels since March 22 and at the end of August 22, 16 departments no longer had used agency staff with plans in place to continue to reduce agency use. She said that the Emergency Department (ED) was the highest user of agency and would be fully recruited to at end November 22. Ms Carroll said the Trust was on track, as predicted, to cease agency usage on ward areas by the end of the calendar year and would be looking at the collaborative bank moving forward. She reported that engagement on the Clinical Systems Framework and the work to launch it across the organisation and the Royal Wolverhampton NHS Trust in January 23 would coincide with the launch of the vaccination hub. Ms Carroll advised of the sad loss of two members of the nursing workforce who had died suddenly (Mr Roberto Villanueva, a Charge Nurse on ICU, and Ms Surinder Swarnn, a Clinical Support Worker in Outpatients). She said that appropriate support was being provided to their families and colleagues. Prof. Steve Field , on behalf of all the members of the Board extended their condolences to the families of Mr Villaneuva and Ms Swarnn. Ms Rowe referred to the safeguarding team recruitment and raised a concern, regarding the repeated issue of compliance with level 3 safeguarding training. Ms Carroll said there would be greater focus to ensure compliance and that a shortened version of training had been prepared at RWT and that Ms Pickford, Head of Safeguarding was looking at this being adopted at Walsall. Ms Muflahi said the team had to be commended for the work on nursing recruitment and the clinical fellowship programme and recognised the consideration taken into the skill mix to enable safe, high quality care. She said she was pleased to note that student nurses were returning to work for the organisation an indication of the good and positive experiences they had had as students. Mr Hemans asked about management and training development and sought assurance that managers were ensuring that relevant training and development was up to date. Ms Carroll confirmed there was a programme in place for divisional directors of nursing and matrons with mandated days for ward manager away days and that the Trust was looking at a wider development programme next year for aspiring managers and other staff on the wards. Prof. Toner acknowledged the letter from Health Education England confirming that the National Education and Training Survey (NETS) reinforced the message of students receiving a good experience at the Trust and wanting to work with the Trust. She asked if 35 was a good number to be recruiting locally and Ms Carroll confirmed it was with another 15 nurses. She said that the Trust would also be looking to triple the number of placements and said that engagement of students would be strengthened as a student shared decision making council in place. **Resolved: that the Director of Nursing Report be received and noted.** **The board convened for a 10 minute break at 11.08am**
376/22	**Hospital Mortality report**
	Mr Mirza presented the Hospital Mortality Report in the absence of Dr Shehmar highlighting the most recent published Summary Hospital level Mortality Indicator (SHMI) illustrated an upward trend at the 90% upper limit rating the Trust as Red. He advised that the inflation of the SHMI was due to the inclusion of palliative care patients at Goscote Hospital. Mr Mirza advised that the Mortality team had met with NHS Digital to discuss SHMI

	reporting on the NHS digital platform identifying the SHMI for separate sites that had provided assurance that the Trust was not an outlier and levels were within the expected range. He said the Trust benchmarked against other Trusts SMI Data to improve the quality of reporting and the Mortality Surveillance Group had recommended moving to the NHS Digital platform. Mr Mirza reported on the ethnicity of Covid-19 positive in-patients and advised the majority were white, British. He said that future reports would look at Covid-19 deaths by ethnicity and he confirmed the perinatal report would be included in the next report as a quarterly update on Ockenden. Mr Mirza reported on the HSMR alert relating to Lung cancer and said that a deep dive into patient level data had indicated no concerns and that 50% of the deaths had been due to palliative care. He highlighted the quality improvement programmes in the lung cancer specialty. Mr Mirza said that the National audit for care at end-of-life recommendation had been to implement the acute based core standard framework. He reported a 33% reduction in outstanding structured judgement reviews (SJRs) monitored by the Mortality Surveillance Group. Prof. Field said that the SHMI data was worrying and noted the mixture of coding and other issues. He asked how much work had been undertaken by Walsall and Wolverhampton Trusts to improve the performance in Walsall. Prof. Cannaby advised that the Chief Medical Officers at both Trusts, Dr Shehmar, Mr B McKaig and Dr Odum had regular meetings to review the work undertaken at RWT and shared advice, guidance and cross learning. She advised that Dr Shehmar had also sought external expert input to assist. Prof. Toner queried where the good practice support needed would be provided from. Mr Mirza confirmed that the support required had been identified from the Care Group specialties to the Division and said that the recommendation was that the Division supported Care Group's in developing the services to provide better patient care and experiences. Mr Assinder said that the 12 months SHMI figure for Walsall to May 2022 was 116 and said that anything over 100 was a cause for investigation and would impact on the Palliative Care Centre. He said the Manor Hospital SHMI was lower which indicated that this was not a concern. Mr Mirza confirmed the first figure related to the combined total for palliative care patients and the acute trust and that the lower figure was just for the acute Manor site and this was the reason that as a Trust they need to make the data site specific. **Resolved: that the report from the Hospital Mortality Report be noted.**
377/22	**Palliative Care (Goscote Hospice)**
	Mr Dodd reported that the service had transferred over 2 years ago during a time of Covid-19 and reported on the acute staffing problems. He said that it had been important to ensure continuity with a facility in Walsall and the Palliative Care Team had taken the opportunity to integrate the hospice team with existing specialist services and increased the range of patient choice around palliative care and supporting people to go home. He said the offer of palliative care was being expanded into the community. Ms Martin queried the funding to cover existing services and the extra developments. Mr Dodd said that for the time being the service was being funded for its delivery and said that the issues related to development and expansion funding. Ms Muflahi asked for additional assurance regarding community nursing, and how future

	modelling would align with recuritement, specifically to district nursing services, as that was a depleting workforce. Ms Dhallu advised this was a wider piece of work and that the Hospice recognise that they had a depleted workforce. She said that the communication between community nursing teams, specialist palliative care teams and the hospice was prevalent in the way patients move between the services, and that the service continued 7 day/24 hour support. She reported that part of the palliative virtual ward would be identifying early interventions for patients. Prof. Field thanked Mr Dodd and Ms Dhallu for the report and said Board members would arrange to visit the hospice in the near future. **ACTION: Prof. Steve Field and Board members to visit Goscote Hospice in the near future.** **Resolved: that the report from the Palliative Care (Goscote Hospice) Report be noted.**
378/22	**Patient Experience Annual Report - Spiritual, Pastoral and Religious Care (SPaRC) 2021-2022**
	Ms Carroll reported on the activity of chaplaincy team over the past 12 months advising that Reverend Linford Davis had been appointed as Head of Spiritual, Pastoral and Religious(SPaRC) and was working across both the Walsall and Wolverhampton Trusts. **Resolved: that the report from the Patient Experience Annual Report - Spiritual, Pastoral and Religious Care (SPaRC) 2021-2022 be noted.**
379/22	**Director of Midwifery Service Report**
	Ms Wright presented the report in the absence of Ms Jones-Charles. She reported 100% compliance of 1:1 care for women in labour and said that Midwifery staffing continued to be a challenge, the service had been significantly recruited to through September 22 and would continue. She advised the service was currently matching staffing to acuity to maintain a safe service. Ms Wright reported on the General Medical Council (GMC) report relating to culture in obstetrics, which highlighted feedback from junior doctors who had expressed the need for greater senior support. She said that an action plan had been developed and implemented to ensure that junior doctors continued to feel supported. Ms Wright highlighted the service was compliant in 7 of the 10 safety actions of the Clinical Negligence Scheme for Trusts (CNST) and that the 3 outstanding actions were on track to meet targets. She advised that the CNST submission date was now February 2023. Ms Wright reported on a Serious Incident in July 22, in relation to a patient who had her maternity care booked with WHT but had then received later antenatal care at Sandwell and West Birmingham NHS Trust (SWBH). She said that WHT maternity services were working closely with SWBH and providing them with support in relation to the incident. Ms Wright advised that the initial review had found there had been missed opportunities in the community as well as the plan for scans and that the investigation would encompass the care provided at SWBH. Prof. Toner queried when compliance of the 3 outstanding safety actions would be expected. Ms Wright reported they would be completed by end of January 2023. Prof. Toner asked if there were any maternity support workers specifically prepared for that role within the organisation and Ms Wright advised that the Division was currently undergoing a management of change with Band 2s/3s. Prof. Toner advised that apprenticeships were available at Levels 3/4/5 as progression for maternity support workers. **Resolved: that the Midwifery Services report be received and noted.**

380/22	**Safeguarding Adults and Children Quarter 1 Report**
	Ms Carroll reported that the Safeguarding Business Case which had been agreed in February 22 had allowed for recruitment to the Safeguarding Team with one administration post still to be recruited to. Ms Carroll advised that support continued to be provided to WHT by the Head of Learning Disabilities, Royal Wolverhampton Trust (RWT), 2 days a week. She said that a review was also being undertaken to consider one Learning & Disability (L&D) service across both Trusts. She said that Learning Disability Training had been included within the Level 3 Adult training programme and the Trust was awaiting further guidance on the plan to roll out the Oliver McGowan L&D national training programme. She reported that school nursing supervision which had dropped in August 22 but was now back on track. Prof. Toner asked for clarification of the recording of Disclosure and Barring Service (DBS) compliance and Ms Carroll said that external national DBS compliance reporting had commenced as part of the requirements of the safeguarding dashboard and a working group was meeting across WHT and RWT to oversee this work. **Resolved: that the Safeguarding Adults and Children Quarter 3 Report be received and noted.**
381/22	**Trust Risk Register/Board Assurance Framework**
	Mr Bostock provided an update on the data between June-July 22 and said the position remained stable over this period. He advised that profile changes related to the 'Use of Resources' due to financial challenges in the system and health visiting capacity due to the 50% vacancy rate. He referenced the actions overdue and said that these were overdue from planned review dates and timescales had been re-evaluated. He said that robust controls were in place. Mr Bostock advised that the new strategic objectives would be aligned to a new Board Assurance Framework (BAF) and revised Risk Register (RR) which would be moving from the Ulysses Safeguard system to a Datix system over the next few months. Ms Martin said that with the new strategic objectives, as Audit Chair, she would be looking for a much greater degree of integration between the RR and BAF and asked for an update on the process. Mr Bostock said the BAF would be simplified and that work would be undertaken to transfer risks to the new Datix platform and risks associated with previous objectives would be re-evaluated. He said this would be run through a test environment with stakeholders to ensure connectivity works and that the new and old systems would be run alongside each other until there was confidence that everything was working correctly. **Resolved: that the Trust Risk Register/Board Assurance Framework Report be received and noted.**
382/22	**Annual Health and Safety Report**
	Mr Bostock provided the Annual Health and Safety Report 2021/22 which outlined the achievements and difficulties experienced in maintaining the health and safety oversight during the pandemic. He said that the Trust had achieved well in their health and safety oversight during that period. He reported an electronic platform was to be introduced to improve efficiency and visibility. Ms Muflahi asked for additional assurance regarding long Covid and whether reasonable adjustments needed to be made for staff who may have long Covid. Mr Bostock said that level of detail would not normally be included in the annual report, but he confirmed the Health and Safety and Occupational Health teams had systems to detect those issues and to risk assess individual staff to ensure any reasonable adjustments that needed to be made were being made.

	Resolved: that the Annual Health and Safety Report be received and noted.
383/22	**Director of Infection Prevention and Control Report – Q2 Update**
	Ms Carroll reported on the NHS England Inspection undertaken in August 22 on Infection Prevention and Control and advised on the recognition of significant improvements. She said the overall Trust rating for infection prevention as "green", previously rated as "amber' and said that this had been the first time in 10 years that the Trust had been rated as "green". She advised a sustainability visit was scheduled in Q1 of 2023. Ms Carroll reported that the Trust's guidance for Covid-19 had been updated in line with national guidance and all respiratory illnesses was managed using a clear process flow chart. She said that the Trust had been asked to present at the National Infection Prevention Society. **Resolved: that the Director of Infection Prevention and Control – Q2 Update be received and noted.**
384/22	**Pharmacy and Medicines Management Optimisation**
	Mr Mirza reported on the improvements in medicines management compliance following collaborative efforts between pharmacy, the divisions and care groups. He said that by placing the risks on the risk register for the care groups and the divisions there had been local improvement in the ownership and compliance. He advised ward storage audits had shown an overall compliance of 80% with those areas not compliant being escalated to divisions for further challenge and improvement. Mr Mirza advised a Task and Finish group in place with RWT looking at medicine storage standardisation. He said regarding areas non-compliant, the pharmacy staff were working with staff on the wards around education and training. He reported electronic drug storage units had been purchased for wards across the Trust and the main pharmacy dispensary. He reported on the success of Walsall Greener NHS, and the reduction of nitrous oxide and desflurane. He reported that both teams at Walsall and Wolverhampton were looking at enhanced security around the nitrous oxide storage areas. **Resolved: that the Pharmacy and Medicines Management Optimisation Report be received and noted.**
385/22	**Biannual Skill Mix Review**
	Ms Carroll reported on the skill mix review undertaken in June 2022 utilising the Safer Nursing Care Tool and professional judgement. She advised the recommendation was to increase the establishments on wards 7 and 17 to increase the staffing of Band 5 RNs and Band 2 CSWs and Ward 4 would have Nursing Associates. She said there were a small number of Nurse Associates qualifying every year and this would provide them opportunities. **Resolved: that the Biannual Skill Mix Review Report be received and noted.**
386/22	**Complex Case Review**
	Mr Mirza reported on the media release by the BBC on Monday26 September 22 that included patient stories from Walsall Healthcare and Spire Hospital, Little Aston naming the surgeon. He said the Chief Executive and Chief Medical Officer had been interviewed as part of the media release. Mr Mirza reported the next steps for the Trust included a review and recall process. He reported on the progress on patient review and recall letters that had been posted to patients on 27 September 22, and the press release statement published on the Trust website, with a contact helpline phone number and email address. He said that training had been provided for staff to support them with dealing with the calls and emails that may come in.

	Mr Mirza said that staff had been briefed by the Chief Executive, Chief Medical Officer and the Director of Communications, supported by the Director of People and Culture and that a log of all calls made formed part of the review and analysis. He advised that the patient review and recall programme' and medical records had been added to the Trust's risk register and would be reviewed by four external consultants with specialty in peer reviews and upper limb surgery. He said a clinical harms framework had been developed and patients triaged using this framework, with case reviews to commence on 7 November 22. Mr Mirza advised of the resource implication associated with this work. Ms Martin thanked Mr Mirza for his report and queried what the assurance for the process completion. She said she was aware the consultant had been suspended but asked if it was normal to proceed with the process. Mr Bostock reported that patient notification exercises and recalls were becoming more common both in the NHS and the private sector. He said the time taken from identifying concerns to validating whether those concerns warranted a patient notification exercise and subsequent recall, in line with other recalls in NHS trusts and the independent sector. Mr Bostock said the process in this situation had been the planning and preparatory work and consideration had been given regarding any ongoing clinical harm identified. Mr Hemans said that the Trust would have gone through several processes of revalidation to assess their doctors and asked what assurances could be provided that the Trust was undertaking careful review of doctors and consultants. Mr Bostock said that the function of medical governance and reappraisal had been restructured, and they had recruited a specialist in medical governance and created a database to collect live performance information on all the doctors connected to the Trust which would detect any deviations from expected norms or standards. He advised that there was stronger assurance in place than previously, and would be further strengthened once electronic systems were in place. Mr Mirza agreed with Mr Bostock and advised that the clinical governance processes had been reviewed for those patients who had had complications and had to return for further surgery. He said this information would be collected and triangulated as performance reflection for the individual consultant or care group which would allow the Trust to benchmark that specialty or procedure. Ms Rowe questioned how information was shared across organisations that doctors were working in and how the Trust was assured about performance of a doctor also working in another organisation. Mr Bostock reported that the process described was known as a 'whole practice appraisal' and the Trust had identified pre-existing deficiencies in their systems for gathering information from other organisations to feed into the 'whole practice appraisal'. He said that the revalidation system had identified weaknesses which had been strengthened. Mr Bostock reported on the work undertaken shared with other organisations to identify any of their doctors had been connected to in advance of their appraisals. He said that all relevant performance data would then be fed into the electronic system. He advised that the Trust had also been reviewing connections with other provider systems. Dr Parkes asked for reassurance about the letters and the helpline and whether the helpline had managed to cope with the volume of work and how many people had contacted it. Ms Evans confirmed that all letters, as part of the notification, had been sent out and said that the helpline was for patients and staff and to date the Trust had received 300 phone calls and 100 emails. She said that the helpline was open 7 days a week. Ms Evans expressed her thanks to Mr Perry and the Patient Experience team for their management of this

	process. Mr Hemans asked if counselling or psychiatric support had been put in place for staff and patients. Ms Evans advised that patients or staff who had contacted the Trust had been offered a counselling service. Prof. Loughton expressed his apologies to the patients that had suffered harm in this case, and said that some of these had been life changing. He apologised on behalf of Walsall Healthcare and thanked Mr Mirza, Dr Odum, Mr McCaig and Dr Shehmar for their input in the process. He commended Mr Bostock for implementing the governance processes and said there would need to be an external review to understand the incidences between the period 2010 and 2021, when different Executive Team was in place at the Trust. Prof. Loughton said that he had visited the staff working on the helpline as well as staff that had also been affected. He said the Trust would need to undertake remedial reviews and assess if any further surgery was required for some of these patients. He reiterated his apologies for the harm caused to patients and said he would be committed to the Trust doing whatever was needed, both psychologically and physically to support these patients. Prof. Field thanked everyone involved in this important and sad issue, and said that updates would continue to be presented to the Board. **Resolved: that the Complex Case Review update be received and noted.**
CARE AT HOME	
387/22	**Charitable Funds Chair's Report**
	Mr Assinder highlighted the current financial turbulence in the economy and said that as the Charity benefits from investment funds, these would be monitored and managed by carefully selected brokers. He reported the Committee had approved three items of expenditure, for the annual funding of the long service awards, special training packages for clinicians in relation to the benefits available to end of life for patients, support for hot meals for staff (£1.50) through the purchase of special equipment to keep food hot. He advised there were a range of fund-raising activities planned during the year. **Resolved: that the Charitable Funds Chair's Report be received and noted.**
388/22	**Walsall Together Partnership Board Chair's Report**
	Prof. Vernon highlighted the work with stakeholders and the community working group to look at innovative ways on how to minimise pressures experienced across the community including food and warm hubs. Prof. Vernon said that the Walsall Together Partnership Board (WTPB) also received patient stories and asked how WHT could align their patient stories with the work being undertaken by WPTB that included the wider inequalities agenda and the support being provided in the communities. He reported on the last patient story linked to diabetes and said that more work was needed diabetes support and awareness, as there were cases of late diagnosis of diabetes within the community. Prof. Vernon said that the focus for WPTB was health inequalities, collaboration and the community voice. He said that discussions had taken place on how to align Walsall's PLACE based approach with that of the Integrated Care Board (ICB) approach. Mr Hemans referred to diabetes issues and the increased number of amputations due to diabetes and asked what diabetic clinics were available in the borough, and whether plans needed to be put in place to develop them. Mr Dodd reported that one of the programmes of work within WPTB was to look at reshaping the diabetes services, and that WPTB was working with a GP within the Primary Care Network which included community based

	diabetic services with GP based diabetic services. He said there had been an increase in the number of patients diagnosed as diabetic throughout Covid-19. **Resolved: that the Chair of Walsall Together Partnership Board report be received and noted.**
389/22	**Care at Home Executive Report**
	Mr Dodd reported that the level of activity for care at home had increased. He said delays in confirmation of funding for bids from the Integrated Care Board (ICB) had improved with the service now receiving access to some of that funding. Mr Dodd reported a greater demand for complex discharge and the increase in the number of people from other boroughs. He said that these patients were classified as 'delayed discharge' and this had been raised with the ICB who had asked the Trust to lead on the process. He said that he would chairing a meeting today to work on a systematic approach within the Black Country and other systems to adopt a variety of different approaches. Mr Dodd reported on the issues in health visiting and said that the Team had been working with partners and the Safeguarding Board to understand the recovery trajectory, restarting services, skill mixing options for the services, managing risks and dealing with vulnerable people. Mr Dodd advised that commissioning arrangements, accountability and responsibility were being discussed with WTPB as the host organisation. He said that draft governance arrangements had been circulated and agreed in relation to a PLACE Integrated Commissioning Committee with a view to move resources delegated from the ICB and Health Wellbeing Boards. He said that further discussions were required with Walsall Healthcare as one of the key partners and that further updates on these discussions would be provided at future Board meetings. **Resolved: that the Care at Home Executive Report be received and noted.**
390/22	**Emergency Preparedness Annual Self Assessment & EPPR Core Standards**
	Mr Hobbs reported on the Trust's annual self-assessment against NHS England's Emergency Preparedness, Resilience and Response (EPRR) Core Standards. He said the self-assessment against each of the core standards had led to an overall assurance rating of 'substantial' compliance which had been scrutinised at the EPRR Steering Group, Trust Management Committee and Performance and Finance Committee and the new Stage 2 scrutiny at ICB level. He said there were no material changes recommended by the ICB scrutiny but the Trust had received constructive comments about strengthening the Trust's evidence. He reported the assessment would be presented to NHSE/I and explained that if NHSE/I changed any of the ratings there would be a possibility for the Trust to lapse into 'partial' compliance. **Resolved: that the Emergency Preparedness Annual Self-Assessment & EPPR Core Standards Report be received and APPROVED.**
391/22	**Update from the Black Country Acute Collaboration Board**
	Mr Evans said that all four trusts in the Black Country had presented the report at their respective Boards. He outlined the next steps for the Provider Collaborative to consolidate the position of a North/South split (Walsall/Wolverhampton integrated model) and closer working relationship between the South (Sandwell and Dudley). Mr Evans reported that Sandwell and Dudley Trusts had appointed Sir David Nicholson as their joint Chair for both trusts and said that the commitment and it was proposed to move to a single chair, across the Black Country, at an appropriate point. Prof. Field confirmed Walsall Healthcare NHS Trust Board as a sovereign board and said

	this sovereignty would be maintained within the Black Country Provider Collaborative. **Resolved: that the Black Country Acute Collaboration Board update be received and APPROVED.**
392/22	**Sustainability Report including Green Plan Update**
	Mr Evans reported on the successful reduction of medical gases and desflurane, the production of the Green Adaptation Plan and that work was underway on the next steps with good progress being made. He reported that the Sustainability Assessment Tool was to be included as part of all future business cases for consideration by the Investment Group. **Resolved: that the Sustainability Report including Green Plan Update be received and noted**
USE RESOURCES WELL	
393/22	**Audit Committee Chair's Report**
	Ms Martin reported that the Trust had been subject to a mandate fraud in June 22 via a cyber threat and that the Trust, supported by local counter fraud services, was undertaking further investigations. Ms Martin advised that leadership within the security services across Walsall and Wolverhampton Trusts was being reviewed with a view to having the services tendered to a single service across both Trusts to help share experience and knowledge. Ms Martin reported that further to the Audit Committee's request for an IT road map, a digitalisation road map was now expected. **Resolved: that the Audit Committee Chair's Report be received and noted.**
394/22	**Urgent & Emergency Care Resilience: Winter Plan 2022/23**
	Mr Hobbs reported the pressures across urgent and emergency care across the Country and the impact on both acute and community services, as well as partner organisations. He said the pressures in winter included the prevalence of infectious diseases and the cost-of-living crisis which may impact on urgent and emergency services and staffing resilience in health and care services. Mr Hobbs said the Trust's Winter Plan outlined the preparation to ensure emergency care services were as resilient as possible in delivering high-quality care. He said the Winter Plan had been developed by the Trust's divisions, community and partner organisations, and included strategic focus on providing care outside the hospital setting where clinically appropriate, strategic focus over the festive period to maximise the number of patients that could safely be discharged over Christmas and New Year. Mr Hobbs reported on three packages of interventions (options 1, 2 & 3) and said that the Performance and Finance Committee (PFC) had endorsed approval of Option 1, however the recommended and preferred option was Option 2. He said the difference in funding between the Options 1 & 2 was c£600K and the Trust had been pursuing funding sources to deliver Option 2 if the additional funding was secured. Ms Martin said that as Option 1 had been recommended by PFC, she was concerned that having completed this process that the Board would approve Option 2. She asked what additional funding was being pursued and assurance that there were any opportunities to receive additional funding. She asked what mitigations were in place to deal with the shortfall should the additional funding not be secured. Mr Hobbs advised there were three potential funding routes being pursued with strong cases to secure income. He advised that majority of the difference between option 1 and 2

	pertained to continuing interventions through March 23 and said there would be opportunity to secure funding before that time. He said that a further paper would be submitted to PFC in January 23 with an executive assessment undertaken of the ability to continue those interventions through March 23. **Action: Mr Hobbs to provide an update at the next Board meeting on the funding for Option 2.** **Resolved: that the Urgent & Emergency Care Resilience: Winter Plan 2022/23 Report be received and APPROVED Option 1.**
VALUE OUR COLLEAGUES	
395/22	**Staff Voice - Divisional Spotlight - Occupational Health**
	Ms Griffiths reported that the People and Organisational Development Committee had received a presentation from Ms Maninder (Manni) Kaur from Occupational Health and introduced Manni to present her experiences. Ms Kaur presented her previous background in cardiac theatres (New Cross Hospital) which she said she had enjoyed but had been ready for change and new challenges. She said she had secured a job in Occupational Health at the Manor Hospital in 2020 and after a year had been offered to study at Derby University for her PG Dip in Specialist Community Public Health Nurse in Occupational Health. Ms Kaur provided an inspirational account of her experience, challenges and achievement and confirmed that she had completed the course and achieved the highest grade and the winner of an Award for Excellence in Occupational Health which she would be collecting in 2023. She said she was grateful to the Occupational Health team for providing her the opportunity and the Board for being able to share her journey. Prof. Field thanked to Ms Kaur for an excellent presentation and wished her well for the future. Board members expressed thanks to Ms Kaur for her inspirational story, her positive energy and her achievements. Mr Mirza said that some of the attributes and qualities that Ms Kaur had spoken about demonstrated approaches applied with clinical leaders in the NHS and suggested that this should be something Ms Kaur should think about within her sector. **Resolved: that the Staff Voice - Divisional Spotlight - Occupational Health Report be received and noted.**
396/22	**Trust Board Pledge - People and Organisational Development Committee Update**
	Ms Griffiths highlighted that the Pledge referred to zero tolerance, being an anti-racist and anti-discriminatory organisation and said that whilst there had been improvements, there was still work to do around cultural elements. Ms Griffiths highlighted the change in data being presented from 2019 to current, and said the organisation had taken a positive interest in staff health and wellbeing which was above the national benchmark. She reported another positive change regarding representations of Black, Asian and Minority Ethnic colleagues at Band 7 and above and the review of all the roles within the Trust to employ from within the Walsall Community. She added there had been a decrease in the number of bullying cases, however this was not a trend. Prof. Field said the representation of high-quality employees from a diverse background was important and the work done on the RACE Code was excellent. **Resolved: that the Trust Board Pledge - People and Organisational Development Committee Update report be received and noted.**

397/22	**People Culture - Towards Excellence in People Management**
	Ms Griffiths said that the report outlined the framework for 'what motivates staff' and 'what had motivated staff to join the NHS'. She said there was more detailed work needed the next step being on organisational development approach. She said the key areas of focus were staff health and wellbeing, diversity inclusion and equality and compassionate leaders. She reported on a joint piece of work with Wolverhampton Trust in relation to behaviours to underpin the values and the Joint Strategy previously approved by the Board. **Resolved: that the People Culture - Towards Excellence in People Management report be received and noted.**
398/22	**Chair's acknowledgement of Ms Glenda Augustine**
	Prof. Field reported Ms Augustine would be retiring at the end of the month from her role as Director of Planning and Strategy. He thanked Ms Augustine for her contribution to the Trust through her unique skill set and strong leadership and said that the Trust had all benefitted from her perception, innovation and commitment to reducing health inequalities. Prof. Field said that Ms Augustine had sadly and suddenly lost her husband, Ray, and thoughts remained with her and her family as they continued to deal with that tragedy. He said colleagues and friends would be gathering at the Trust Headquarters on 18 October 2022 at 11am to wish her well for her retirement.
REPORTS FOR INFORMATION – MINUTES OF COMMITTEE MEETINGS	
399/22	**Quality, Patient Experience and Safety Committee (QPES)**
	The Board Members received, for information, the confirmed minutes of the QPES held in July 2022. **Resolved: that the minutes of the Quality, Patient Experience and Safety Committee held in July 2022 be received for information.**
400/22	**Performance and Finance Committee (PFC)**
	The Board Members received, for information, the confirmed minutes of the PFC held in July 2022. **Resolved: that the minutes of the People and Organisational Development Committee held in July 2022 be received for information.**
401/22	**People and Organisational Development Committee (PODC)**
	The Board Members received, for information, the confirmed minutes of PODC held in July 2022. **Resolved: that the minutes of the People and Organisational Development Committee held in July 2022 be received for information.**
402/22	**Audit Committee Meeting**
	The Board Members received, for information, the confirmed minutes of the Audit Committee held in June 2022. **Resolved: that the minutes of the Audit Committee Meeting held in June 2022 be received for information.**
403/22	**Charitable Funds Committee**
	The Board Members received, for information, the confirmed minutes of the Charitable Funds Committee held in July 2022. **Resolved: that the minutes of the Charitable Funds Committee held in July 2022 be received for information.**
CLOSING ITEMS	
404/22	**Any Other Business**
	Prof. Field noted that there was no other business was raised.

	Prof. Field asked if anyone had questions around the reported case of Mr Shah and there were no questions raised. Mr Wilshere said that if anyone had questions after the board, to send them via the Trust's website to send him an email.
405/22	**Date and time of the next meeting**
	Prof. Field confirmed that the next meeting was to take place on Wednesday 7th December 2022.
406/22	**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 13:02pm**

Walsall Healthcare NHS
NHS Trust
30 November 2022 11:24

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 05/10/2022 15.2 Urgent & Emergency Care Resilience: Winter Plan 2022/23				
542.	Minute Ref: 394/22 - Urgent & Emergency Care Resilience - Winter Plan 2022/23 - Mr Hobbs to provide a further update at the December Trust Board, in particular in relation to Funding for Option 2.	Hobbs, Ned	07/12/2022	Completed
	Explanation Hobbs, Ned Further to additional ICB issued Community funding, Option 2 now confirmed to be covered November 2022.			
485.	Hospital Mortality Report - Mr Dodd to provide a paper to public board on Health Inequalities strategy to the Board in December 22.	Dodd, Matthew	26/11/2022	Completed
	Explanation Dodd, Matthew Paper submitted for Trust Board 07.12.22			
Public Trust Board 05/10/2022 12.2.1 Palliative Care (Goscote Hospice)				
541.	Minute ref: 377/22 - Following Mr Dodd's report on Palliative Care (Goscote Hospital), Prof. Fields said that the Board would arrange for a visit to the Hospital in the near future.	Field, Steve Prof.	08/02/2023	Pending
Public Trust Board 03/08/2022 10.3 Patient Experience (& Complaints Report) - Quarterly Report				
465.	Patient Experience (& Complaints Report) - Prof. Field to arrange a meeting with Mr Perry to discuss the work with Blessed to Bless	Field, Steve Prof.	04/01/2023	Pending
Public Trust Board 03/08/2022 13.1 Staff Voice - Staff Story				
470.	Staff Voice, Staff Story - Acute Oncology Service - Following the presentation to Trust Board, Prof. Field agreed that he and the Non Executive Directors would visit the Acute Oncology Service later in the year.	Field, Steve Prof.	04/01/2023	Pending

Public Trust Board 03/08/2022 10.7 Director of Infection Prevention and Control Report - Quarter 1 Report				
466.	Director of Infection Prevention and Control Report - Prof. Loughton to arrange a walkabout to the wards with Ms Wallett	Loughton, Prof. David	23/12/2022	Pending
Public Trust Board 03/08/2022 10.10 Safeguarding Adults and Children - Quarterly Report				
467.	Safeguarding Adults and Children Quarterly Report - Ms Pickford agreed to share with the Board in December 22, the training package being developed for the Learning Disability Agenda	Carroll, Lisa	07/12/2022	Pending
Public Trust Board 05/10/2022 8 Chief Executive's Report				
540.	Minute Ref: 368/22 - Chief Executive's Report : Mr Stringer to liaise with Ms Rowe to discuss a solution for joint working with other public sectors for the storage of medical record archives	Rowe, Sally Stringer , Kevin	07/12/2022	Pending
539.	Minute Ref: 368/22 - Chief Executive's Report: Prof. Loughton and Mr Stringer to report back to Trust Management Committee on the review of medical records department	Loughton, Prof. David Nightingale, Gayle Stringer , Kevin	07/12/2022	Pending
Public Trust Board 03/08/2022 10.2 Hospital Mortality Report (April – May 2022)				
416.	Hospital Mortality Report - Dr Shehmar to report at the December 22 Trust Board -the feedback on coding and mortality	Shehmar, Manjeet	07/12/2022	Pending

Nolan Principles of Public Life & Trust Values

NHS
Walsall Healthcare
NHS Trust

Committee on Standards in Public Life - Guidance

The Seven Principles of Public Life

Published 31 May 1995

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.*

Principle	*I will show this by*
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.	

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.

MEETING OF THE PUBLIC TRUST BOARD – 7 December 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 no Consultant Appointments since I last reported:
3.0	**Policies and Strategies**
	October 2022 • Policies, Procedures and Guidelines - Quarter 2 Report • CP948 V2 - Engagement with Supplier/Commercial Representatives Policy • GI02 V4 - Standing Orders, reservations and Delegation of Powers and Standing Orders Policy • HR923 V2 - Procedure for Recovery of Overpayments Policy • HR955 V1 - Menopause for Colleagues Policy • HR956 V4 - Raising Concerns at Work (Whistleblowing) Policy • HR957 V4 - The Performance and Development Review (PDR) and Pay Increment Policy • IG005 V8.1 - Information Risk Management Policy • IP950 V6 - Isolation Policy • IP951 V4 - Influenza Policy • IP952 V6 - Safe Handling and Management of Used Linen Policy • IP953 V5 - Management and Control of Norovirus Policy • OP938 V2 - Care After Death Policy • OP939 V4.1 - Budgetary Control and Virement Policy • OP940 V3 - Category II Fees Policy • OP941 V2 - Losses and Special Payments Policy • OP944 V3 - Disposal of Surplus, Redundant and Obsolete Assets Policy • OP949 V1.4 - Inter/Intra Patient Transfer Policy (Adults) • OP962 V3 - Guidance for the Management of Violence and Aggression Interim Policy (6 months review date) • Parenteral Nutrition in Adults Trust wide Guideline – V6 • Managing Relationships at work - Trust wide Guideline - V3 • Child Death - when a child dies SUDIC Management Trust Guideline - V2 • Safe Performance of Peripheral Nerve Blockade: Stop Before You Block Trust wide – Standing Operating Procedure • Water Soluble follow through Trust wide – Standing Operating Procedure **November 2022** • Policies, Procedures and Guidelines - Quarter 3 Report

	• CP935 V1 – Administration of Low Molecular Weight Heparin by Healthcare Support Workers Policy • HR954 V4 – Moving and Handling – Load and People Policy • HR958 V3 – Medical Appraisal and Revalidation Policy • MH960 V1 – Mental Health Act Administration Policy • OP92 V2.1 – Petty Cash Policy • OP959 V11 – Theatre Services Operational Policy • OP961 V3 – Elective Access including Did Not Attend (DNA) Guidance Policy
4.0	**Visits and Events**
	• Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • 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 • 20 September 2022 – chaired the West Midlands Cancer Alliance Board and participated in the Walsall Council Health and Well Being Board • 21 September 2022 - participated in the Regional Cancer Board and Walsall Proud Partnership meeting • 28 September 2022 – participated in the virtual Annual General Meeting (AGM) • 29 September 2022 – met with Pat Usher and Jane Wilson, Joint Staff -side Leads • 3 October 2022 – participated in a virtual NHS Providers - Next steps for the COVID-19 public inquiry webinar • 4 October 2022 - met with Mark Axcell, Chief Executive – Black Country Integrated Care System (ICS) • 6 October 2022 – chaired a virtual staff briefing and presented at a ceremony for the Volunteer Awards • 11 October 2022 – participated in a virtual Deliottes well-led preparation session • 12 October 2022 - participated in a virtual Black Country Collaborative Executive Committee • 13 October 2022 – participated in a National System Leadership event – ICB and Trust Chief Executives with Amanda Pritchard – NHS Chief Executive • 18 October 2022 – undertook a Non-Executive Directors (NEDs) briefing and participated in a virtual West Midlands Acute Provider meeting • 19 October 2022 – participated in a Black Country Provider Collaborative Clinical Summit • 20 October 2022 – chaired the Joint Negotiating Committee (JNC) and participated in The National Guardian for the NHS – Freedom to Speak Up Webinar • 25 October 2022 – chaired the Trust Management Committee (TMC) • 26 October 2022 – met with Professor Ian Campbell, Interim Vice Chancellor – University of Wolverhampton and participated in a National Institute of Healthcare Research Hosting event

	• 27 October 2022 - met with Dr Sonia Ashraf, Deputy Clinical Director – West Midlands Cancer Alliance, met with Dr Helen Paterson, Chief Executive – Walsall Council and participated in a virtual Walsall Council Health Scrutiny meeting • 1 November 2022 – undertook a general site visit including maternity services • 3 November 2022 – undertook a light switch on for Diwali • 9 November 2022 – participated in the opening event for the Care Quality Commission (CQC) – well-led inspection • 10 November 2022 – virtually presented at the Institute of Health and Social Care Management (IHSCM) on organisational collaboration, met with the CQC as part of the well-led inspection and participated in the CQC feedback session • 11 November 2022 – virtually met with Mark Axcell, Chief Executive – Black Country Integrated Care System (ICS) and participated in the Institute of Health and Social Care Management (IHSCM) Executive Advisory Committee • 15 and 16 November 2022 – attended the NHS Providers Annual Conference • 17 November 2022 – virtually met with Dr Helen Paterson, Chief Executive – Walsall Council • 18 November 2022 - participated in a virtual Joint Oversight meeting with the Integrated Care System (ICS) and NHS Midlands
5.0	**Board Matters**
	There were no Board Matters to report on.

MEETING OF THE PUBLIC TRUST BOARD – 7 December 2022			
Chair's report of the Trust Management Committee (TMC) held on 25 October 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 • Midwifery Service Report • Safeguarding Adults and Children 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 • Care Quality Commission (CQC) Update Report • CQC Insight Report • Integrated Quality Performance Report (IQPR) • Trust Financial Position (Revenue and Capital) - Month 6 Report • Finance Strategy Report • Walsall Together Report • Workforce Summary Report • Workforce Metrics Report • Retention and Exit Monitoring Report • Schwartz Round Annual Training 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**
	• Provider Collaboration Report • Quality Improvement Team Report • Sustainability and Green Plan Report • Trust Strategy Report • Revalidation Steering Group Report • Pharmacy and Medicines Optimisation Quarterly Report • Research and Development Report • Urgent and Emergency Care Centre's Capital Build Update Report • Digital Improvement Report • Corporate Risk Register/ Business Assurance Framework Report
5.0	**Business Cases – approved**
	• Business Case to appointment Scheduling Assurance and the Management of the Follow-up Backlog

6.0	**Policies approved**
	• Policies, Procedures and Guidelines - Quarter 2 Report • CP948 V2 - Engagement with Supplier/Commercial Representatives Policy • GI02 V4 - Standing Orders, reservations and Delegation of Powers and Standing Orders Policy • HR923 V2 - Procedure for Recovery of Overpayments Policy • HR955 V1 - Menopause for Colleagues Policy • HR956 V4 - Raising Concerns at Work (Whistleblowing) Policy • HR957 V4 - The Performance and Development Review (PDR) and Pay Increment Policy • IG005 V8.1 - Information Risk Management Policy • IP950 V6 - Isolation Policy • IP951 V4 - Influenza Policy • IP952 V6 - Safe Handling and Management of Used Linen Policy • IP953 V5 - Management and Control of Norovirus Policy • OP938 V2 - Care After Death Policy • OP939 V4.1 - Budgetary Control and Virement Policy • OP940 V3 - Category II Fees Policy • OP941 V2 - Losses and Special Payments Policy • OP944 V3 - Disposal of Surplus, Redundant and Obsolete Assets Policy • OP949 V1.4 - Inter/Intra Patient Transfer Policy (Adults) • OP962 V3 - Guidance for the Management of Violence and Aggression Interim Policy (6 months review date) • Parenteral Nutrition in Adults Trust wide Guideline – V6 • Managing Relationships at work - Trust wide Guideline - V3 • Child Death - when a child dies SUDIC Management Trust Guideline - V2 • Safe Performance of Peripheral Nerve Blockade: Stop Before You Block Trust wide – Standing Operating Procedure • Water Soluble follow through Trust wide – Standing Operating Procedure
7.0	**Other items discussed**
	There were none this month.

MEETING OF THE PUBLIC TRUST BOARD – 7 December 2022			
Chair's report of the Trust Management Committee (TMC) held on 22 November 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 • Midwifery Service Report • Patient Experience – Quarter 2 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 • Care Quality Commission (CQC) Report • Integrated Quality Performance Report (IQPR) • Trust Financial Position (Revenue and Capital) - Month 7 Report • Accountability Framework Report • Walsall Together Report • 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**
	• Provider Collaboration Report • Integrated Care System (ICS) report • Research and Development Report • Urgent and Emergency Care Centre's Capital Build Update Report • Data Security and Protection Toolkit report
5.0	**Business Cases – approved**
	• Business Case for a Joint WHT and RWT Cyber Security Partnership Service
6.0	**Policies approved**
	• Policies, Procedures and Guidelines - Quarter 3 Report • CP935 V1 – Administration of Low Molecular Weight Heparin by Healthcare Support Workers Policy • HR954 V4 – Moving and Handling – Load and People Policy • HR958 V3 – Medical Appraisal and Revalidation Policy • MH960 V1 – Mental Health Act Administration Policy • OP92 V2.1 – Petty Cash Policy

	• OP959 V11 – Theatre Services Operational Policy • OP961 V3 – Elective Access including Did Not Attend (DNA) Guidance Policy
7.0	**Other items discussed**
	There were none this month.

Trust Board Meeting
Committee Chair's Assurance Report

Walsall Healthcare NHS Trust

Name of Committee:	**Performance and Finance Committee**
Date(s) of Committee Meetings since last	**Wednesday 26th October 2022**
Chair of Committee:	**Paul Assinder, Non-Executive Director / Mary Martin, Non-Executive Director**
Date of Report:	**Wednesday 26th October 2022**

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	**Financial Position 2022/23** **Revenue** • The Trust has a £2.8m deficit and is £5.4m adverse to the revenue plan at month 6. • Forecast in August on run rates evidences an annual outturn of a deficit of c£8.7m • The revenue position at Month 6 YTD across the ICB shows a £42m deficit (£34.6m adverse to plan). This position contains risk for the Trust as a risk share arrangement has been agreed between the partners within the ICB. • BCWB ICS is an outlier regarding financial performance for 2022/23 (of the 11 systems) with potential regulator intervention and escalation to level 4 within the Operating Framework • Efficiency and Cost Improvement Programme are behind on delivery of the level of savings needed to attain plan, with schemes rated as red risk • Temporary staffing costs remain high and require significant reduction to deliver within planned run rate. **Capital** • The Trust is yet to secure resources to support essential theatres reconfiguration and upgrade works, this presents a risk to breach of capital resource limit at close of the financial year (ICS & NHSE slippage has been bid for). It was noted the Trust was to progress the purchase of the Mako Robot also bid for from slippage on national and local allocations. **Performance Issues** • The Trust continues to have strong ambulance handover times. However, challenges remained in cardiac Physiology and endoscopy.
ADVISE **Areas that continue to be reported on and / or where some assurance has been noted / further assurance sought**	**Financial Performance** • Re-forecast will be presented to the Performance and Finance Committee in November 22 and will progress through to Trust Board in December 22. **Performance** • The Community Services Division has bid for additional resources for virtual wards. A confirmation of the bids totaling in £1.7m was confirmed • Emergency performance remained strong relative to system performance • Breast Cancer service has remained stable following additional actions with the main being an increase in Breast capacity.

	Procurement Update • The current 2022 / 23 total forecast Procurement related savings position when cost avoidance from expected inflation is taken into consideration is £1,464,7572.68% of influenceable spend. • There is wider Procurement Collaboration across the Staffordshire & Stoke-on-Trent and Black Country Integrated Care Systems (ICS's) • 3 posts out of 20 based at Walsall out to advert. Recruitment remains a challenge. Temporary medical Staffing spend • The Committee received an agency update on medical agency workforce. • Concern was raised over the cost of back filling consultants posts with locums due to multiple individuals having restrictions on their practice or being excluded pending due process.
ASSURE **Positive assurance & highlights of note for the Board / Committee**	**Capital & Cash** • The Trust has delivered two theatres full upgrade's, four ward refurbishments and continues to conclude work on the development to open in year the new Emergency Department. • The Trust has a strong cash position for the 2022/23 financial year. **Performance** • Performance on the 62-day standard was better than the West Midlands and National average • Members received assurances over elective care performance, noting that the diagnostic performance was within the upper third, with the key concern the continued increase in emergency care referrals.
Recommendation(s) for the Board	Board to note: • Members approved the Finance Enabling Strategy. • Members approved the revised Efficiency Terms of Reference.
Changes to BAF Risk(s) and TRR Risk(s) agreed	The BAF would be re-aligned following the implementation of the Organisations new Strategic Objectives. It was agreed that SO 03, Working with Partners was no longer a strategic risk.
ACTIONS Significant Follow Up	A forecast model is to be produced for next Committee, indicating mitigations following engagement with the Operational teams on future run rate and mitigations to cost overruns, results to be presented to Trust Board in December 22. A clear focus will be placed on the temporary workforce use by Medical and Nursing colleagues.
ACTIVITY SUMMARY	As stated above
Matters presented for information	BAF and CRR relative to committee and business cycle
Future Work Plans	Forecast outturn to 30th November Committee meeting
Items for Reference	Not applicable

Trust Board Meeting
Committee Chair's Assurance Report

Walsall Healthcare NHS Trust

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

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	**Financial Position 2022/23** **Revenue** • Month 7 Year to date the Trust is £6.544m adverse to the revenue plan. The Trust is reporting a £3.583m deficit. • The revenue position at Month 7 YTD across the ICB shows a c£49m deficit which is c£45m adverse to plan. This position contains risk for the Trust as a risk share arrangement has been agreed between the organisations of the ICB. • BCWB ICS is an outlier regarding financial performance for 2022/23 (of the 11 systems in the Midlands) with potential regulator intervention and escalation to level 4 (mandatory intervention). The regional team have asked for an update on the BCICB position with further work before Christmas. • Temporary staffing costs remain high and require significant reduction to deliver within planned run rate. Agency costs are forecasted to decrease. **Capital** • The Trust is yet to secure resources to support essential theatres reconfiguration and upgrade works and funding for a Mako Robot, this presents a risk to breach of capital resource limit at close of the financial year • The Trust has bids with NHSE for funding of both the theatres and Mako Robot. A response is expected soon. • However, the BCICB is also forecast to have slippage in the programme and Walsall could receive additional funds through that route. • Due to the new Emergency Department opening later than originally planned, there is the potential of slippage in the capital programme. Funds could be realigned to the Mako Robot if bids were unsuccessful • There is a pressing need for a new Endoscopy stack and the capital programme is being reviewed to accommodate this at the earliest opportunity. • PF Committee has requested a revised detailed capital programme. **Performance Issues** • The Trust continues to have strong ambulance handover times. Members expected to see an improvement on the Breast pathway with the practitioner expected to be running their own clinics by January 2023.
ADVISE **Areas that continue to be reported on and / or where some**	**Financial Performance** • A re-forecast of outturn deficit was presented to Committee and it was agreed to be discussed further at the December 2022 Private Trust

assurance has been noted / further assurance sought	Board. It was noted that there had been ICB Chief Executive level discussions since the forecast paper had been produced and the product of these discussions will form the basis of the Board's decisions about submitting a revised outturn plan to NHSE. **Performance** • Emergency performance remains strong relative to system peers and despite 154 out of area conveyances in October. • 62 Day Cancer care continues to improve at 67.6% in October and recovery continues to be amongst the strongest locally. • Diagnostic waits in cardio physiology, endoscopy and breast cancer care are being carefully monitored and good quality recovery plans are in place. **Digital Strategy** • The strategy aligns with local strategic drivers and mandated national drivers for Digital Maturity that the trust is expected to achieve by the end of 24/25 financial year. Following completion of the Minimum Digital Foundation digital maturity assessment the trust has been provisionally allocated £7.8 million over the next 3 years to support delivery of the core EPR functionality that underpins this strategy. • Members approved the strategy but requested further risk context prior to it being progressed to Trust Board.
ASSURE **Positive assurance & highlights of note for the Board / Committee**	**Capital & Cash** • The Trust has delivered two ward upgrades in year and has refreshed key medical equipment despite supply chain challenges. The Emergency Department remains on target for the revised handover date. • The Trust has a strong cash position for the 2022/23 financial year. The Committee requested more detailed working capital modelling to be presented at its next meeting. **Performance** • Performance on the 62-day standard was better than the West Midlands and National average. • Members received assurances over elective care performance, noting that the diagnostic performance was within the upper third, with the key concern the continued increase in emergency care referrals. **Backlog Maintenance** • Latest survey indicated that 78% of assets were at Category B with a further 20% included in plans to restore to B in the next 5 years. • The current estimated cost to restore assets to Category B is c£1.9m, with no significant risks reported. **Emergency Preparedness (EPRR)** • NHSE validation of our self-assessment of EPRR has confirmed a 'partially compliant' status. **Business Case for validation of OP Pathways** • Business case for £179,000 to fund a validation exercise, was approved.
Recommendation(s) for the Board	**Board to note:** • Members approved the Digital Strategy but requested more risk context to be included ahead of progressing to Trust Board in December 2022. • Members approved the Appointment Scheduling Assurance and the Management of the Follow Up Backlog Business Case.
Changes to BAF	Members noted there was a draft cyber attack risk and would be brought to the

Risk(s) and TRR Risk(s) agreed	next meeting in January 2023.
ACTIONS Significant Follow Up	A clear focus will be placed on the temporary workforce use by Medical and Nursing colleagues.
ACTIVITY SUMMARY	As stated above
Matters presented for information	BAF and CRR relative to committee, Emergency Department New Build and business cycle
Future Work Plans	Nursing Temporary Workforce paper to be brought to the January 2023 Committee and Medical Temporary Workforce to be presented at the February 2023 meeting.
Items for Reference	Not applicable

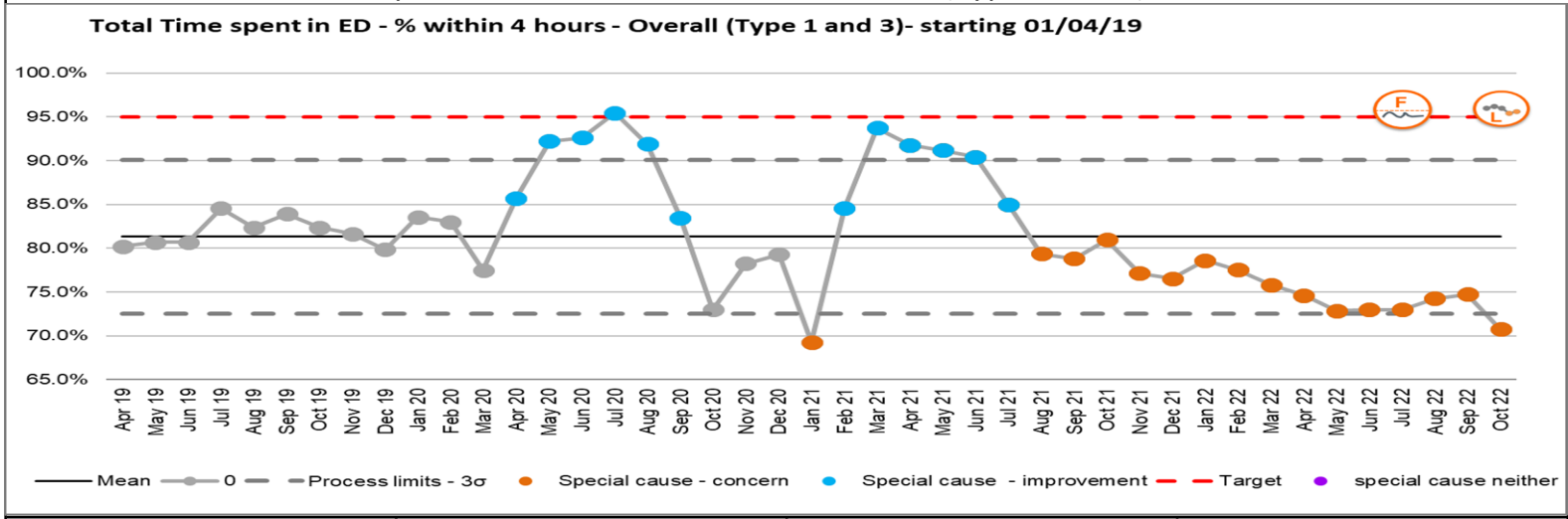
Walsall Healthcare NHS
NHS Trust

P&FC

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
PERFORMANCE & FINANCE COMMITTEE							
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Oct-22	58.96%	59.87%	92.00%		
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	Oct-22	1367	990	0		
%	Ambulance Handover - Percentage of clinical handovers completed within 30 minutes or recorded time of arrival at ED	Oct-22	86.59%		95.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment	Sep-22	74.41%		93.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	Sep-22	9.43%		93.00%		
%	Cancer - 62 day referral to treatment from screening	Sep-22	78.26%		90.00%		
%	Cancer - 62 day referral to treatment of all cancers	Sep-22	67.65%		85.00%		
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnositc Test	Oct-22	17.73%		1.00%		
%	Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)	Oct-22	70.76%	74.00%	95.00%		
%	Locality Teams - % of Hours Demand Unmet	Oct-22	14.54%		20.00%		
Ave	MSFD - Average number of Medically Fit for Discharge Patients in WMH	Oct-22	51		50		
%	Rapid Response - 2 Hour Response Rate	Oct-22	93.63%		95.00%		

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
%	Rapid Response - % Admission Avoidance	Oct-22	90.17%		87.00%		
£	Total Income (£000's)	Oct-22	31225	See Financial Performance for further detail			
£	Total Expenditure (£000's)	Oct-22	31961	See Financial Performance for further detail			
£	Total Temporary Staffing Spend (£000's)	Oct-22	3655	See Financial Performance for further detail			
£	Capital Expenditure Spend (£000's)	Oct-22	3335	See Financial Performance for further detail			

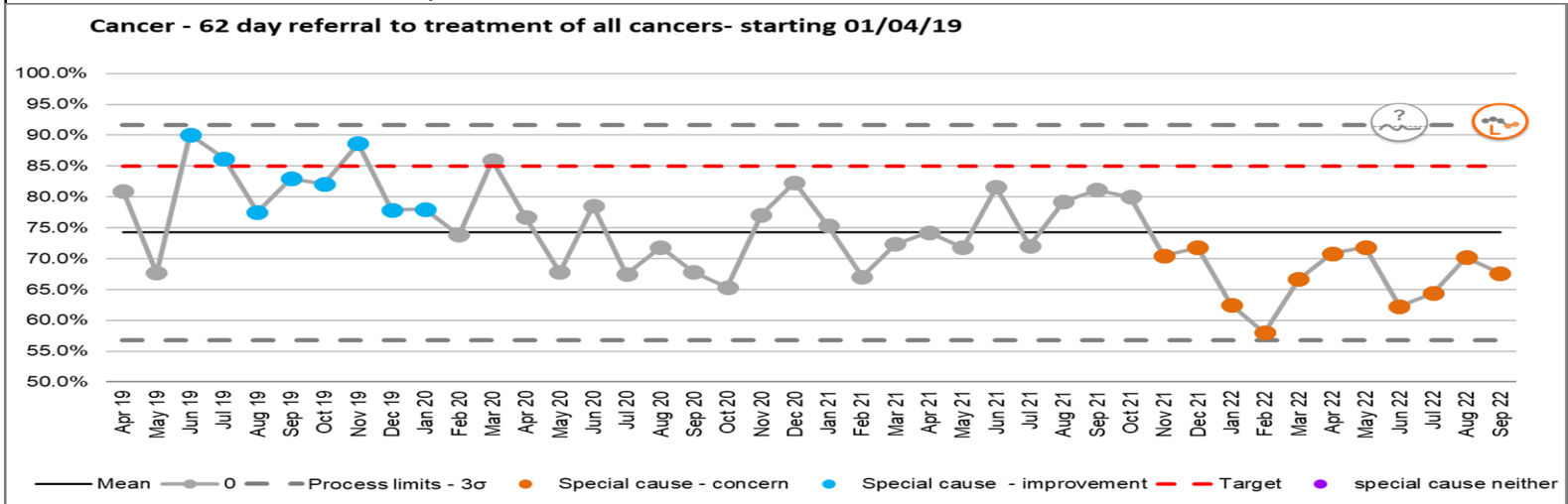
Metric Name: Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)



Month
Oct-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, performance continues to be lower than average (15 data points). October reported performance is 70.76%. Urgent and emergency care remains under significant pressures, the forecast month end performance for November is expected to improve.	Pressures continue across the urgent and emergency care pathway. Type 1 attendances remain high at 8396. The Trust received 154 out of borough ambulances intelligently conveyed to Walsall in October.	Pathway development to schedule GP patients in UTC to support AEC admissions. Implementation programme for the ED Emergency Decision Unit signed off. Recruitment progressing with 4 new Middle Grade posts advertised.	WHT's national ranking was 32nd out of 110 Trusts in October. The Trust's UEC resilience Winter Plan approved by Trust Board in October commenced in November.

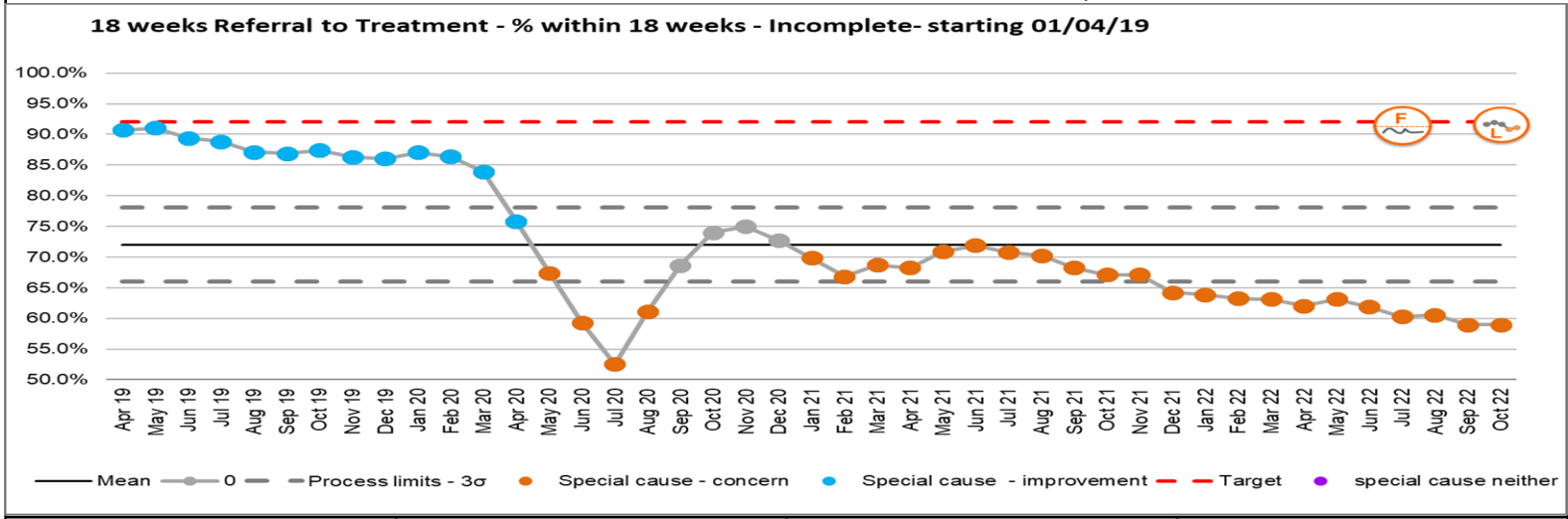
Metric Name: Cancer - 62 day referral to treatment of all cancers



Month
Sep-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	There remains statistical special cause concern with 11 data points below average. September's performance shows a performance level of 67.6%. In September 2022, for 62-day Cancer performance the Trust was materially better than the West Midlands average (49.2%) and the national average (60.5%)	Suspected Breast Cancer and Breast symptomatic outpatient waiting times have been challenged for some months Urology has seen a deterioration in performance. Access to timely endoscopy & urgent histopathology results.	Increase breast capacity: additional rapid access clinics (with Your Medical Services), circa 150 appointments. Closer monitoring of Urology PTL. Endoscopy supported by YMS insourcing. Additional funding from the Cancer Alliance to support increased activity.	The Trust has received support for significant expansion Medical Oncology service and will be recruiting to Consultant, ACP and Pharmacist positions to support clinical and MDT cover on a 52 week basis. Reintroduced reminder calls to Breast appointment patients. 3 navigators have been recruited.

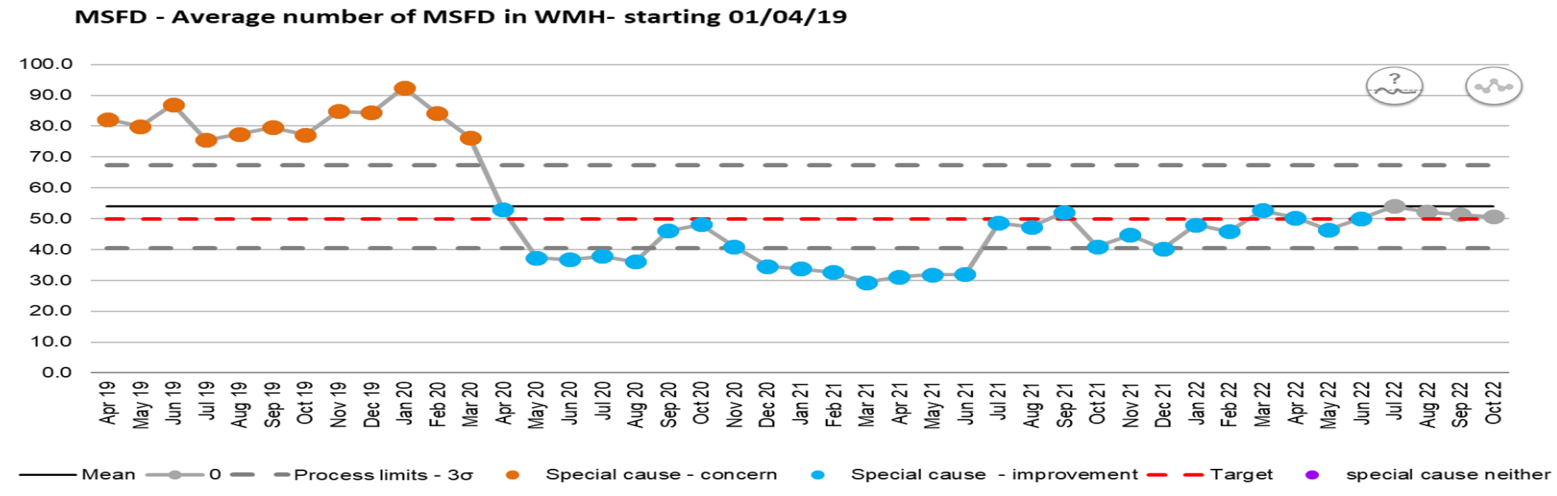
Metric Name: 18 weeks Referral to Treatment - % within 18 weeks - Incomplete



Month
Oct-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 statistical special cause concern. In October, performance is below the trajectory at 58.96%. There were no 104 week incomplete breaches. The national ranking position is 74th (out of 120 Trusts) for September 2022	There has been an increase in the number of dropped sessions during October due to issues around non contractual pay rates, particulraly for Anaesthetists. Anaesthetic Consultant vacancies are 3.8wte. October 2022 has seen an increase in on the day cancellations from last month	Text validation and telephone contact with patients is planned in November for those patients who will wait beyond 52 weeks by 31/03/2022. Patients will be managed in line with the Trust's Elective Access Policy. Issues around pay are being addressed with Exec Team decision re WLI rates due 29/11/22	Recently approved business cases: Theatres & Anaesthetics General Surgery T&O Extensive validation and review of non-admitted pathways continues, with a text validation exercise planned for November

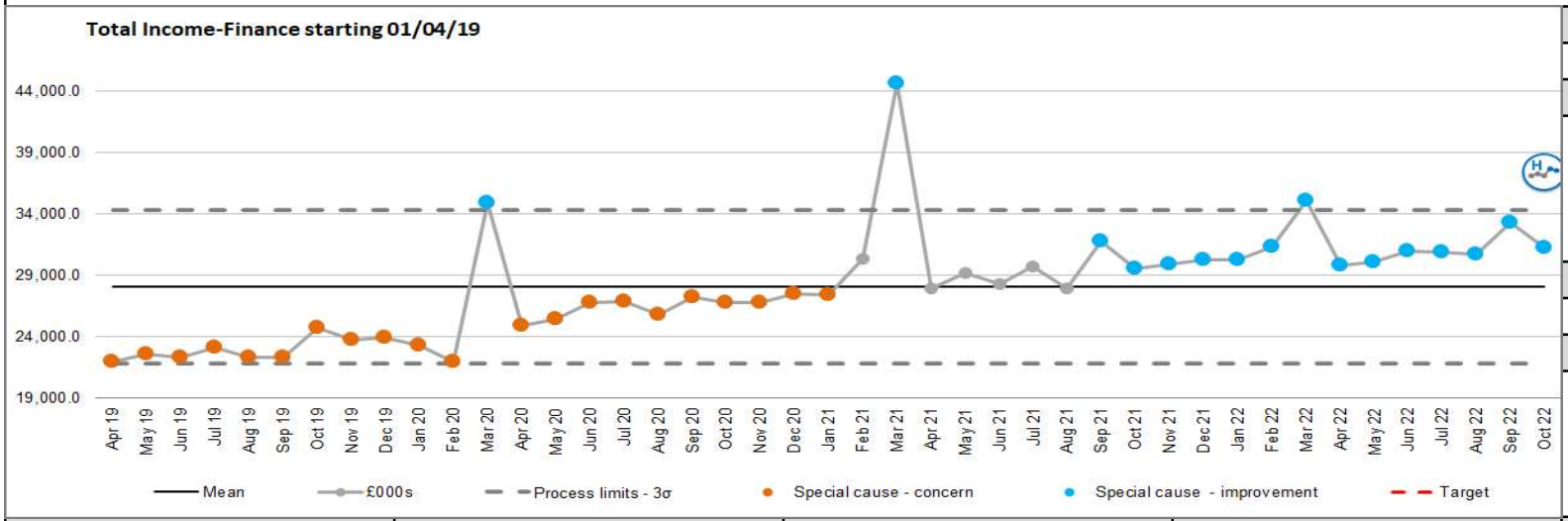
Metric Name: MSFD - Average number of MSFD in WMH



Month
Oct-22
Variance Type
Common Cause - No Significant Change
Target
50
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
The number of medically stable for discharge patients (average). These are patients who do not need hospital bed for their acute management (ICS pathways 1-4)	The Service delivered a strong performance in October 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. The Length of Stay however improved in month from an average of 4.6 days in September to 4 days in October.	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.

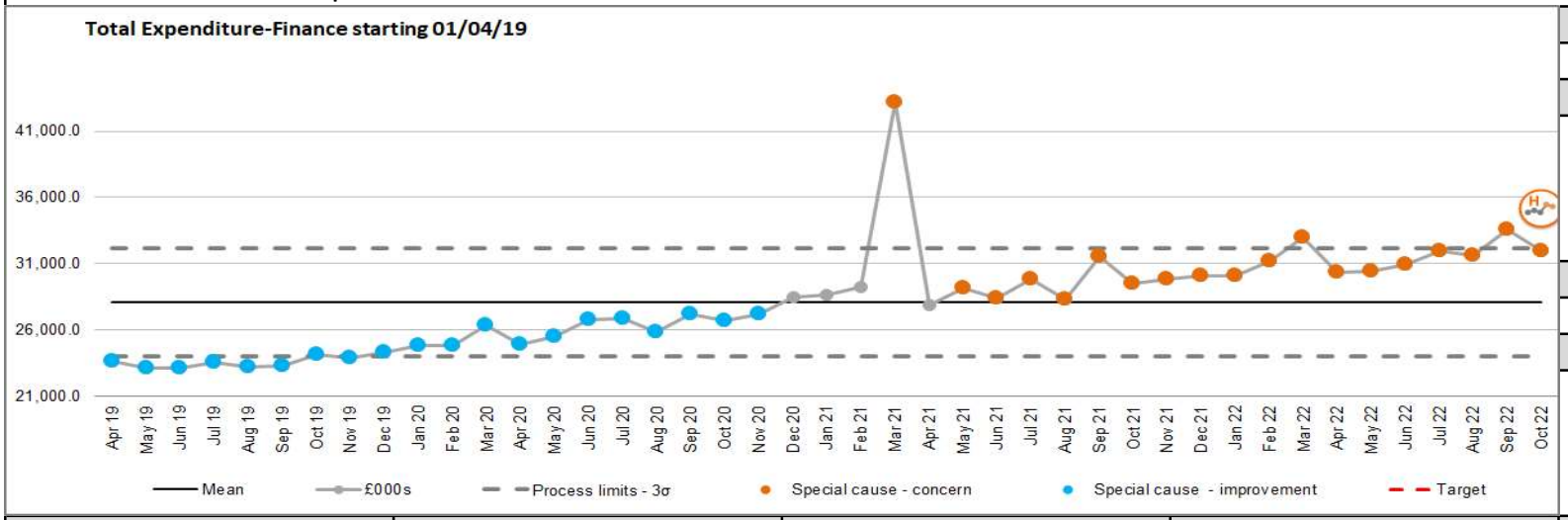
Metric Name: Total Income



Month
Oct-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. Covid 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 funding to be managed to secure as much income as possible to support the Trust planned delivery of breakeven for the financial year.

Metric Name: Total Expenditure

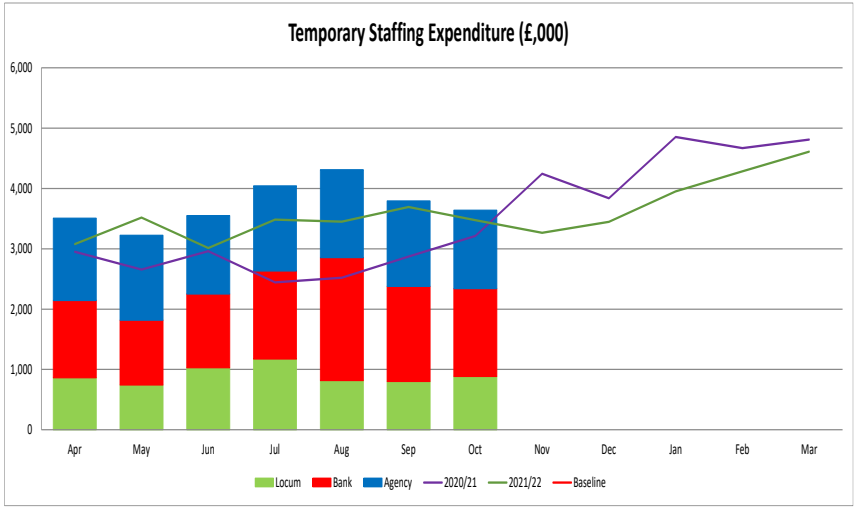


Month
Oct-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
Target Achievement

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	Delivery of the 2022/23 efficiency target of £6.3m. The Trust to move back into more 'normal' business, with a requirement for efficiency attainment, removal of agency usage and cessation (where safe to do so) of COVID designated expenditure

Financial Performance to October 2022 (Month 07)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Subtotal Income	**216,403**	**217,012**	**609**
Subtotal Pay Expenditure	**(139,956)**	**(144,473)**	**(4,517)**
Subtotal Non Pay Expenditure	**(66,939)**	**(69,650)**	**(2,712)**
Subtotal Finance Costs	**(6,659)**	**(6,641)**	**17**
Total Surplus / (Deficit)	**2,849**	**(3,752)**	**(6,602)**
Donated Asset Adjustment	111	169	**58**
Adjusted Surplus / (Deficit)	**2,961**	**(3,583)**	**(6,544)**



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.
- The 2022/23 financial plan requires the trust to move back into more 'normal' business, with a requirement for efficiency attainment, removal of agency usage and cessation (where safe to do so) of COVID designated expenditure.
- In accordance with national planning guidance, the Trust submitted a Board endorsed financial outturn of a £7.6m deficit in April 2022, system deficit for the Integrated Care System (ICS) being c£48m.
- The regulator required a further national round of planning following release of additional funds. The Trust re-submitting the financial plan for the 2022/23 financial year from the £7.6m deficit to break-even, as endorsed through the Extraordinary Performance and Finance Committee on the 17th of June 2022
- In month 7 the Trust reported a £0.736m deficit, which is £1.097m adverse to plan. This was driven by higher than planned temporary staffing costs and non achievement of CIP plan, both elements remaining a risk to delivery.
- The Trust is now forecasting a £6.7m deficit as the most likely forecast but ongoing discussions are taking place with the ICB.
- Walsall is reporting 91.4% YTD ERF performance against a target of 104%. This is in line with other local providers. Sept in month was 91.5%.

Capital

- The approved programme for the year includes the Emergency Department, ward refurbishment and theatres 1-4 upgrades
- Capital expenditure totals £19.6m YTD. This is against an annual programme of c£38m though the Trust is still to secure the capital resources required to finance the theatres case of £4m for the 2022/23 financial year (the scheme continuing into 2023/24).

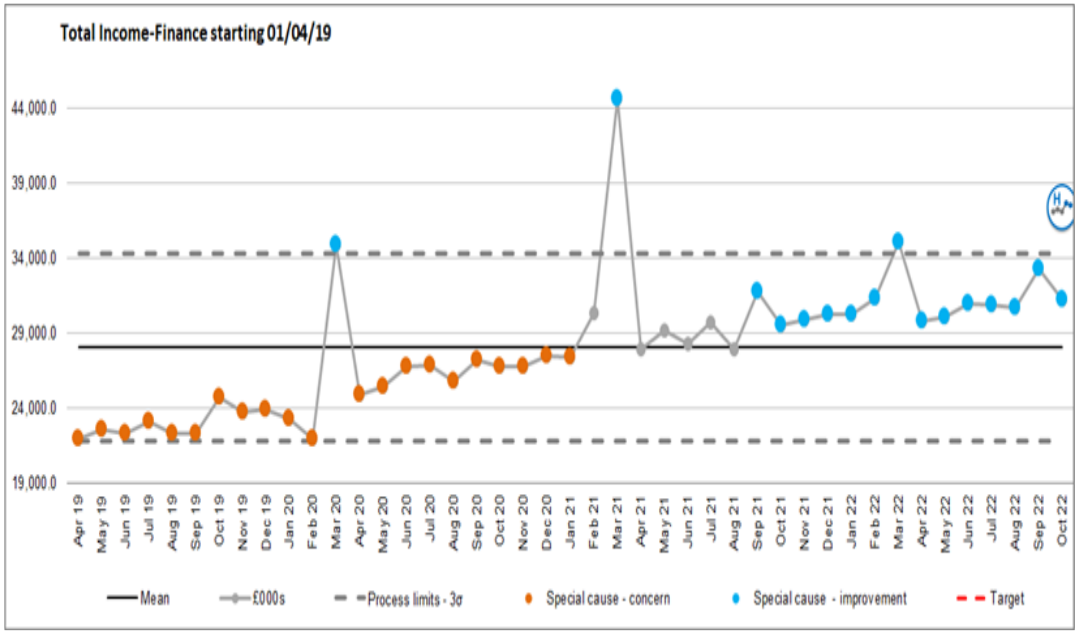
Cash

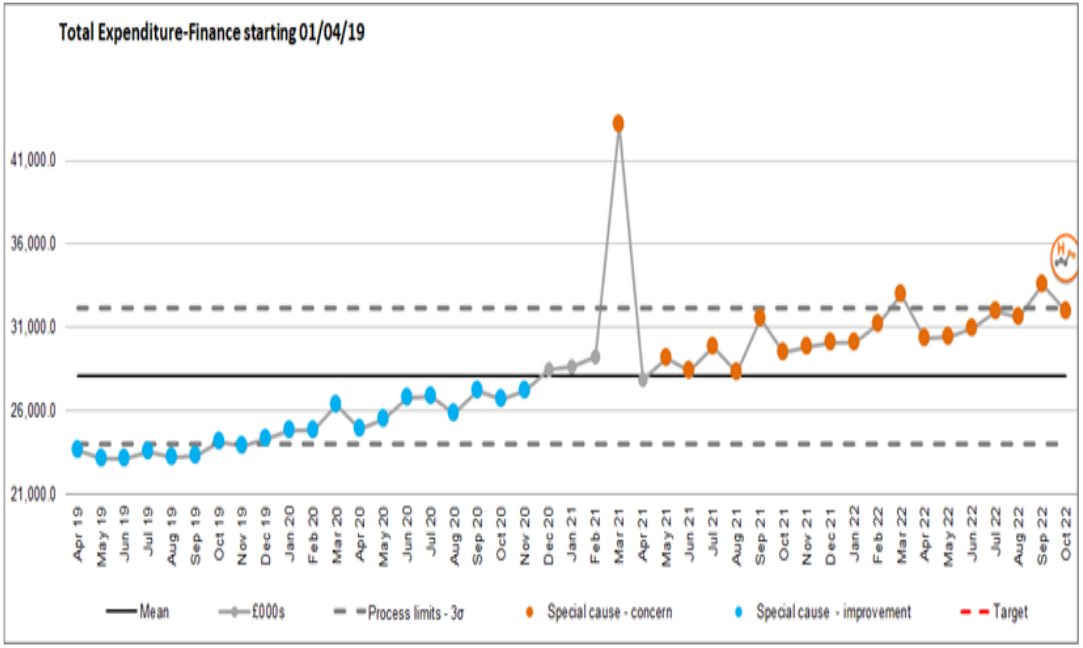
- The Trust continues to have a strong cash position which is sufficient to support a planned revenue deficit plan and the programmed capital expenditure

Efficiency attainment

- The Trust has an annual efficiency target of £6.3m, against which a plan of £6.04m (of which some schemes are rated as red) has been identified, leaving a planning gap of £0.3m.
- YTD performance has been £2.9m against a plan of £2.9m which reflects the plan phasing, if delivered equally through the year the target to date would have been £3.7m.

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 20 there will no longer be retrospective top up funding received, block income has been agreed based on operation run rates.
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.
- In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment.
- The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears.

Expenditure additional information

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

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	28th October 2022
Chair of Committee/Group:	Dr Julian Parkes
Date of Report:	28th October 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• 2 week wait for suspected breast cancer and symptomatic breast pathways continue to challenge. Only 8.18% of patients were seen within the 2 week window in August 2022. Booking times in September are around 18 days. Mutual aid from surrounding Trusts and mitigations are being applied • The national shortage of Health Visitors continues to be reflected locally with a 50% vacancy rate and this is affecting service provision • Utilisation of beds in discharge pathways and amount of equipment have both increased beyond the level of funded expenditure • Stage 2 Mental Capacity Act compliance shows an improvement to 38.46%. Work continues in this area • Prevalence of timely observations is slowly climbing to 80.63% • VTE Compliance remains below target at 92.55 % • Level 3 children's and adult's safeguarding remains below target. Additional training is being provided • Two priority 7 day service standards were not met, standard 2 (first consultant review within 14 hours) – 60%, target 90% and standard 8 (ongoing consultant review, all patients reviewed every 24hrs) – 75.5%, target 90% • 6 cases of Clostridium Difficile were reported in September 2 of which were deemed avoidable. Overall performance is now above trajectory • Significant work underway following Section 29A warning notice for medicines management
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Challenges to Cardiac Physiology (CP) investigations and Endoscopy waiting times due to increased referrals and also sickness and vacancies in the case of CP • One hour antibiotic times for sepsis were achieved in 78.29% in ED and 82.46% inpatients in September. For Paediatrics the one hour antibiotic time was 47.37% • The 18-week RTT performance remains in line with trajectory (58.94% of patients wait less than 18 weeks). Nationally those waiting more than 52 weeks are rising and this is the case with WMT. It remains 9th best in Midlands out of 20 Trusts • Falls per 1000 bed days was 5.12 in July and 3.85 in August (June 3.68%) • Staffing in maternity continues to a challenge with rising maternity leave. There have been 14 WTE new starters • There are currently 181 overdue incident actions

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Ambulance hand over times continue to be the best in the West Midlands • 74.25% of patients were managed within 4 hrs in ED, making it 25th out of 109 reporting Trusts in the West Midlands. • 70.2% of patients are seen within the 62 day performance target for cancer, which is better than both West Midlands and national performance • Performance remains strong in the Community Based Hospital Avoidance and Step Up bed service. Winter Plan funding has been secured to expand capacity until April 2023 • Virtual Ward development funding has been allocated to offer pathways for Acute Respiratory Infection, Hospital at Home, Heart Failure and Frailty • Falls per 1000 bed days was 3.4 in September
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 • Constitutional Standards and Acute Services Restoration and Recovery • Community Services Report • Safe High Quality Care Oversight report • Maternity Services update • Serious Incident Update • Safeguarding update • VTE Audit Report • 104 day harm update • CQUINs update
Matters presented for information or noting	
Self-evaluation/ Terms of Reference/ Future Work Plan	• Terms of Reference received
Items for Reference Pack	•

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	25th November 2022
Chair of Committee/Group:	Dr Julian Parkes
Date of Report:	26th October 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Following the Section 29A Notice for Medicines Management, assurance has not yet occurred to show improved practice and adherence to change • The Trust is at risk of prosecution if the Section 29A notice is not complied with by 31st December 2022 • 2 week wait for suspected breast cancer and symptomatic breast pathways continue to challenge. Only 5.81% of patients were seen within the 2 week window in September 2022. days. Mutual aid from surrounding Trusts and mitigations are being applied • The national shortage of Health Visitors continues to be reflected locally with a 50% vacancy rate and this is affecting service provision • 7 cases of C Diff were reported in October. Performance is now above trajectory • Work continues to understand the issues with MCA reporting and a change is now being made to how the data is collected • Prevalence of timely observations is now 80.13% . There is a variation in Divisions • VTE Compliance remains below target at 91.13 % • Level 3 children's and adult's safeguarding remains below target. Additional training is being provided • 17 Structured Judgement Reviews are currently outstanding. 5 sets of notes are currently unobtainable
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Challenges to Cardiac Physiology (CP) investigations and Endoscopy waiting times due to increased referrals and also sickness and vacancies in the case of CP • Overall Trust performance for diagnostics has improved from 22.7% to 17.7% of patients waiting for more than 6 weeks • One hour antibiotic times for sepsis were achieved in 77.81% in ED and 80.17% inpatients in September. This is in line with national performance. For Paediatrics the one hour antibiotic time was 39.47% • Staffing in maternity continues to a challenge with rising maternity leave. Recruitment continues • There are currently 217 overdue incident actions

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Considerable work is being done to ensure compliance with the Section 29A notice in Medicine Management • Ambulance hand over times continue to be the best in the West Midlands • 70.8% of patients were managed within 4 hrs in ED, making it 32nd out of 109 reporting Trusts in the West Midlands. • Falls per 1000 bed days was 3.3 in October – it has been below 6.6 for 28 months • 67% of patients are seen within the 62 day performance target for cancer • Performance remains strong in the Community Based Hospital Avoidance and Step Up bed service. Winter Plan funding has been secured to expand capacity until April 2023 • Summary Hospital-level Mortality Indicator (SHMI) is 0.995 and within the expected range for the year to June 2022 • Excellent response times for maternity triage calls. 87.9% answered with an average wait time of 2 mins
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 • Constitutional Standards and Acute Services Restoration and Recovery • Community Services Report • Safe High Quality Care Oversight report • Maternity Services update • Serious Incident Update • Safeguarding update • VTE Audit Report • 104 day harm update • Medicines Management 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	Oct-22	7	2	27	?	
No.	MRSA - No. of Cases	Oct-22	0	0	0	?	L
%	VTE Risk Assessment	Oct-22	91.12%		95.00%	?	
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Adults	Oct-22	77.81%		90.00%	F	H
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Paeds	Oct-22	39.47%		90.00%	F	
No.	Falls - No. of falls resulting in severe injury or death	Oct-22	2	0	0	?	
Rate	Falls - Rate per 1000 Beddays	Oct-22	3.30	6.10	6.10	?	
No.	National Never Events	Oct-22	0	0	0	?	
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	Oct-22	3				
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Oct-22	0				
Rate	Midwife to Birth Ratio	Oct-22	29.4	28	28	?	
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	Oct-22	15				
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	Oct-22	6				

Metric Name: Clostridium Difficile - No. of Cases

MONTH

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

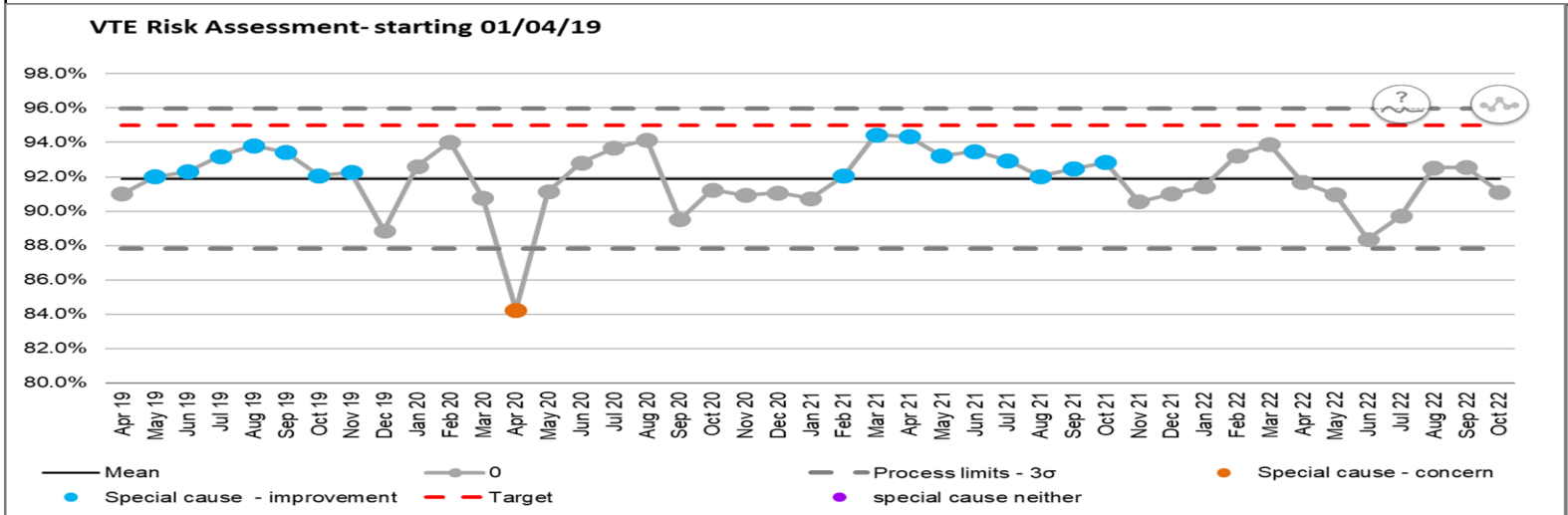
CUMULATIVE

	Actual	Traj.
Apr	0	2
May	1	4
Jun	5	6
Jul	6	8
Aug	8	10
Sep	14	12
Oct	21	14
Nov		16
Dec		18
Jan		21
Feb		24
Mar		27

Month
Oct-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
27
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Minimise rates of Clostridium difficile The Trust target for 2022/23 has been set by commissioners as 27.	There were 7 cases reported in October taking the year to date to 21, this is over the trajectory of 14.	7 cases of Clostridium Difficile toxin were reported in October 2022. Overall performance year to date is now above trajectory.	Root cause anaylsis have been undertaken and lessons learnt within the clinical areas.	N/A

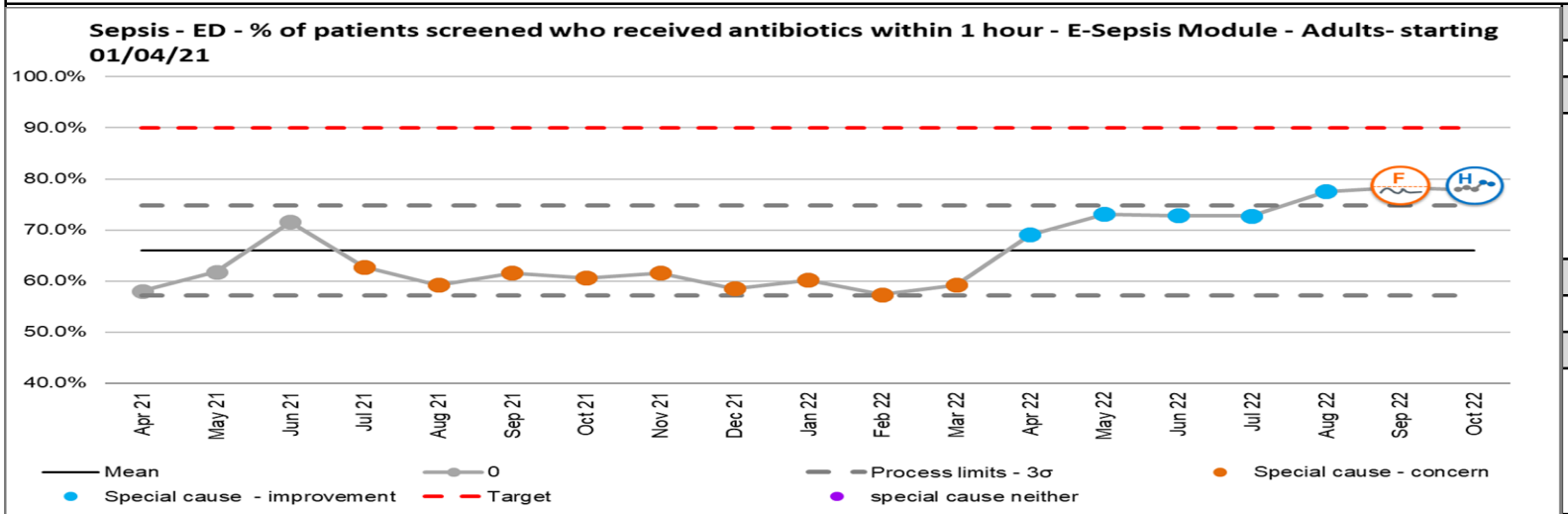
Metric Name: VTE Risk Assessment



Month
Oct-22
Variance Type
Common Cause - No Significant Change
Target
95.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
VTE risk assessment: all adult inpatient Service Users undergoing risk assessment for VTE (agreed cohorts applied)	Performance remains below the target of 95% and within normal variation. October reported 91.13% dropping below the average 92%.	The timeliness of completing the initial assessments continues to be the main issue. Monthly reports continue to be sent to Divisions, in addition to the daily reporting to consultants.	Audits have shown a number of process and IT issues which are now being worked through in QI projects.	Hospital acquired thrombosis (HATS) are reported on Safeguard and discussed at Divisional Quality Boards. HATS are also reported to the Thrombosis Group and each Division continues to report on the outcome of investigations.

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



Month
Oct-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
Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis (Adults)	The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department in October 2022 was 77.81%. The data shows improving statistical variation and has been above the mean for the last 7 months.	The previously reported concerns regarding the accuracy of the E-sepsis data have been resolved with validation of data from the Sepsis team. Focus on staff training.	The PBI report has been refreshed to focus on the Antibiotics within the hour. Training on vitals to be refreshed. Sepsis performance is now reviewed via the newly formed deteriorating patient group.	The sepsis team reviews all open sepsis assessments on vital pac ensuring they are closed down when appropriate. They are also responding to sepsis alerted patients. Results are comparable with high perfoming trusts.

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	People and Organisational Development Committee
Date(s) of Committee/Group	Monday 24th October 2022 and Monday 28th November 2022
Chair of Committee/Group:	Junior Hemans
Date of Report:	29th November 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	Workforce Metrics • The Trust retention rates, and turnover rates continue to show an adverse trend with the Trust 24-month retention rate at 80.2% - this is 2 percentage points down on last year, with work-life balance now the most prevalent reason for voluntary resignations. Turnover is increasing amongst colleagues aged 56 – 60, up 4% since March 2022 (12%). • Reductions in long-term sickness have been offset by a spike in winter illnesses. Cases of Cold, Cough, Flu – Influenza have doubled since Sep-22. • The Winter vaccination rates remain low, the uptake rate amongst substantive colleagues for 22/23 influenza immunisation was 16.3%. Uptake of the 22/23 Covid-19 booster stood at 15.8%. • Mandatory training compliance remains stable, with the Safeguarding Adults Level 3 (79%) and Adult Basic Life Support (66%) competencies key outliners. • Annual appraisal compliance has begun to consolidate above the 80% average.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The Guardian of Safe Working report was received, and committee heard that the Junior Doctor forums and work schedules for Medicine and Long-Term Conditions Division and for the Division of surgery had provided assurance that concerns are being addressed. A sufficient handover has taken place with the new Guardian of Safe Working and the chair of committee thanked Miss Naqvi for her contributions as Guardian of Safe Working. • The committee approved the Library and Knowledge Service Delivery Plan 2022 – 2025. • The committee were pleased to note that the Trust's BAME Council won the Outstanding Staff Network Award and Sabrina Richards, Head of Talent, Diversity and Inclusion won the Changemaker of the year award at the recent NHSE Midlands Inclusivity and Diversity Awards, held during November 2022. • The committee heard a staff voice story from the physiotherapy team and noted the various learning from recent changes to the service. • Following the recent board development session relating to retention, the committee noted and approved and recommended the following pledge: 1.) The Trust Board values work life balance for all and advocates good flexible working arrangements. A good flexible working arrangement is one that provides greater choice in when, where and how individuals work whilst balancing individual needs with patient experience, service delivery and work life balance of colleagues. Flexible working arrangements support high levels of retention, improves, and includes engagement and is core to effective talent management. • The Quarterly Freedom to Speak Up report was received by committee for reference.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The recruitment to full establishment for nursing and midwifery is on target and 230 nurses from the International Recruitment program have now arrived in the Trust, with 135 now registered with the Nursing and Midwifery Council. The current vacancy rate is 8%. In addition, 35 Student Nurses qualified in September 2022 and have been accepted into roles across the Trust with another one member of staff due to commence employment in January 2023. • The committee received an update on the progress with Schwartz rounds within the Trust, noting that Dr Esther Waterhouse is the Clinical Lead for Schwartz and 88% of those attending a round would recommend attendance to a colleague. • The committee welcomed the Leadership and Talent Management report, welcoming the collaborative approach and agreeing to receive further assurance updates on delivery plans. The committee expressed satisfaction with the Learning and Development opportunities offered and noted positive feedback from junior clinical colleagues. The committee commissioned a spotlight report on career opportunities and further work on promoting the learning and development offer to raise awareness. • The committee chair noted with concern ongoing cultural and racial abuse cases evidenced from a recent event attended. The committee emphasized the need to support the Clinical Fellows and noted there is a live survey aimed at capturing staff experience, along with face-to-face meetings arranged to take place in clinical areas to assure staff. There are some positive reports emerging through staff side networks, however poor and negative experiences are still evident. The committee resolved to receive an update report on the survey results and on the work taking place on the Behavioral Framework supporting the joint Trust Strategy. • The committee welcomed a report on Retaining Generation Z, noting the need for a different response culturally to the needs of different generations. The committee agreed to receive a further report on retention, flexible working, and work life balance. • The committee welcomed the update on the Annual Equalities report and improvements in WRES indicators and against the core objectives.
Recommendation(s) to the Board/Committee	That members of the Board note the contents of the report.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• BAF S04 – Culture (lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention, and patient care)

ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• The Annual Equalities Report collating all actions including WRES, WDES and Pay Equality data to PODC and Trust Board • Program of staff voice (board to ward) to be scheduled to year end. • Report on Retention and spotlight report to be scheduled for next PODC.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• Guardian of Safe Working Report Annual approved by PODC to be received by Trust Board. • Healthy Attendance Project (HAP) – assurance action plan approved PODC
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	The committee resolved the following items be referred to the Trust Board for further discussion and information. 1.Trust Workforce Metrics and escalation of exception reports specifically staff turnover and retention concerns. 2. Guardian of Safe Working Report 3. Leadership and Talent Management Report 4. Schwartz Round Engagement 5. Annual Equalities, Diversity, and Inclusion Progress Report WRES and WDES data.
Matters presented for information or noting	There were no comments or queries to the items tabled for information, therefore committee resolved to note the following reports: • Health and Wellbeing Group. • Joint Negotiating and Consultative Committee. • Local Negotiating Committee (report to follow). • Education Steering Group. • Equality, Diversity, and Inclusion Group • Local Negotiating Committee • WRES 2022 Indicators
Self-evaluation/ Terms of Reference/ Future Work Plan	• Terms of reference and future work plan are in place. • Meeting evaluation takes place each month – agenda item

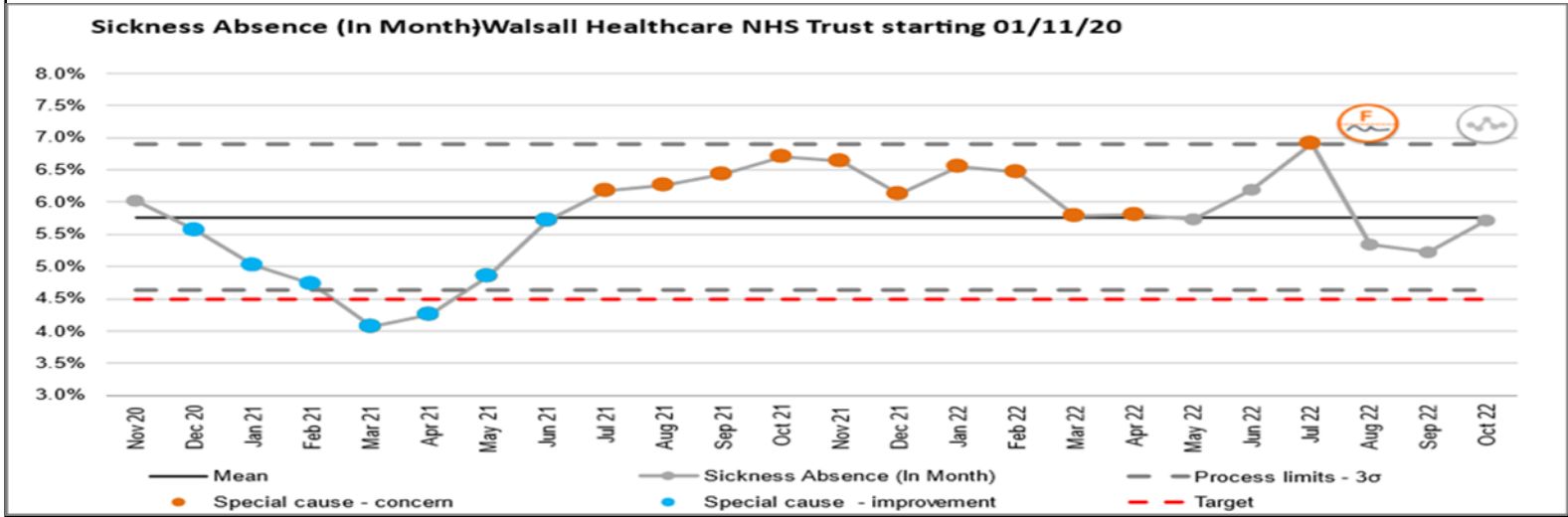
Items for Reference Pack	• None

Walsall Healthcare NHS
NHS Trust

POD

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE							
%	Sickness Absence	Oct-22	5.71%		4.50%		
%	PDRs	Oct-22	81.06%		90.00%		
%	Mandatory Training Compliance	Oct-22	88.50%		90.00%		
%	% of RN staffing Vacancies	Sep-22	8.05%				
%	Turnover (Normalised)	Oct-22	11.79%		10.00%		
%	Retention Rates (24 Months)	Oct-22	80.16%		85.00%		
%	Bank & Locum expenditure as % of Paybill	Sep-22	11.05%		6.30%		
%	Agency expenditure as % of Paybill	Sep-22	5.35%		2.75%		

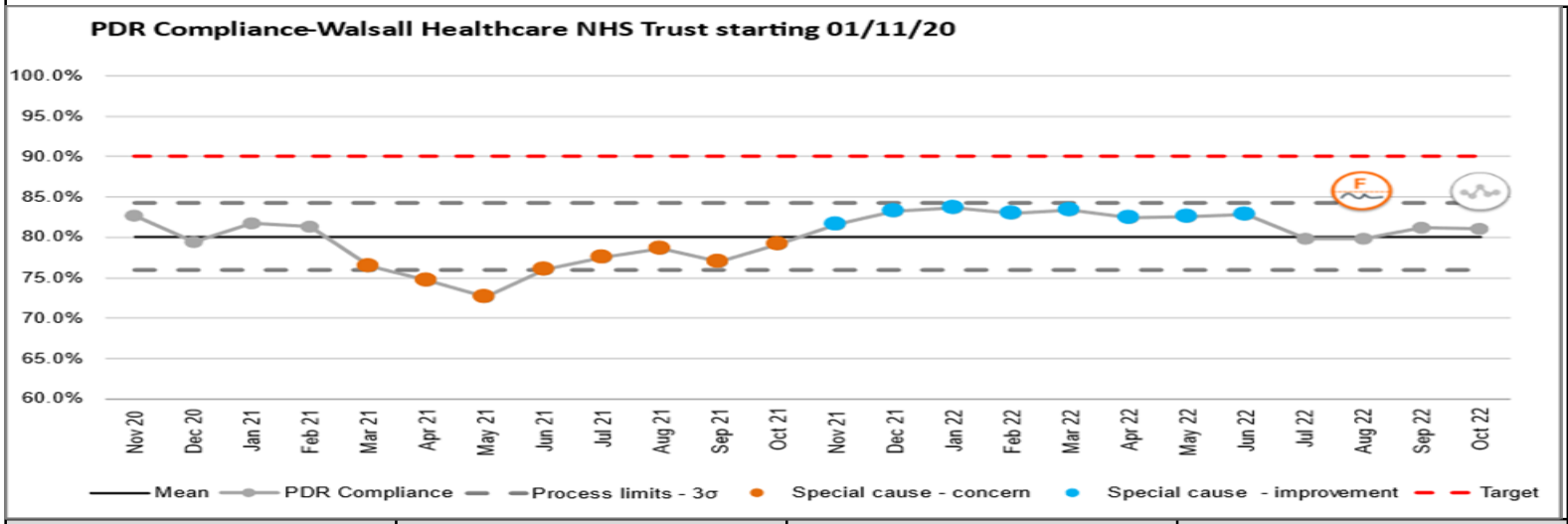
Metric Name: Sickness Absence



Month
Oct-22
Variance Type
Common Cause - No Significant Change
Target
4.50%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Sickness Absence outturns have been normalised through the exclusion of COVID-19 illnesses. Separate updates of COVID-19 absence rates are shared daily with operational leads.	Sickness absence rates are reverting to the 24 month average.	Reductions in long-term sickness are offset by a spike in winter illnesses. Cases of Cold, Cough, Flu – Influenza have doubled since Sep-22	Realising the procedural improvements and colleague lifestyle benefits identified within the recently drafted Health & Well-Being strategy will represent a significant catalyst towards restoration of pre-pandemic absence levels.	Monitoring of sickness absence includes Executive oversight at the monthly Divisional review meetings. Fast track referrals by the Occupational Health Team to Physiotherapy Services will ensure that injured colleagues receive early recovery interventions.

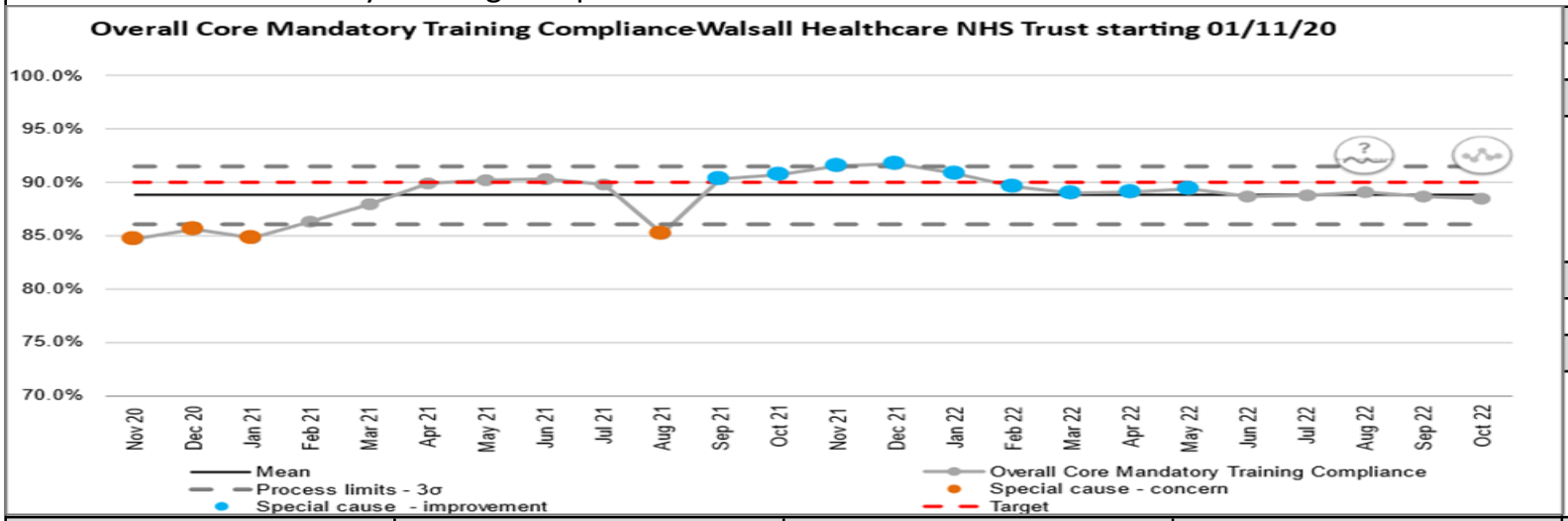
Metric Name: PDRs



Month
Oct-22
Variance Type
Common Cause - No Significant Change
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.	PDR compliance has begun to consolidate above the 80% average.	Compliance amongst Medical colleagues remains high (89%), whilst completion rates amongst Admin & Clerical colleagues have stabilised (77%).	Line managers have been emailed directly, in addition to Heads of Service, requesting the reasons for non-compliance. These confirm and challenge style emails contain relevant information on how to access the appraisal forms, and signposting to training if required.	Monitoring of PDR compliance is reviewed at the monthly executive led Divisional review meetings.

Metric Name: Mandatory Training Compliance



Month
Oct-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
90.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Training compliance is calculated using exclusion lists.	Mandatory training compliance remains stable just below the 90% target.	Safeguarding Adults Level 3 (79%) and Adult Basic Life Support (66%) competencies key outliners. Patient Handling compliance continues to improve, whilst e-Learning delivered competencies remain above the compliance target.	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

Integrated Quality & Performance Report

October 2022

EXECUTIVE SUMMARY

FINANCE	PERFORMANCE
• The Trust enters 2022/23 with clear risks to revenue and capital, income reduced by 57% of Covid-19 resource and an efficiency ask. The 2022/23 financial plan requires the Trust to move back into more 'normal' business, with a requirement for efficiency attainment, removal of agency usage and cessation (where safe to do so) of COVID designated expenditure • The ICB reported position is a £49m deficit at month 7, £45m adverse to plan and Trusts have reported a most likely year end position of a £71m deficit. • The Month 7 Year to Date deficit is £3.583m, which is adverse to the financial plan by £6.544m. This being driven by temporary staffing spend above planned levels, which includes under-delivery against the Cost Improvement Efficiency target, non-delivery of additional Elective Recovery Funding and increased non-pay expenditure. Trust Board approved a level of capital expenditure of £41.450m. However, following subsequent review (the material change being the removal of the Skin Hospital) the total capital programme for 2022/23 has been redefined as £38.188m. However there remains a £4m gap in funding the programme.	• The Trust continues to deliver the best Ambulance Handover times (<30 mins) in the West Midlands, being the top performing organisation for 20 of the last 21 months. This has been achieved despite continuing to support neighbouring Trusts with 154 out of borough ambulances intelligently conveyed to Walsall in October. • 4-hour Emergency Access Standard performance in October was 70.8% of patients managed within 4 hours of arrival. WHT's national ranking was 32nd best out of 110 Acute Trusts. •In September 2022, for 62-day GP RTT Cancer performance the Trust treated 67.6% within 62 days, this is materially better than the West Midlands average (49.2%) and the national average (60.5%). The national ranking position is 43rd out of 121 Trusts. • The Trust's 6 Week Wait (DM01) Diagnostics performance is 48th (September 2022 reporting), out of 119 reporting Trusts. Cardiac Physiology and Endoscopy services continue to be the most challenged. The Trust's performance in October 2022 has improved to 17.73% of patients waiting over 6 weeks. • The Trust's 18-week RTT performance remains stable with 58.96% of patients waiting under 18 weeks at the end of October 2022, the national ranking position is 74th (out of 120 reporting Trusts) for September 2022. The Trust's 52-week waiting time performance remains at 9th best in the Midlands (out of 20 Midlands Trusts). There were no incomplete 104 week breaches reported in October. Board should note the following risks: • Patients referred by their GP on 2 week wait suspected cancer and Breast symptomatic pathways are experiencing longer waiting times. Mutual aid has been provided from Royal Wolverhampton Trust, Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust. Additional funding from the Cancer Alliance will support increasing activity.
QUALITY	**WORKFORCE**
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 for October 2022 was 91.13% which shows a slight decline from September 2022 (92.53%) and continues to be below the 95% target. Divisional teams continue to report on their performance and improvement plans into Patient Safety Group (PSG). The prevalence of timely observations for October 2022 was 80.13% compared to 80.63% in September 2022. There continues to be a significant Divisional difference in observation standards with the Surgical Division supporting the overall figure. Falls per 1000 bed days was 3.30 in October 2022 and in line with the previous consistent performance. The Trust target for Clostridium difficile 2022/23 has been set at 27 cases with 7 cases of reported in October 2022, a review is underway to determine whether their avoidability. Overall performance year to date is above trajectory. The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 77.81% by E-sepsis in October 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 and additional training is being provided by the safeguarding team.	• Sickness absence rates are reverting to the 24 month average. Reductions in long-term sickness are offset by a spike in winter illnesses. Cases of Cold, Cough, Flu – Influenza have doubled since Sep-22. • PDR compliance has begun to consolidate above the 80% average. Compliance amongst Medical colleagues remains high (89%), whilst completion rates amongst Admin & Clerical colleagues have stabilised (77%). • Mandatory training compliance remains stable just below the 90% target. Safeguarding Adults Level 3 (79%) and Adult Basic Life Support (66%) competencies key outliners. Patient Handling compliance continues to improve, whilst e-Learning delivered competencies remain above the compliance target.

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.

IQPR Ragging Methodology

Performing against Trajectory	SPC Assurance	SPC Variation	Rationale	Ragging Applied
Yes			Monthly performance has achieved the set trajectory and is showing continual improvement in performance over recent months. In some cases, the current process is fully capable of achieving the target set for the metric.	Green
Yes				Green
Yes				Green
No			Monthly performance has not achieved the set trajectory and is showing continual decline in performance over recent months. In some cases, the current process is not capable of achieving the target set for the metric.	Red
No				Red
No				Red
Yes			Monthly performance has achieved the set trajectory but performance across recent months is showing inconsistencies against set trajectories and targets	Amber
Yes				Amber
Yes				Amber
Yes				Amber
Yes				Amber
Yes				Amber
No			Monthly performance has not achieved the set trajectory but performance across recent months is showing improvements towards set trajectories and targets	Amber
No				Amber
No				Amber
No				Amber
No				Amber
No				Amber

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 7th December 2022			
Director of Nursing Report			
Report Author and Job Title:	Lisa Carroll Director of Nursing Christian Ward Associate 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	• Safeguarding adults and children's training is achieving the Trust target for all level 1 and level 2 training. 11 Nursing Associates have registered with the NMC • 230 Clinical Fellowship Nurses have commenced employment within the Trust and 198 are registered with the Nursing and Midwifery Council (NMC). • Falls per 1000 bed days was 3.30 in October 2022 (3.40 in September 2022). Weekly falls accountability meetings are continuing, identifying lessons learnt and shared learning.		
Advise	• Issues with Scale 2 usage within NEWS2 have been identified and logged as a corporate risk. An e-Learning package has been uploaded to ESR, implementation plan agreed, and compliance will be monitored. • The total number of hospital acquired pressure ulcers reported in October 2022 has decreased in month. • Within the ED department, 77.81% of patients received antibiotics within 1st hour in October 2022 and inpatient area performance was 80.17%.		
Alert	• 7 cases of Clostridium Difficile toxin were reported in October 2022. Overall performance year to date is now above trajectory. • MCA compliance for October was 30.95%, a decrease from 38.46% in September 2022. On-going work is continuing to review the audit methodology to ensure it is fit for purpose. • The prevalence of timely observations for October 2022 was 80.13% compared to 80.63% in September 2022. There continues to be a significant Divisional difference in observation standards with the Surgical Division supporting the overall figure.		

	• VTE compliance for October 2022 was 91.13% which shows a slight decline from the performance in September 2022 (92.53%) and continues to be below the 95% target for compliance • Safeguarding level 3 adults and children's training remains consistently below Trust target, additional training is being made available to improve compliance.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF IPC BAF **208** - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks (Risk Score 16). **2066** – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 20 increased from 16 in month). **2245** - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). **2325** – Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes (Risk Score 16). **2430** – Risk of harm to children due to fragmented record storage (Risk Score 20). **2439** - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety' (Risk Score 20). **2475** - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services (Risk Score 5). **2540** - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems (Risk Score 12). **2581** – Internal risk for patients awaiting Tier 4 hospital admission (Risk Score 20). **2587** - Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks (Risk Score 9). **2601** - Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6 (Risk Score 20). **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 ☒	

Walsall Healthcare NHS
NHS Trust

Director of Nursing Report – October 2022

Introduction

The following report details the Trust position 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.

Current Position

CQC update

The Trust had unannounced inspections of the core services for Children and Young Peoples on the 20th September 2022 Surgery and Medicine and Long Term Conditions on the 4th and 5th October 2022.

On the 18th October 2022 the Trust received a Section 29a warning notice. The reason for the warning notice stated by the CQC was:

'The management of medicines, including prescribing, administration, recording and storage was not safe and put patients at risk of harm.'

The Trust is required to demonstrate significant improvement by the 31st December 2022.

An action plan is in place with weekly oversight meetings led by the executive team.

Joint Targeted Area Inspection (JTAI)

The Trust participated in the JTAI between the 7th and 10th November 2022. The JTAI includes inspectors from the CQC and Ofsted and covers health, education, the local authority and police services and focuses particularly on safeguarding and the Multi-Agency Safeguarding Hub (MASH) function. CQC Inspectors visited the Emergency department, Maternity, Health Visiting and School Nursing service.

There were no priority actions identified and the final report is expected in early December 2022.

Falls

The number of Trust falls recorded for October 2022 is 54 following a September 2022 rate of 53.

Hospital falls were reported as 49 in September and October 2022.

Community falls were reported as 4 in September 2022 and 5 in October 2022.

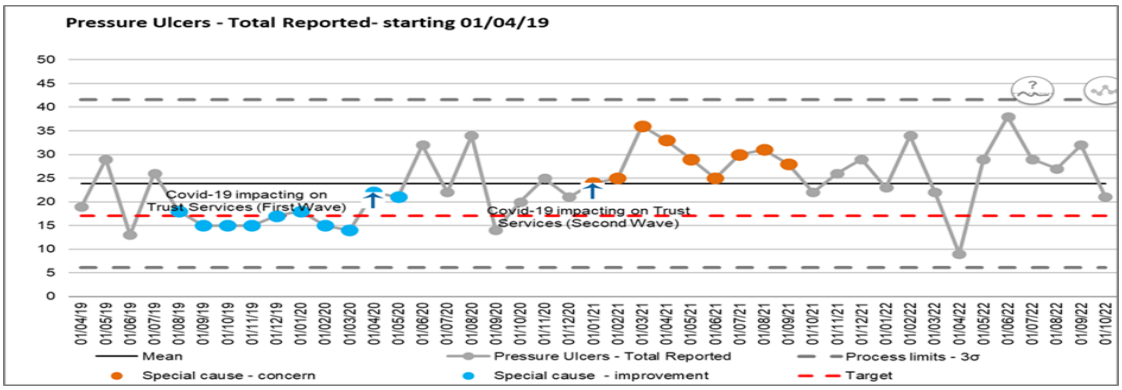
The Royal College of Physicians average performance of 6.63 falls per 1000 occupied bed days has been achieved continuously for the past rolling 28 months.

Falls per 1000 bed days was 3.40 in September 2022 and 3.30 in October 2022

Weekly falls accountability and review meetings are continuing identifying lessons learnt and promoting shared learning.

Tissue Viability

The Trust reported a total number of Trust acquired pressure ulcers of 32 September and 21 in October 2022. Lessons continue to be learnt using the RCA process. The new hybrid mattress contract has been awarded to Direct Healthcare this is linked to Risk 1856 on the Risk Register. A delivery date for the new mattresses is awaited.



Venous Thromboembolism (VTE)

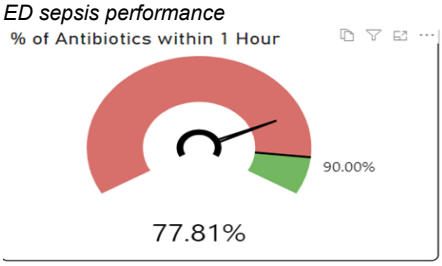
VTE compliance for September 2022 was 92.55% and for October 2022 was 91.1%. This continues to be below the 95% target for compliance.

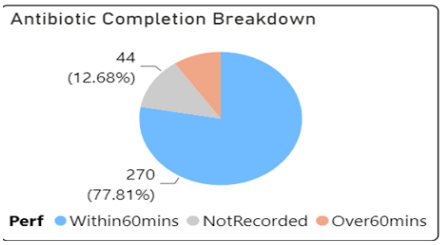
Sepsis

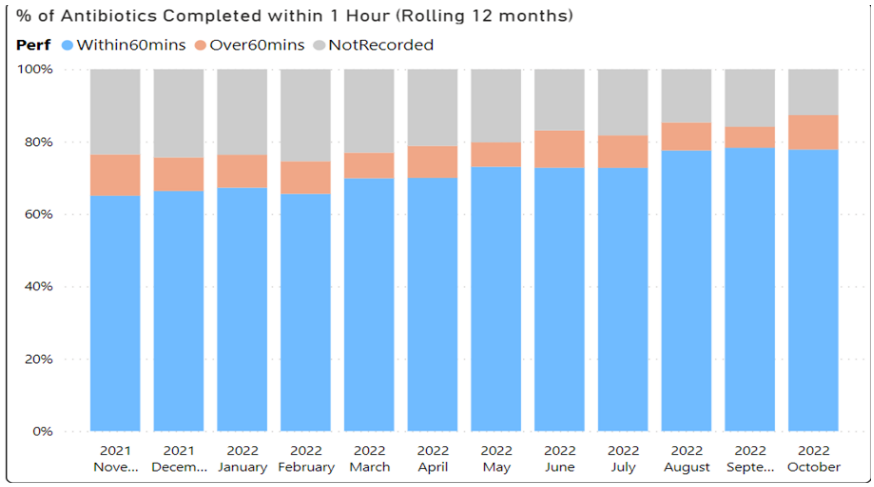
A Trust wide deteriorating patient group is established and reviews the management of sepsis and actions being taken to improve compliance and practice.

With the support of the sepsis and outreach teams the electronic data is a reflection of practice and demonstrates that there is still a lot of work to do to improve practice.

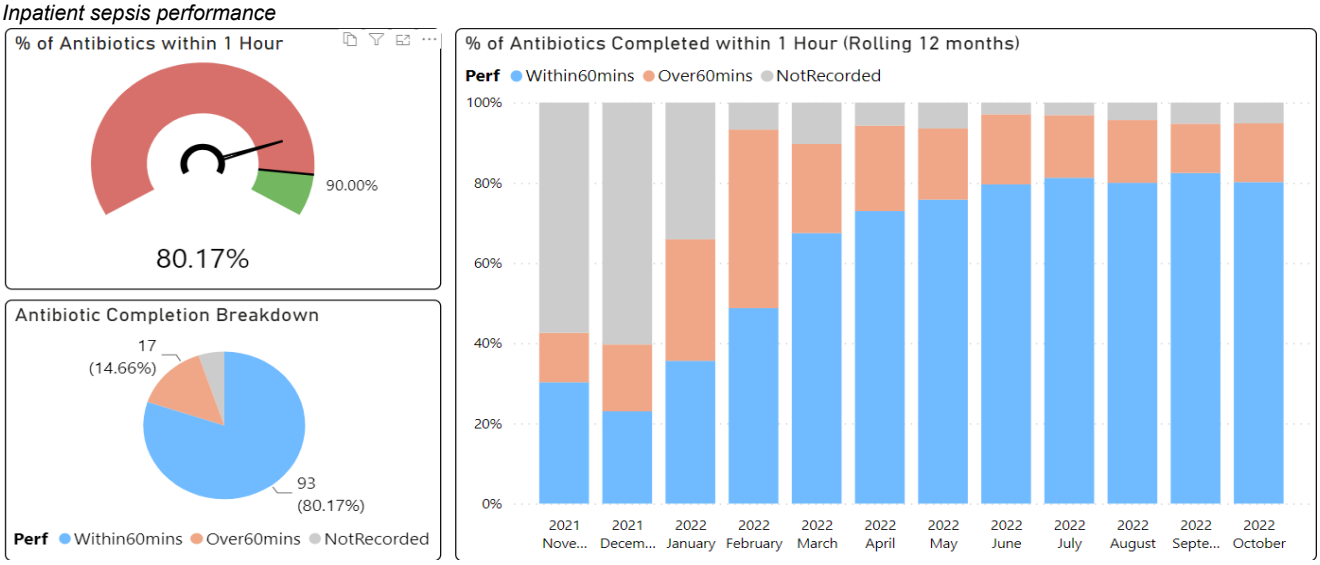
ED sepsis performance







Inpatient sepsis performance



National Audits for sepsis highlight sepsis compliance across the United Kingdom is 60-80% for antibiotics within an hour after drivers backed by the surviving sepsis campaign – previously studies undertaken by the Royal College of Emergency Medicine identified that local hospitals were 50% compliant of giving antibiotics within the hour. (Audit data published based on two acute NHS hospitals in the West Midlands 2019). The Trust currently sit within the top percentage at 79-80% antibiotic therapy within the hour, this has improved consistently since the initiation of the sepsis team.

Surgical Site Infections (SSIs)

The Trust reported one SSIs in September 2022 relating to Trauma and Orthopaedics but following investigation the case did not meet the criteria for an SSI. There were no SSIs reported in October 2022

Clostridiodes difficile (C. diff)

The National Trust trajectory for 2022/23 is 27.

6 acute toxins were identified in September 2022; Of the 6 cases, 2 were avoidable. Information and learning has been shared with the relevant clinical areas and will be presented to Infection Prevention and Control Committee
7 acute toxin cases were identified in October 2022; all cases are currently being reviewed to determine if they were avoidable.

C.*diff* cases

2022/23	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Max Cases per Month	2	2	2	2	2	2	2	2	3	3	2	3
Actual acute cases	0	1	4	1	2	6	7					
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	27
Acute Cumulative actual	0	1	5	6	8	14	21					

Percentage of observations undertaken within timeframe

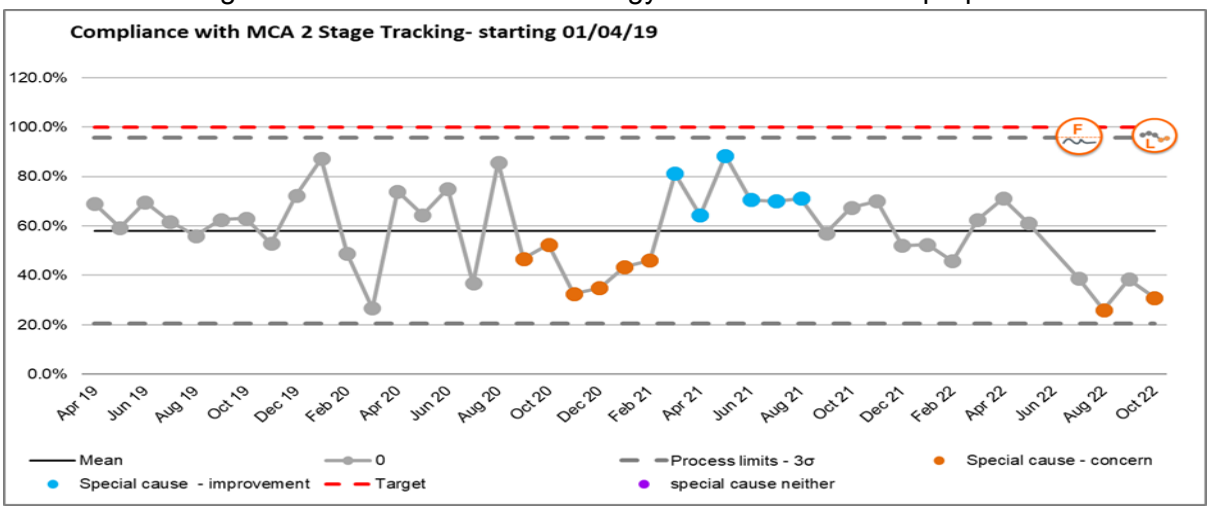
As reported previously changes have been made to the threshold for late observations, and how late observations are classified. The previous threshold of 33% has been reduced to 10% for all observations at a frequency of greater than 1 hour. The 33% threshold remains in place for observations that are recorded hourly.

The Trust target has also increased from 85% to 90%. This has resulted in an expected decrease in observation performance; the results are however in line with the performance at RWT.

The prevalence of timely observations for September 2022 was 80.13% and for October 2022 was 80.63%.

Mental Capacity Assessment (MCA)

MCA compliance for October was 30.95%, a decrease from 38.46% in September 2022. On-going work is continuing to review the audit methodology to ensure it is fit for purpose.



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.
Additonal training is being provided to allow more opportunity to complete this training.

The Safegurading business case has been recruited and senior nurses have joined the team in September and October 2022.

Safe Staffing

Vacancy position

The RN and Midwifery vacancy rate for September 2022 has decreased to 8%

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

Recruitment

230 Nurses have arrived in the Trust on the Clinical Fellowship Programme, 198 of these are now registered with the NMC.

Eleven Nursing Associates joined the NMC register in September 2022.

Nine Trainee Nursing Associates commenced the programme in September 2021 and will be expected to qualify in November 2023.

Nine Nursing Associates commenced the NA to RN programme with Birmingham City University in September 2022.

Thirty-five student nurses taken up posts within the Trust in September 2022.

Temporary staffing

A total of 641 hours off-framework was used during September 2022 and 760.25 hours were used during October 2022.

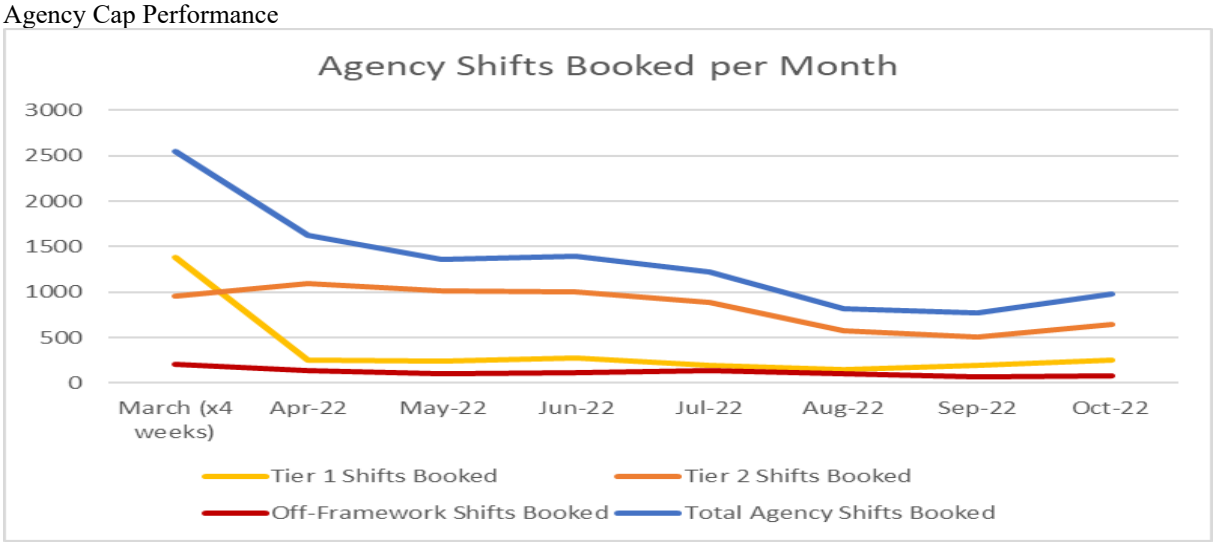
In September 2022 the highest use areas for Tier 2 agency staff are ED using 133.5 hours, Endoscopy using 142 hours and AMU using 185.5 hours.

In October 2022 the highest use areas for Tier 2 agency staff are ED using 234.75 hours, Endoscopy using 192.5 hours and ward 21 using 224.5 hours.

During October 2022 there has been a decrease in both Tier 1 and Tier 2 agency bookings, but off framework use has increased.

At the end of October 2022 there are 19 departments where agency is no longer in use at any Tier.

Agency Cap Performance



Staffing hub

The Virtual Staffing meetings are embedded and 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.

Through the safe staffing meetings 1100 hours of RN and 1096 hours of CSW were re-deployed across the Trust during September 2022 and 1601.50 hours of RN and 938.40 hours of CSW were re-deployed across the Trust during October 2022.

Red Flags

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

In October 2022 there were 229 open red flags in, an increase of 34 open red flags recorded compared to September 2022

71% of Red Flags are reported during the day, 29% at night. The majority of Red Flags continue to be recorded on weekdays and not weekends (64%).

43% (99) of the Red Flags recorded in October 2022 were for the reason of 1 to 1 not covered.

Red Flags are cross referenced with dates of incidents raised in the Trusts incident management system on the same date. Cross referencing does not confirm a correlation between Red Flag and incident reported.

A review was undertaken to examine if there were falls with harm recorded on wards and dates that had a red flag raised for 1:1 not available. Based upon October 2022 activity there was 1 incident reported of a fall (low harm) on a shift where a red flag was raised for a 1:1 not being covered, and 1 incident recorded as no harm. The falls recorded did not involve the patients requiring the 1:1.

Acute Medical Unit (AMU) Board Update

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:

- The AMU team now have a draft communication strategy which was supported by the team.
- The AMU team were asked to provide a plan as to how they will achieve 100% Mandatory Training compliance.
- An AMU award scheme has been linked with the divisional team to ensure staff are recognised for good work.
- The QI team are now working with AMU to improve the transfer process.
- Job plans have been scheduled, they are now pending validation and sign off by Divisional Director and Chief Medical Director.
- The team are firming up the HEE response in readiness for their visit in November 2022.

- The team are developing a plan for a locum usage cessation.
- A clinical fellow standard operating policy has been drafted and is pending approval by the team.

Clinical Systems Framework (CSF)

Development of the CSF is ongoing. Work is now underway to draft the metrics and a final draft is expected in December 2022 with the aim of launching in January 2023.

Band 7 Quality Away Days

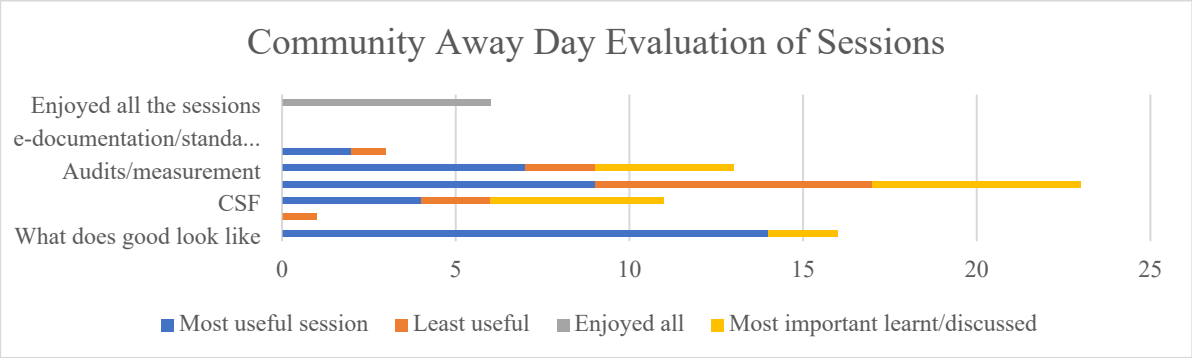
In recognition of the vital leadership role the ward/unit managers have within both, and the need to ensure they are provided with protected time to re-set, following the very challenging Covid-19 pandemic period, and collectively shape the key nursing and midwifery agendas, the Quality Away Days were organised.

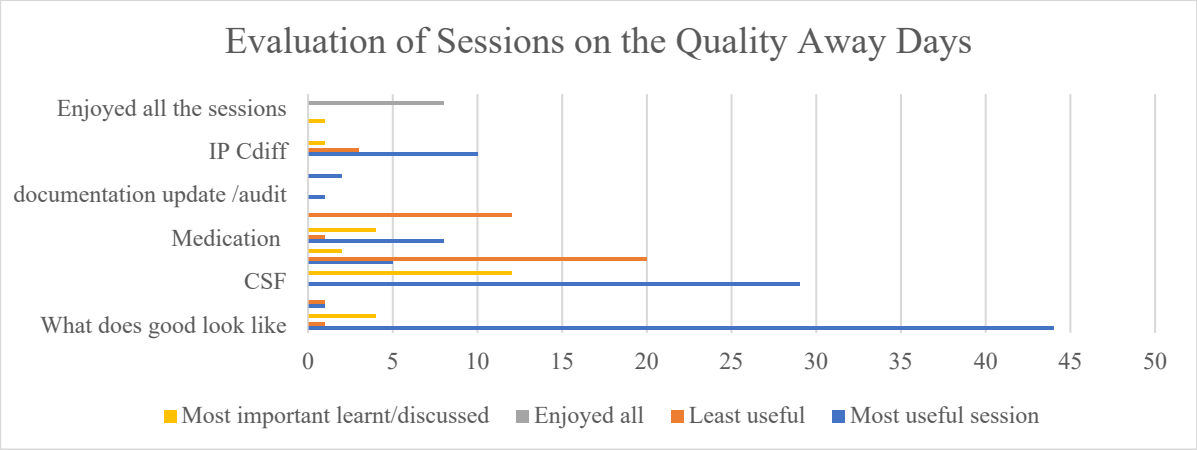
The aim of the Quality Away Days was to bring all ward/unit managers from RWT and WHT together and to provide:

- A protected and safe development space.
- An opportunity to receive updates in relation to current quality and safety challenges for nursing and midwifery and the wider multi-disciplinary team.
- An opportunity to hear from the Senior Nursing Leadership Team, discuss key challenges in nursing and midwifery and generate ideas and solutions on how these could be addressed.
- A platform for ward/unit managers to be involved collectively in shaping the nursing and midwifery priorities for the next two years as part of the development of the Clinical System Framework (CSF).
- An opportunity to reflect and network, by meeting colleagues from both organisations.

In total, five Quality Away Days with set agendas took place during October and early November 2022. One day was devoted solely to the community teams and four to the acute Trusts nursing, midwifery and AHP teams. 116 staff attended.

Evaluation of the days is detailed below:





The engagement during the away days and subsequent feedback was overall very positive, with staff requesting similar days in the new year and to expand this to other colleagues. Feedback from the staff from the away days will be used to support the already existing or new developments pertaining to nursing, midwifery and AHP wider quality agendas.

Similar away days for band 6 staff are to be developed for early 2023.

Back to the floor

On Friday the 4th November 2022 the Trust, along with colleagues at RWT, commenced Back to the Floor. The aim of Back to the Floor is to improve patient experience through strengthened, visible, senior clinical nurse, midwife and Allied Health Professional (AHP) leadership.

Every Friday, all nursing, midwifery and AHP colleagues, who do not work in patient facing roles, will participate in the Back to the Floor for the whole day. No meetings will be scheduled on Fridays to enable colleagues to focus on being 'back to the floor'.

Findings and themes from the back to the floor days will be shared at Senior Nursing, Midwifery and AHP Leaders meetings across the Trust and actions agreed to resolve more complex matters that cannot be resolved at a local level.

End of Report

MEETING OF THE PUBLIC TRUST BOARD – WEDNESDAY 7TH DECEMBER 2022			
Hospital Mortality Report (September - October 2022)			
Report Author and Job Title:	Mr Salman Mirza, Deputy Chief Medical Officer Lorraine Moseley, Business Manager, Medical Directorate	**Responsible Director:**	Dr Manjeet Shehmar, Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☒ Inform ☒ Assure ☒		
Assure	• The most recent published SHMI value for the 12 month rolling period (published by NHS Digital November 2022) July 2021 to June 2022 is 0.995 which is within the expected range (this relates to the acute Trust excluding palliative care).		
Advise	• The medical examiner team reviewed 100% of the total eligible inpatient deaths for the months September and October. • Community ME pilot is progressing with 10 Walsall GP Practices' deaths being reviewed. • 2 LeDeR deaths were reported during this period. • SJR training is being arranged to ensure mortality leads are up to date with training.		
Alert	• There are currently 17 SJRs outstanding and these are being followed up by the Learning from Deaths Administrator. A monthly report is sent to all mortality leads highlighting the outstanding SJRs. Specialties are working to reduce this number. Particular emphasis in on general surgery and urology who have the highest number of outstanding SJRs. • 5 sets of notes in general surgery are unobtainable and therefore the mortality lead is unable to complete the SJRs.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF001 Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm • Performance against SHMI is recorded on the trust risk register • Systems and processes for the identification and learning from issues in care have been identified as ineffective by the CCG		
Resource implications	None		
Legal and/or Equality and Diversity implications	• The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations. • National legislation relating to the review of child and perinatal deaths has been implemented.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Introduction

This report details:

1. **Performance** data relevant to the trust, compared with regional and national comparator sites, where appropriate
2. **Key areas for attention**, together with analysis, actions and outcomes
3. **Future actions** and developments in understanding mortality data

1. Update on Standardised Mortality Rates (SMRs) and inpatient data relevant to these calculations

1.1 Activity levels over this period is as follows:

	Admissions	Hosp Deaths	Total Discharges	Covid Deaths
July-22	7669	96	7579	15
Aug-22	7624	94	7474	11
Sept-22	7796	97	7805	9
Oct-22	7882	110	7830	25

1.2 SHMI (Inpatient deaths plus 30 days post discharge)
The most recent published SHMI value for the 12-month rolling period (published November 2022) July 2021 to June 2022 is 0.995 which is within the expected range (this relates to the acute Trust excluding palliative care).

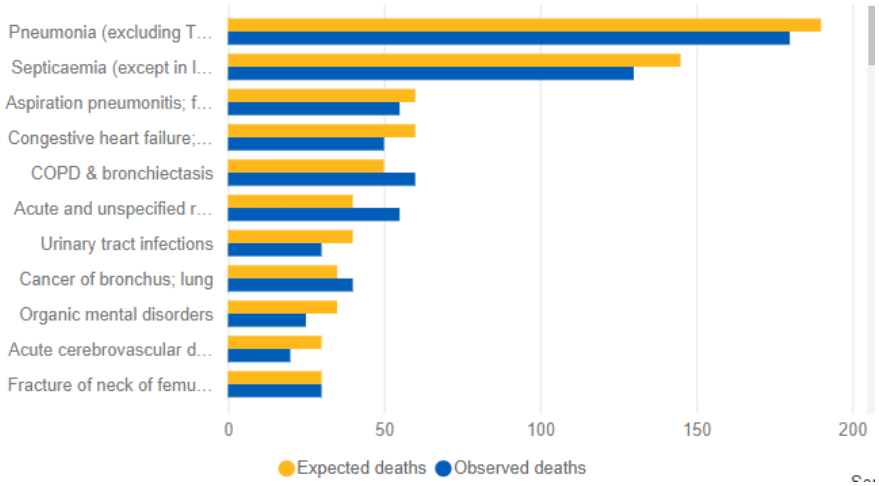
SHMI in comparison with neighbouring Trusts (*NHS Digital)

Trust	July 2021 - June 2022
Walsall Healthcare NHS Trust	0.995
The Royal Wolverhampton NHS Trust	0.965
The Dudley Group NHS Foundation Trust	1.138
Sandwell And West Birmingham Hospitals NHS Trust	1.022

The overall Trust SHMI breakdown is as follows:

Site Name	Provider spells	Observed deaths	Expected deaths	SHMI value	
Manor Hospital	61715	1345	1350	0.9946	As expected SHMI
Holly Bank House	110		15		
Walsall Hospice	185	120			

Comparison of observed and expected deaths:



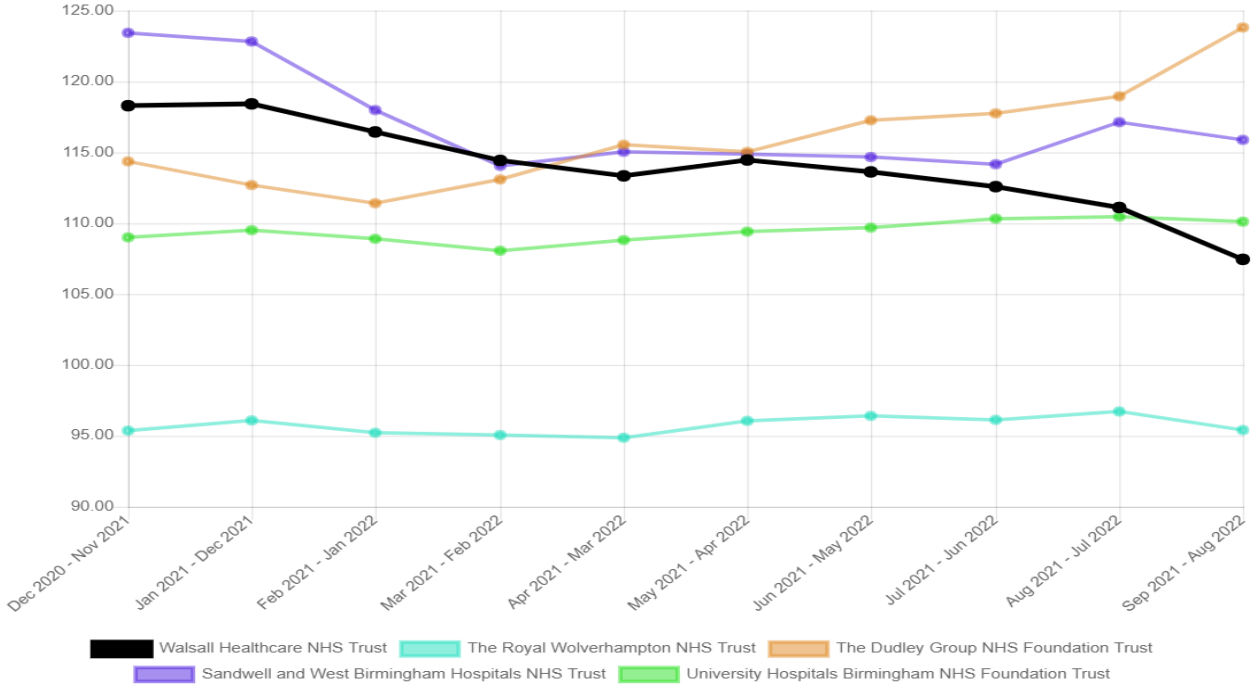
It can be seen from the above that there are three areas where observed deaths are higher than expected deaths: COPD and bronchiectasis; acute and unspecified renal failure; and cancer of bronchus. Patient level data has been provided to the relevant specialty and will subsequently be reported at the Mortality Surveillance Group.

2. HMSR

The chart below is taken from available data within HED and illustrates the Trust's performance in relation to peer group. Although HMSR remains higher than the national average (99.78) there is a steady reduction in HMSR.

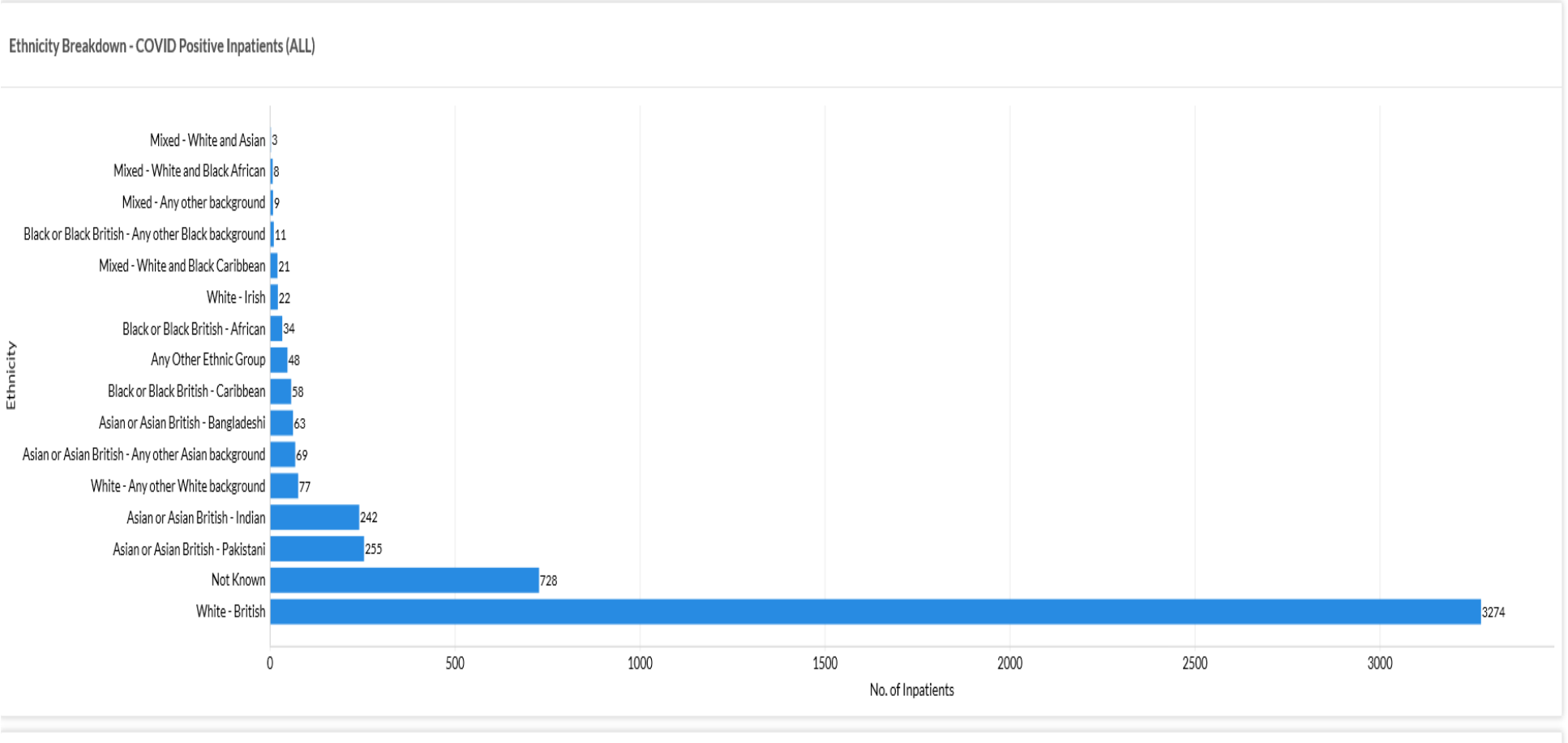
The following table includes the expected HMSR level to August and illustrates a continued decrease in HMSR.

Latest Trust's Value: 107.45

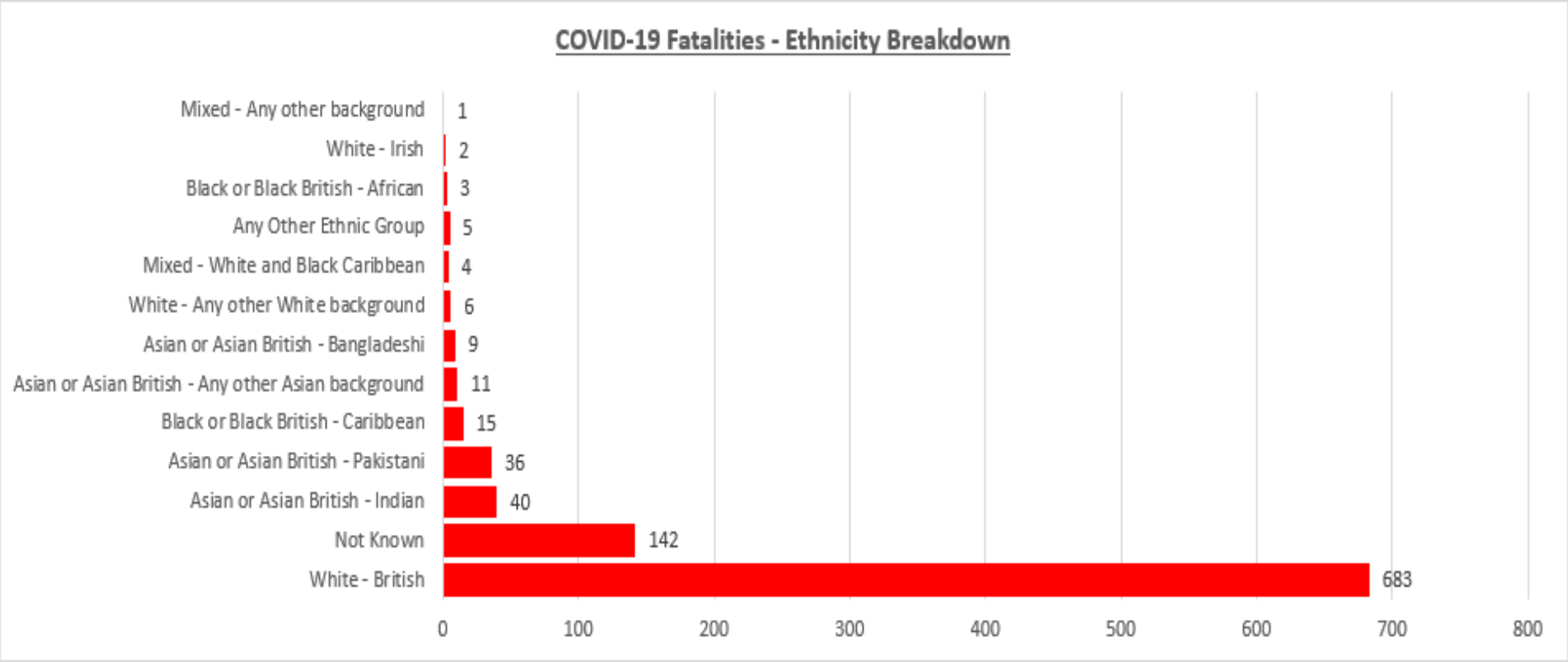


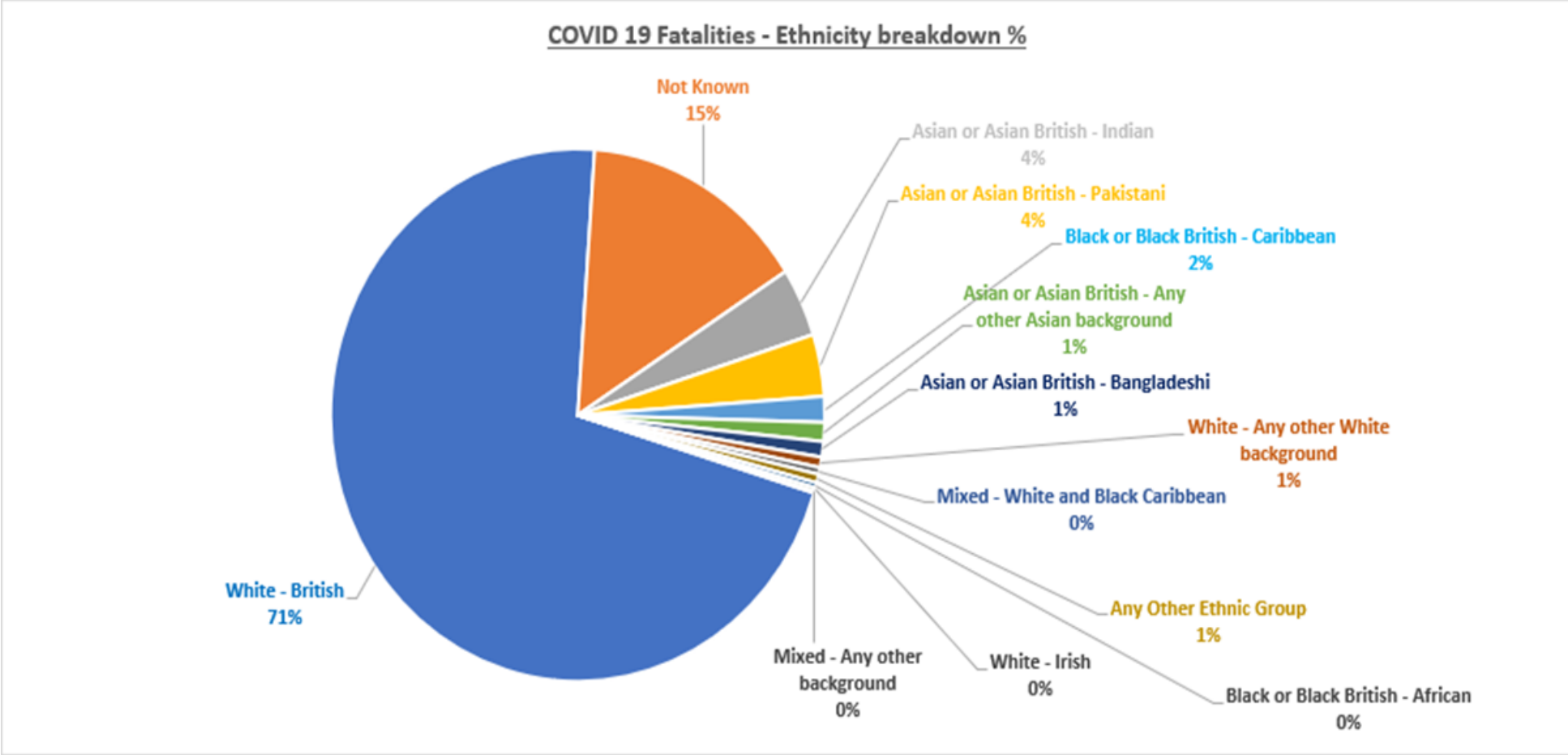
3. Covid 19 inpatient/ethnicity

The graph below shows ethnicities for all covid positive inpatients.



The graphs below show ethnicities for all covid positive deaths.




COVID 19 Fatalities - Ethnicity breakdown %
Not Known
15%
Asian or Asian British - Indian
4%
Asian or Asian British - Pakistani
4%
Black or Black British - Caribbean
2%
Asian or Asian British - Any other Asian background
1%
Asian or Asian British - Bangladeshi
1%
White - Any other White background
1%
Mixed - White and Black Caribbean
0%
Any Other Ethnic Group
1%
Black or Black British - African
0%
White - Irish
0%
Mixed - Any other background
0%
White - British
71%

4. Alerts

The Trust has received the following SHMI alerts during this period:

Alert	Alert Period	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score	Alert Level
SHMI	Aug 2021 - Jul 2022	24 - Cancer of breast	2.89	10	83	346.47	Red
	Aug 2021 - Jul 2022	29 - Cancer of prostate	3.74	12	30	321.08	Red
	Aug 2021 - Jul 2022	59 - Deficiency and other anemia	12.16	26	583	213.83	Red
	Aug 2021 - Jul 2022	55 - Fluid and electrolyte disorders	21.38	37	343	173.02	Red
	Aug 2021 - Jul 2022	19 - Cancer of bronchus; lung	31.72	48	103	151.32	Red
	Aug 2021 - Jul 2022	157 - Acute and unspecified renal failure	41.99	62	318	147.67	Red
SHMI	Aug 2021 - Jul 2022	224 - Other perinatal conditions	0.71	10	792	1413.44	Amber

Patient level data has been provided to the specialties for subsequent reporting at Mortality Surveillance Group.

5. Specialty Learning / Feedback

The following specialties presented at the Mortality Surveillance Group.

Elderly Care

The elderly care team reviewed seven deaths and identified the following areas for improvement:

- There should be a regular review of patients
- The review highlighted areas relating to Duty of Candour that need to be improved
- DNACPR decision in malignancy. Adherence to hospital policy- if not reason to be documented

- Training on CORS for new clinicians
- Every patient aged 65 and above should have a ReSPECT form in place especially those with multiple co-morbidities

Actions:

- Every patient aged 65 and above should have a ReSPECT form in place especially those with multiple co-morbidities
- ReSPECT forms should be a part of nursing handover to prompt in the morning board rounds, if missed.
- The white boards used for MDTs should have a column of ReSPECT form on them
- Ward Juniors to make sure that missing ReSPECT forms are done during ward rounds.

Gastroenterolgy

The gastroenterology team reviewed deaths and identified the following areas for improvement:

- Patients with liver disease have low muscle mass hence low creatinine values (as a base line for normal) which should be considered before planning any procedure/investigation which can involve the renal system.
- Lack of filtration facility (in case of single organ involvement in patients only requiring dialysis)
- Early involvement of Speciality in decision making
- Early involvement of Family and next of kin in discussions about diagnosis and management plans
- No specific room availability for sensitive discussions with family and next of kin on the ward

The following good practice was noted:

- Discussion of mortality reviews in Gastroenterology group meetings
- Presentation of gastroenterology emergencies in acute medical unit to highlight specific points

The specialty identified the following actions:

- Teaching of junior colleagues while discussing the nature and severity of disease with patient's relatives and assessment of their opinions.
- The team are available to deliver training on gastroenterology topics to wider medical colleagues. Following the board round in AMU, the team go into AMU to give advice and pull patients.

Emergency Department

The team provided an overview of ambulance handover and triage with positive feedback received from WMAS for the early release of ambulances. However, there were delays experienced with specialty review, with no bed movements resulting in no space to see the patients and increase in the waiting time to be seen. This also leads to overcrowding and breaches.

The emergency department team reviewed deaths and identified the following areas for improvement:

- Staff awareness and education about the importance of good documentation (nursing staff and medical team). To include
    - ALS timeline
    - Discussion with next of kin
    - Discussion with the Medical examiner/Coroner referral
    - Investigations results.

- The team continue to improve understanding of mortality by:
    - Holding Monthly Mortality Meeting on the last week of the month (started on April 2021)
    - Item on the agenda of the Monthly Emergency Care Group Meeting
    - Regular feedback to the staff from the Mortality Meeting, MSG meeting & appreciation to staff regarding good teamwork & documentation
    - A&E guidelines website (Askearl.co.uk) which includes information on Coroner service and the Medical examiner (including working hours and coroner referral pathway)

The team have developed several ways to share good practice:

- A&E Clinical Steering Group Meeting 1-2 times/month
- 3 Consultants, Middle Grade Doctors, Seniors ACPs, Matron & Lead Sister
- A&E Guidelines Lead - A&E Consultant - Dr Andy Foot
- Simulation sessions every 2 weeks-most common scenarios attending A&E
- Department Newsletter every 2 months
- Emergency Care Group Meeting - Monthly (Performance, Complaints, Mortality Review, Incidents, Staff Training update, Patients feedback)
- Department teaching every week, including internal & external speakers from other hospital departments.
- New Online Referral System to the Medical team — Careflow Connect
- Expedite & minimise the time spent to refer the patients.

Child Death Reviews

There has been a total of 17 deaths (to date) for the year 2022-2023. Of these, 5 were neonatal deaths and 12 were older children.
There are 22 reviews outstanding:

- 1 awaiting police investigations
- 10 awaiting coroner review
- 5 awaiting PMRT (perinatal mortality review tool) from other sites
- 2 awaiting PMRT from Walsall
- 2 awaiting CDRM (child death review meeting) from Birmingham
- 2 reviews ongoing

Two specific cases were presented by the team. The following good practice was noted:

- All support services were in place
- APLS (advanced paediatric life support) and SUDIC (sudden unexpected death in childhood) protocols followed
- Parents fully supported
- Involvement of paediatric consultant
- Home visit completed
- Bereavement support

There were 2 development point identified:

- Home visits should be joint (Trust and Police)
- PAU calls are recorded, and staff have an understanding prior to making the call

Diabetes and Endocrinology

The team reviewed a number of deaths. From the deaths reviewed the team reported the following:

- 1 serious incident was identified, incident report was completed, and duty of candour carried out
- There were 3 complaints which resulted in one incident report (Duty of Candour was completed)
- 1 incident report was completed following the outcome of a mortality review and investigation completed.

Improvement identified

- Clinical notes need to be improved and include discussions with next of kin
- Documentation around post take ward round needs to improve
- Hyponatraemia guidelines have been updated

Good practice

- Good, regular documented discussions with relatives
- Sepsis treated based on culture sensitivities
- Good MDT input (SALT/OT/PT/dietician)

Renal

The team reviewed seven acute kidney injury (AKI) deaths (May to September 2022), with an age range of 77-93. Out of the 7 cases, 5 did not have any degree of significant AKI. None of these cases required an SJR

Top themes for improvement:

- Accuracy of recording for AKI related deaths
- Dashboard of all AKI cases within the Trust
- 7-day service from January 2023, working in collaboration with New Cross.
- Extend work to Community sector (teaching)
- Delay in guideline approval

Areas of learning:

- Observed decrease in ITU admission need audit data
- Timely review by specialists
- Family discussions
- No secondary mortality reviews needed

Next steps:

- Improvement – AKI Nurse 7-day service commencing on 19th November supported by RWT consultants
- Working with coding on agreed documentation for better identification of data for AKI mortality in the Trust
- Working with Black Country Network to improve access to patient`s blood results from primary care
- Working with informatics to create a dashboard for AKI in the Trust
- Support by AKI nurses/consultants with daily visits to pull patients from other specialties - Same Day Emergency Care, AKI to Acute Medical Unit/Ambulatory Emergency Care/Emergency Department and providing training

Quarterly Perinatal Mortality

1 out of 8 Neonatal deaths (<27 weeks) in the West Midlands was delivered at Walsall Local Neonatology Unit. The death was reviewed with external peer review and actions developed to address the recommendations.

The external review on all 8 neonatal deaths highlighted the following contributory factors:

- Incomplete risk assessments of the mother
- Lack of appropriate onward referral
- Lack of senior staff involvement
- Poor documentation which impacted on handover

Action taken by the neonatal team:

- Twice daily consultant obstetrician ward round has been implemented since Feb 2021 and been audited to show implementation
- All Neonatal deaths and still births are reviewed through PMRT (perinatal mortality review tool) with external obstetrician and neonatologist peer review
- Maternity team attends Webex daily with 4 providers in LMNS (Local Maternity and Neonatal System) to review capacity and facilitate IUT (intrauterine transfusion) for early preterm at risk of delivery
- Main divisional objectives for 2022-23: Compliance to network standards re: babies born in the right place on the right pathway for their gestational age
- Best start workstream through LMNS to address early transfer of <27 weeks to level 3 NNU

The neonatal team will formally present at Mortality Surveillance Group in December.

6. Mortality Reviews - Structured Judgement Reviews (SJRs)

5.1 There are currently 17 SJRs outstanding and these are being followed up by the Learning from Deaths Administrator. A monthly report is sent to all mortality leads highlighting the outstanding SJRs. Specialties are working to reduce this number. Emphasis is on general surgery and urology who have the highest number of outstanding SJRs.

5.2 SJR training is planned for all mortality leads, this should take place in December. The training session will be recorded and available for review at any time.

5.3 1 LeDeR review was identified in September and 1 in October.

5.4 The issue around missing notes/loose filing was raised. Mortality lead for general surgery informed the Mortality Surveillance Group that 5 sets of notes were unobtainable and therefore unable to complete the SJRs. The LfD Administrator delivers relevant notes to the secretaries, however, there have been occasions when these have not been passed to the mortality lead. Administrator will now clearly mark the notes for the relevant mortality lead when delivering to secretaries.

SJR outcomes (total deaths reviewed categorised by outcomes)*

Score 1 Definitely avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	1	0.4%

Score 2 Strong evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	2	7.8%
This Year (YTD)	4	1.6%

Score 3a Probably avoidable (more than 50:50)		
This Month	0	0.0%
This Quarter (QTD)	1	3.8%
This Year (YTD)	20	8.2%

Score 3b Probably not avoidable (less than 50/50)		
This Month	2	33.30%
This Quarter (QTD)	9	34.6%
This Year (YTD)	60	24.6%

Score 4 Probably not avoidable		
This Month	4	66.7%
This Quarter (QTD)	13	50.0%
This Year (YTD)	136	55.7%

Score 5 Slight evidence or definitely not avoidable		
This Month	0	0.0%
This Quarter (QTD	1	3.8%
This Year (YTD)	23	9.4%

*this is reported quarterly and therefore no change to the above - this will be updated in the next report.

7. Medical Examiner

The medical examiners reviewed 100% of deaths in September and October. This included 4 community deaths in September and 10 in October.

The pilot for community reviews is ongoing. There are 52 GP practices in the Walsall area of which 10 have signed up for the pilot scheme. The medical

examiner office is currently in correspondence with 4 other practices. The team is also planning to present at the Practice Manager meeting in December to highlight the process and encourage other practices to take part.

One area of concern is access to GP records. Access to records is included in the statutory process, however the Trust does not currently use EMIS and there is a cost associated with licences. Enquiries to the national medical examiner office have been made to understand what, if any, funding is available.

MATTERS FOR ESCALATION TO QPES FROM MORTALITY SURVEILLANCE GROUP

The following items have been identified for escalation to QPES:

1. Loose/temporary notes being completed on wards. Notes are not being married with main health record and are often kept on the ward area. Health records will not accept these notes unless they are filed in the patient's health record. This is a patient safety issue as treating clinicians do not have a full set of health records and may be unaware of existing conditions and last treatment. Some of the loose/temporary notes cover a period of over 7 days where the main health record has either not been requested or not available (see point 2 below). There is an entry on the Trust Risk Register highlighting this issue.

2. Missing notes. Patient records are not always available and cannot be traced. Records are often transferred from one area to another without being recorded on the system, leading to notes not being available when patients are admitted. This is linked to the item above.

3. Funding for EMIS licences for the roll out of community ME services will need to be considered.

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 7th December 2022**			
Patient Voice Report Quarter 2 – July - September 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	↑		
Advise	Response rates for the Friends and Family Test have increased for Quarter 2 2022 from Quarter 1 2021-2022. 133		
Alert	The Trust average compliance rate for complaints (response timeframes) for Quarter 2 was 78%. This is a decrease of 5% when compared to the previous quarter, which was 83%. This has been impacted by a few contributory factors, including statement delays, cross divisional/area complaints, and a lack of complaint handler engagement in some areas.		
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 ☐		

Quarterly Patient Voice Report (July-September 2022)

1. PURPOSE OF REPORT

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

2. BACKGROUND

A report on patient and carer experiences has traditionally been presented to the Quality Patient Experience and Safety Sub-Committee on a quarterly basis and the Board of Directors as part of the series of quality reports. This report focuses on patient and carer experiences and how people are involved in shaping service developments. Feedback identifies themes for improvement and learning arising from outcomes.

3. DETAILS

3.1 Feedback data

The Trust received a total of **15826** feedback contacts between July and September 2022.This includes all Patient Relations related contacts, along with Friends and Family Test and Mystery Patient responses.

Complaints (including MP letters)	87
Concerns	641
Compliments	80
Friends and Family Test	14827
Mystery Patient (QR code)	121

Table 1. Patient Feedback by contact type

3.2 Complaints and Concerns

The top 3 trends for complaints, concerns and queries in Quarter 2 relate to Appointments (267), Clinical Care, Assessment and Treatment (261) and Access (55). These trends remain the same as Quarter 1, however, there has been a noted decrease in each category.

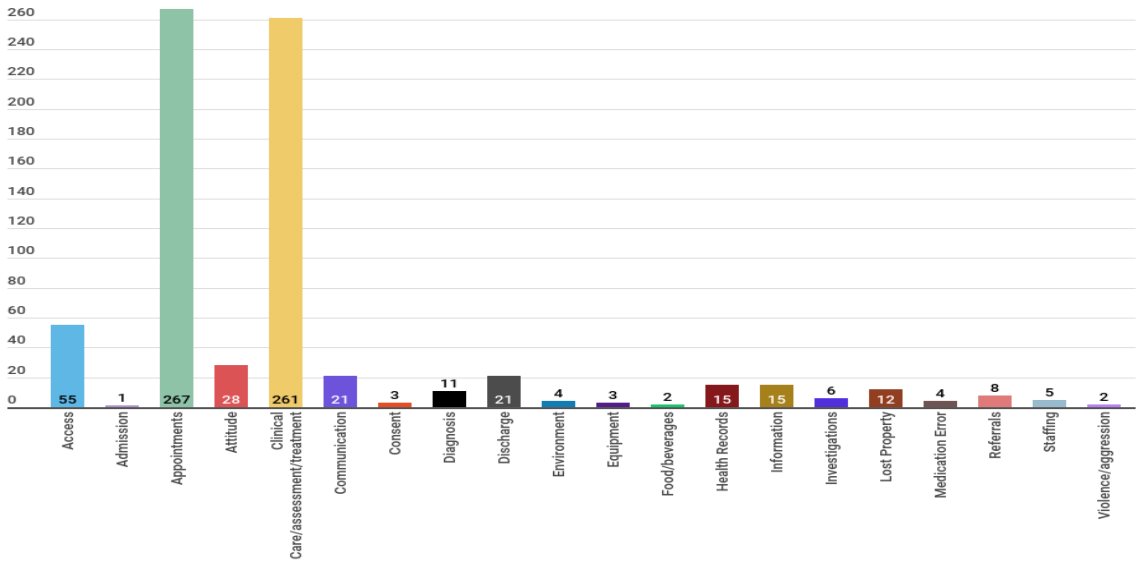


Table 2. Patient Feedback by category type

3.3 Complaint response times

The Trust average compliance rate for complaints (response timeframes) for Quarter 2 was 78%. This is a decrease of 5% when compared to the previous quarter, which was 83%. This has been impacted by a few contributory factors, including statement delays, cross divisional/area complaints, and a lack of complaint handler engagement in some areas.

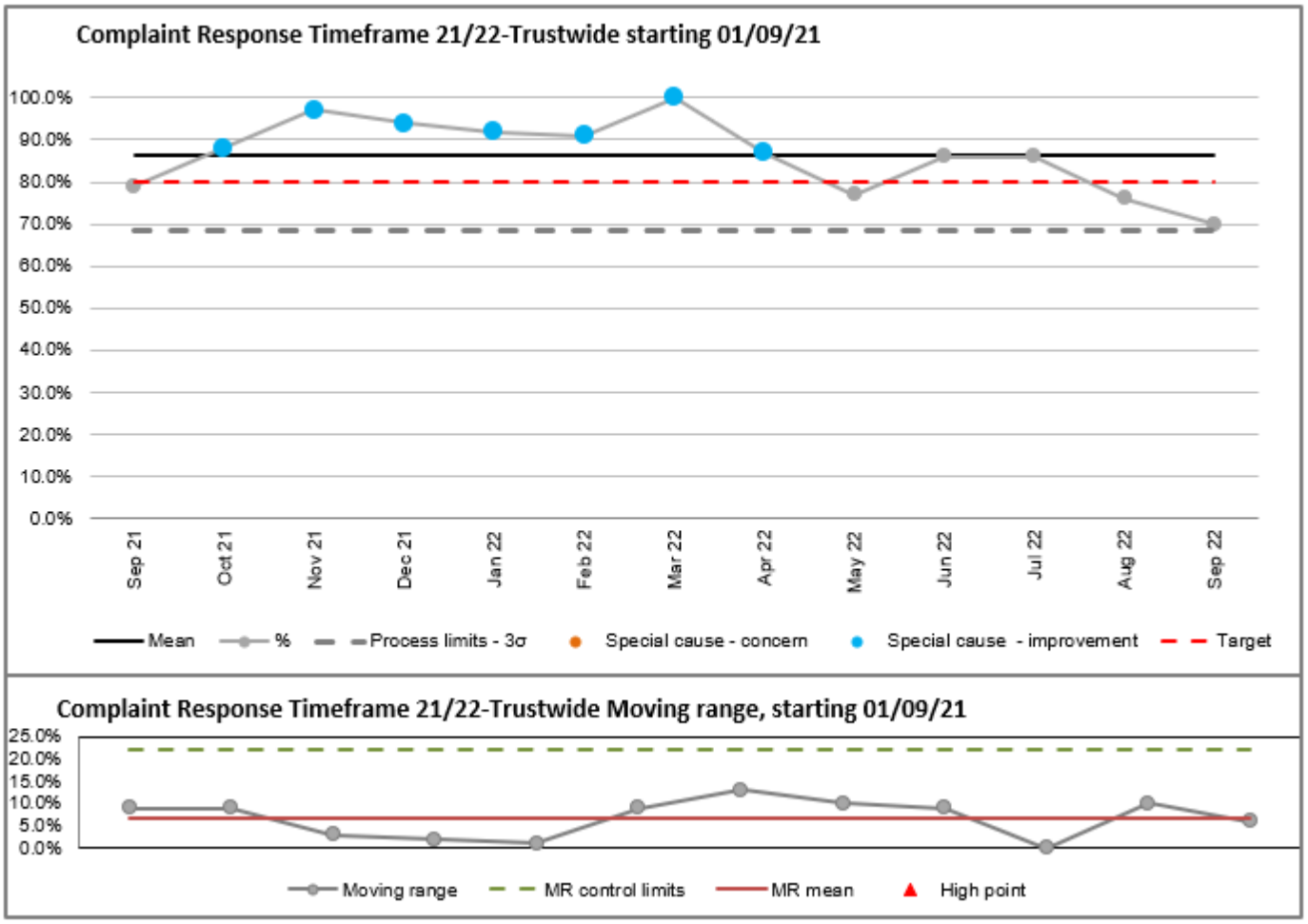


Table 3. Complaint response times

3.4 Parliamentary Health Service Ombudsman – Complaint Standards Update

we continue to be engaged attending the PHSO complaints handling seminars where we are an early adopter pilot of the new national complaint standards. There will be a public evaluation considering all the feedback received from pilot sites and early adopters in January 2023. It was stated that there are no significant changes being made to the original model complaints handling procedure.

- There will be a roll out of support materials in January 2023.
- This process will be repeated in the government next year.
- In January 2023 – the PHSO will be publishing a “learning management system” on their website which will allow staff to access digital learning. There will be learning sessions available throughout the year and there will also be “advanced learning” rolled out in 2024-2025.

- The PHSO confirmed they will not be identifying a "set" time for complaint responses as this differs from organisation to organisation. There was a strong focus on "agreed timeframes" which we already work in line with.

Developing practice taken from the seminars:

- Reporting 48-hour patient contact compliance on monthly divisional reports.
- Adding a "hotspot" page on reports to show key areas of focus
- Adding a monthly "you said, we did" to the webpage
- In the event a complaint handler does not identify an action, they should provide a short summary (no more than 50 words) regarding why an action has not been identified
- Adding into our response letters after actions agreed to the effect of "*If you would like to be kept up to date in relation to our agreed actions, please inform the Patient Relations Team on …….*"

4.0 Friends and Family

4.1 Response Rate

The below table illustrates the Trusts Friends and Family Test response rates as compared internally, nationally, regionally, and locally. (Please note, comparable national, regional, and local data has a 2-month reporting delay). Compared to Q1, the Trust has returned a consistent response rate in Q2 for Inpatients, it has an improved response rate in Q2 for Outpatients and ED and shown a reduced response rate for Community and Birth. When compared nationally, the Trust returned a higher average response rate for Inpatients (+5%), Outpatients (+13%), ED (+9%), Community (+1%) and Birth (+6%). When compared Regionally, the Trust returned a higher average response rate for Outpatients (+15%) and Birth (+6%). When compared to the 3 local organisation, the Trust returned a higher average response rate for Outpatients and Birth, and a similar for Inpatients and ED.

FFT Response Rate	Inpatients	Outpatients	ED	Community	Birth
Trust Q1 Average	24.6	19.3	16.7	7.7	19.4
Jul-22	24.8	19.4	17	7.5	20.7
Aug-22	25.9	20.8	18.1	6.6	15.3
Sep-22	24.4	20.4	21.3	0.6	17.67
Royal Wolverhampton (July 22)	25	3.2	16.4	6	12
The Dudley Group (July 22)	27.6	3.8	26.3	4.5	3.3
Sandwell and West Birmingham (July 22)	15	7.5	10.9		5.9
National Average (July 22)	19.8	6.8	9.9	3.3	12
Black Country ICB (July 22)	25.9	5.2	18.9	4.7	11.8

Table 4. Friends and Family Test response rate

4.2 Recommendation Comparison

The below tables illustrate the Trusts Friends and Family Test recommendation score as compared internally, nationally, regionally, and locally. (Please note, comparable national, regional, and local data has a 2-month reporting delay). Compared to Q1, the Trust has shown an average score improvement for Inpatients, ED, and Postnatal Community; and remained relatively consistent for Outpatients and Community. When compared nationally, the Trust returned a higher average recommendation score for ED (+1%) and Community (+7%). When compared regionally, the trust returned a higher average recommendation score for Outpatients (+1%), ED (+5%), Community (+8%), Postnatal Ward (+9%) and Postnatal Community (+7%).

When compared to the 3 local organisations, the trust returned a higher average recommendation score for Outpatients (+3%), ED (+9%), Community (+11%), Postnatal ward (+34%) and Postnatal Community (+14%).

FFT Recommendation Score	Inpatients	Outpatients	ED	Community
Trust Q2 Average	85	91	74	98
Jul-22	84	92	73	98
Aug-22	88	91	80	98
Sep-22	86	91	75	100
Royal Wolverhampton (July 22)	90	92	72	87
The Dudley Group (July 22)	88	83	69	87
Sandwell and West Birmingham (July 22)	83	88	61	
National Average (July 22)	94	93	75	92
Black Country ICB (July 22)	87	90	71	91

Table 5. recommendation score

FFT Recommendation Score	Antenatal	Birth	Postnatal Ward	Postnatal Community
Trust Q2 Average	89	83	84	84
Jul-22	77	80	88	89
Aug-22	87	73	75	89
Sep-22	78	87	85	85
Royal Wolverhampton (July 22)	85	96	78	74
The Dudley Group (July 22)		70	20	
Sandwell and West Birmingham (July 22)	78	80		
National Average (July 22)	88	92	91	90
Black Country ICB (July 22)	80	86	74	81

Table 6. recommendation score

4.3. Mystery Patient feedback

The below tables illustrate the Mystery Patient feedback received during Q2. The scored questions show an improved picture from July to September. A total of 121 Mystery Patient feedback was received in Q2.

	July	August	September
Courtesy of the staff	6.9	7.7	8.2
Environment and hospital facilities	6.9	7.0	8.1
Treated with respect and dignity?	8.3	8.0	9.0
Involvement in decisions about your care and treatment?	8.2	8.2	8.9

Table 7. scored questions

Mystery Patients	Q2 Monthly Average	July	August	September
Community	0	4	5	11
Emergency Department	1	1	2	2
Inpatients	13	21	25	11
Maternity	3	2	8	6
Outpatients	7	8	6	9

Table 8. number of mystery patient feedback received

5.0 National Survey updates:

5.1 The **2020 Adult Inpatient Survey** (results published in October 2021) action plan has been populated and evidence where available collated. Initiatives relating to communication, discharge, and providing feedback on care have been initiated.

The published findings for the **2021 survey** have now been received and the action plan has been adjusted.

The results have been shared with senior leaders and presented both to the Patient Feedback Oversight Group and Patient Experience Group for dissemination.

- 1250 were invited to take part
- 369 completed representing a 31% response rate against national average of 39% for all participating Trusts, reduction for our Trust of 8% comparted to 2020.
- Compared to the 2020 results the Trust slightly improved its average score by 0.3%.
- Change from 2020-2021 – we scored better by 5% or more for 4 questions
- Indicative National Comparisons place the Trust in the middle tier (same as band) for 38 questions and bottom 20% for 7 questions. (Improvement on 14 questions and by one for the somewhat worse band)
- The following questions saw a 5% improvement score – support at mealtimes, staff explaining how well an op/procedure had gone, hospital staff considering the family/home situation when planning to leave hospital, and information about what to do when a patient has left hospital.
- The remaining questions saw a change below 5% or no change at all compared to 2020.

Where Patient Experience is best

✓ Help with eating, patients being given enough help form staff to eat meals, if needed
✓ Noise from staff, patients not being bothered by noise at night from staff
✓ Quality of food, patients describing the hospital food as good
✓ Noise from other patients: patients not being bothered by noise at night from other patients
✓ Privacy for discussions: patients being able to discuss their condition or treatment with hospital staff without being overheard

Where Patient Experience could improve

- Changing wards during the night: explaining the reason for patients needing to change wards during the night
- Equipment and adaptations in the home: hospital staff discussing if equipment or home adaptations were needed when leaving hospital
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
- Further health or social care services: patients being given information about further health or social care services they may need after leaving hospital
- Information about medicines to take at home: patients being given information about medicines they were to take at home

Even with an improved score there is a renewed focus on noise at night and we have taken delivery of new sleep packs to accompany a re-launch of the noise at night protocol.

The division of Surgery are leading on what constitutes a good ward round which will pick up on the questions were the Trust has scored lower than the national average and communication following a ward round is seen as a key driver for improvement.

We are working with Healthwatch Walsall who have chosen discharge as an insight priority for them this year. This also mirrors feedback received via the national surveys in addition to complaints and concerns.

5.2 Maternity

The 2022 draft survey findings have been shared with us and disseminated internally. Full publication is expected in January 2023. Action planning has begun to align the ongoing improvement initiatives in Maternity with the expected benchmarked outcomes when published against national comparators.

5.3 Urgent and Emergency Care

The 2022 survey process has begun with sampling and fieldwork closing on 10 March 2023. Headline reports will be shared in April 2023 with full publication expected in September 2023.

5.4 National Cancer Survey 2021

The National Cancer Patient Experience Survey 2021 is the 11th version of the survey first undertaken in 2010. It is designed to monitor progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients. The survey was overseen by a national Cancer Patient Experience Advisory Group.

This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development. The survey was commissioned and managed by NHS England. The survey provider, Picker, is responsible for designing, running, and analysing the survey. The 2021 survey involved 134 NHS Trusts. Out of 107,412 people, 59,352 people responded to the survey, yielding an overall response rate of 55%.

For Walsall the overall response rate was 48% (204 patients from 406).

Published in July 2022, the sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2021. The fieldwork for the survey was undertaken between October 2021 and February 2022. The key summary findings are highlighted below:

Questions Above Expected Range

	Case Mix Adjusted Scores			National Score
	2021 Score	Lower Expected Range	Upper Expected Range	
Q12. Patient was told they could have a family member, carer or friend with them when told diagnosis	**81%**	63%	79%	**71%**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	**79%**	65%	78%	**72%**
Q29. Patient was offered information about how to get financial help or benefits	**86%**	60%	79%	**69%**
Q44. Possible side effects from treatment were definitely explained in a way the patient could understand	**82%**	68%	80%	**74%**
Q49. Care team gave family, or someone close, all the information needed to help care for the patient at home	**65%**	47%	64%	**55%**
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	**63%**	41%	62%	**51%**

Table 9: National Cancer Survey findings above expected range

Questions Below Expected Range

	Case Mix Adjusted Scores			National Score
	2021 Score	Lower Expected Range	Upper Expected Range	
Q36. Hospital staff always did everything they could to help the patient control pain	**76%**	78%	94%	**86%**
Q37. Patient was always treated with respect and dignity while in hospital	**82%**	82%	96%	**89%**
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	**60%**	69%	89%	**79%**

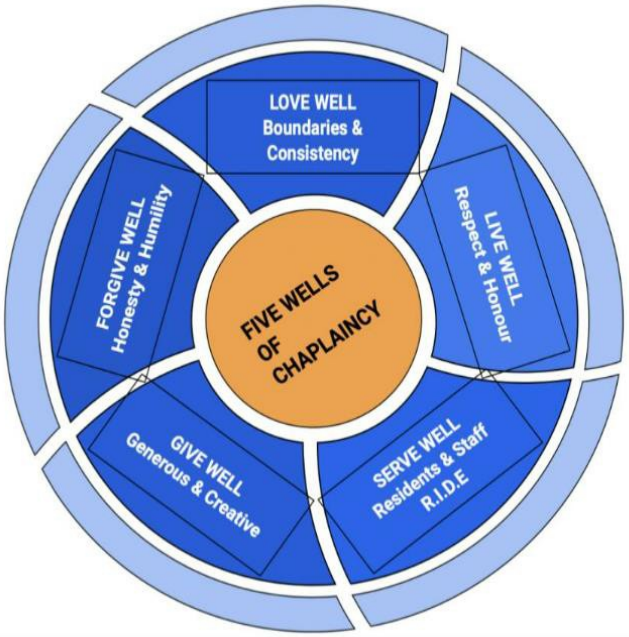
Learning from excellence	Score
Patient was told they could have a family member, carer or friend with them when told diagnosis	81.4%
Patient was able to discuss their needs or concerns prior to treatment Patient	78.6%
was offered information about how to get financial help or benefits Possible	85.9%
side effects from treatment were explained in a way the patient could understand	81.9%
Care team gave family, or someone close, all the information needed to help care for the patient at home	65.1%
During treatment, the patient got enough care and support at home from community or voluntary services	63.5%

Table 10: National Cancer Survey findings above expected range

The survey findings have been reported to the CNS meeting, tumour specific action plans are being formulated led by the Lead Cancer Nurse with monitoring and assurance provided to the Cancer Steering Group and the Patient Feedback Oversight Group.

6. Spiritual, Pastoral and Religious Care (SPaRC) July – Sept 2022

The Chaplaincy, Spiritual Care Department has continued to be about its core business of providing spiritual, pastoral, and religious care and support across all parts of our hospital and healthcare communities. Whether this has been an inpatient encounter at the bedside, supporting worried relatives, conducting a funeral service for grieving parents, or supporting staff as they face challenging work situations, our aim is "to always be there". We continue to work from the foundation of our newly implemented ***"Five Wells"*** values.



Team Recruitment and Training

We have welcomed Rev Linford Davis as the Head of SPARC across both New Cross and Walsall Chaplaincy Spiritual Care Departments. A significant number of the Chaplaincy Department from New Cross retired in July and since the last week of July the Walsall team has been providing Chaplaincy and Spiritual Care across all RWT and WHT sites. This significant increase in our workload has brought challenges and we continue to recruit and train staff and volunteers to ensure we can meet the community need and trust requirements.

WHT – We have appointed a 2nd RC chaplain for Walsall and 2 bank chaplains, commencing shortly.

RWT – We have now employed an administrator (August), an ecumenical chaplain, commencing in November, an assistant Roman Catholic chaplain, currently going through the vetting process, a Team Leader, and will be shortlisting for the Anglican Chaplain post, as we have suitable applicants.

WHT/RWT Team Leaders

Following an assessment of the needs of our provision at RWT and WHT we have proposed innovative step towards alignment by exchanging the Team Leader of WHT and RWT. This will bring experience and stability to the newly forming team at RWT, and reinvigoration and reframed insight to the team at WHT as we work towards a new shared vision and strategy.

Pastoral Encounters

The SPARC tool (a web-based method of recording pastoral encounters) which was previously used at WHT has now been introduced at RWT (August) which enables us to have a greater depth of insight into the scope and impact of our provision.

A brief analysis of our findings show we had at least 2100 separate pastoral encounters between our staff and volunteer team. These encounters have included extensive pastoral and spiritual support for staff. In WHT we were able to capture the content of our encounters, 88% had a Pastoral element, 77% a Spiritual element, and Religious (Faith Specific) care has been present in 49% of our encounters. This is indicative of our personable and needs sensitive approach. Across the Trusts around 80% of our inpatients are registered as having a Faith or Religious belief, we continue to provide appropriate support and care for those with and without Religious affiliation or belief, and will utilise community links to enhance our provision.

Training and Staff support

Across the Trusts we continue to engage with the wider organisation through involvement in the delivery of training, on matters of faith awareness, international nurse orientation, and active participation within the Schwartz round, with WHT team leader Rev Joe Fielder fulfilling an active role within the facilitation and steering panel. Muslim chaplain (Imam) Ahmed Salloo and Sikh Chaplain (Giani) Shyam Singh were also amongst the team that contributed to the WHT Maternity Departments Bereavement Study Day, helping attendees to have a deeper understanding of the Spiritual care that is provided by our department at and after pregnancy loss, as well as educating attendees on some of the Cultural and Religious reactions they may encounter in response to death.

Helping with End-of-Life (EOL) care

We continue to provide support to patients and their families who are facing palliative and end of life care. At WHT We have regularly received referrals from the palliative care team and provided support at Goscote Hospice and Day Care Centre. We will be part of the staff team trained as the Trust adopts the Gold Standards Framework to manage and communicate holistic care for patients identified to be in the last year of their life.

Across both trusts the vast majority of our out of hours call outs have been to provide Spiritual or Religious support in EOL situations.

In the quarter July to September as a WHT and RWT team we conducted 29 hospital arranged baby funerals and 5 adult funerals. In addition, we have been called to delivery suite to conduct simple Naming and Blessing services following pregnancy loss for parents. We continue to maintain and develop stronger working relationships with the respective specialist palliative care teams, the Bereavement midwives, maternity departments and bereavement services. Following the great feedback received at RWT regarding Religious and Pastoral support offered to families during mortuary viewings, WHT has now started offering this additional support in partnership with the mortuary department.

Chaplaincy and Spiritual Care has been a part of several special events, most notably at WHT a series of Back-to-school themed events facilitated by Rev Anthony Swaby at the Palliative Care Day hospice. At RWT Rev Edd Stock conducted the wedding of a palliative care patient in the patient's house, which attracted media coverage, this is an example of the team's willingness to step outside the norm, to deliver the best care. We continue to participate and engage in several groups and committees, including BAME, Occupational Health, Staff wellbeing strategy and End-of-Life Task group.

Poignant and Traumatic moments

Following the death of the Queen, the chaplaincy department sought to provide a prompt, unified approach to our care cross site. This meant chaplains developing and distributing resources, such as prayer, support leaflets, and books of remembrance. But is also meant us reorganising our work schedule to ensure we were available to provide a comforting presence through ward visits, and multi-faith services of prayer and respective across both sites.

This collaborative approach continued, in our response to the sad passing of two members of staff, both being quite sudden. As a team, we jointly and rapidly responded to provide what help we could both immediately to the staff teams in the departments and units affected as well as providing pastoral and religious care to the families and close friends and colleagues; and in the days and weeks that followed.

7.0 Patient involvement Partners (PiP's)

The Patient Partners met in September and received updates from the Patient Experience Team. The partners discussed the Mystery Patient scheme and how this works and expressed involvement with the leaflet being developed by the Emergency Department on what to expect when visiting. In addition, our partners will support PLACE assessments, quality improvement work and National Survey monitoring in response to National Surveys. Three PiP's have also joined the Patient Experience Group.

8.0 Visiting – The Welcome Hub

The welcome hub team have continued to manage Trust visiting arrangements since covid-restrictions were lifted. Pre-booked visits allow up to two visitors per patient per hour. In quarter 2, capacity averaged 36% with 18,168 visits booked and carried on. The booking line and welcome hub desk is manned 7 days per week between the hours of 8.00am and 6.30pm. This provides staff cover in the main hospital atrium and the team deal with general enquiries, way finding, and wheelchair location supported by Trust volunteers.

Table 11. Welcome Hub visiting statistics

8.2 Volunteers

71 Applied to volunteer in Q2 Up 27% on Q1	Volunteers supporting the hospital in Q2 96
Total Hours Logged in Q2 3155	**Top hours for Q2** 1ST 152 2ND 98 3RD 92

Table 12. Volunteer statistics

9.0 Engagement

9.1 Walsall Pride

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

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

10.0 RECOMMENDATIONS

Note the contents of the report

MEETING OF THE TRUST BOARD – 7 December 2022			
The Quality Improvement Team Update			
Report Author and Job Title:	Joyce Bradley Head of Quality Improvement	**Responsible Director:**	Simon Evans, Group Chief Strategy Officer
Recommendation & Action Required	Members of the Committee 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 • Good engagement from the Divisional teams in accessing and applying a QI Approach to making improvements • Addressing the CQC requirements for organisations to develop a mature QI approach • We are working closely with our colleagues based in RWT to develop QI huddle boards which can be used to empower all frontline staff (clinical and non-clinical) by engaging in improvement without having to leave their normal place of work.		
Advise	• Walsall recognised by the national NHSE/I Increasing Capability Building and Delivery (ICDB) Team for their approach to building capacity and capability • The QI board development session recommendations are now part of a QI Action Plan which will be submitted, for approval, to the inaugural Improvement, Innovation and Research Group (02.12.22). This will then require a concerted, Trust-wide effort to move the organisation to the next level of embedding QI at all levels. • Walsall QI Academy and the CQI Team at RWT are now integrated and will be called the Quality Improvement Team (QI Team); a new logo has been agreed and all marketing materials will be changed.		
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.		

Joint Trusts' Strategic Objectives	CARE: Excel in the delivery of **Care - Yes**
	COLLEAGUES: Support our **Colleagues – Yes**
	COLLABORATION: Effective **Collaboration - Yes**
	COMMUNITIES: Improve the health and wellbeing of our **Communities**

QUARTERLY UPDATE FROM THE QUALITY IMPROVEMENT TEAM

1. PURPOSE OF REPORT

1.1 The purpose of the report is to inform the Board of the progress with increasing the capacity and capability of colleagues in an agreed QI Approach, namely the Quality Service Improvement and Redesign (QSIR) programmes across the organisation and beyond through quarter 2 of financial year 2022/23.

1.2 The paper also informs the Board 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 has been delivering the range of QSIR Programmes since January 2019. With the collaborative working that is taking place between The Royal Wolverhampton NHST and Walsall Healthcare NHST the QI Academy has been working more closely with the Continuous Quality Improvement Team at The Royal Wolverhampton NHST. The closer working is being cemented by each team coming together under the same name and branding – the Quality Improvement (QI) Team.

2.2 The QI methodology delivered by both organisations is the Quality, Service Improvement and Redesign (QSIR) programmes that were developed by NHS Improvement. Each organisation has accredited trainers who deliver the training to a consistent and monitored quality.

2.3 The QI Team are working to address the recommendations of 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) that was published in 2017.

2.4 This report relates to the activity of the QI Team at Walsall Healthcare NHST.

3. DETAILS

3.1 The report sets out what has been achieved within the last quarter within the ongoing restrictions imposed for compliance with social distancing for programmes which are accredited for face-to-face delivery during the reporting period.

3.2 The report sets out the progress being made in mapping the complexities of the Antenatal Clinics and working with the teams to make improvements.

3.3 This quarter saw the report, generated by the national Improvement Capability Building and Delivery (ICBD) Team at NHSEI, following the two Board Development sessions undertaken in Q1. Work is under way to articulate how to deliver the recommendations from that report.

3.4 Specific elements of work were undertaken by the QI Team which supported making services safer for patients and staff. This included working with teams ED, AMU, See and Treat and Ambulatory Emergency Care team in readiness for moving into their new facilities.

3.5 Other teams supported during the last quarter include the Cancer Care Navigators, the ESR and Temporary Staffing Teams and working with the Quality team in Community.

3.6 The report identifies the areas which will be the focus of work for the QI Team during Q2 2022/23 and sets out three broad areas of work:-

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

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

- 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 these can become more efficient by applying the Health Care Systems Engineering (HCSE) principles.

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

- Delivery of training programmes specifically for Doctors in Training and SAS Doctors
- Refining the QSIR Delivery plan for the three QSIR programmes and Health Care Systems Engineering throughout the financial year.
- Implementation of Improvement Huddle boards in Community and Estates and Facilities.

4. RECOMMENDATIONS

The Board 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 Team 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 3, 2022/23

Joyce Bradley
Head of Quality Improvement

Meeting of the Trust Board Wednesday 7th December 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 evidence reviewed by DoN and accepted • Positive Insight review of progress made on the implementation of the Ockenden Report.		
Advise	• Culture review on-going. Preliminary report attached to appendix for information. • The service continues to actively recruit as pressure continues due to high maternity leave. • Maternity triage audits continue and has demonstrated excellent response times to calls. • The service continues to monitor and review all perinatal losses		
Alert	• Nothing to alert		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF 1: Safe, high quality care • Risk number 2245: Lack of registered nurses and midwives		
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 Trust Board on the following items:

- Resource
- Perinatal mortality
- QI
- Culture
- Maternity Sis

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. Resource

Midwifery Staffing

There continues to be challenges with staffing due to staff absences, the table 1 below is a breakdown of absence for October 2022. The service has continued its active recruitment. Maternity leave has increased to 8.4% from 6.9%. Sickness management continues.
The care group is awaiting approval of its business case to address both the maternity leave pressure and the requirements outlined by the final Ockenden report.

Table 1

HEALTHROSTER — Unavailability by Grade Type Category
Start Date: 01/10/2022 End Date: 31/10/2022

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Women's Services (Are)	Delivery Suite - Nursing	Registered Midwives	14.4%	1.0%	8.4%	7.2%	4.6%	2.1%	37.6%
		Trainee					2.7%		2.7%
		Unregistered Nurses	18.9%	3.4%		10.8%	6.7%		39.8%

2.2. Activity within the Maternity Unit

Table 2 highlights the delivery activity within Maternity Unit on a month by month basis.

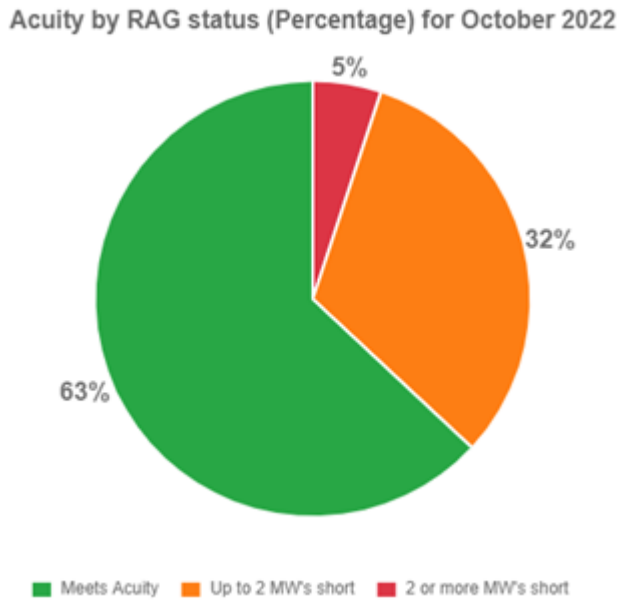
Table 2. Birth Activity October 2021- September 2022

Month	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22
No: Births	294	311	298	287	331	284	300	285	288	312	325	297

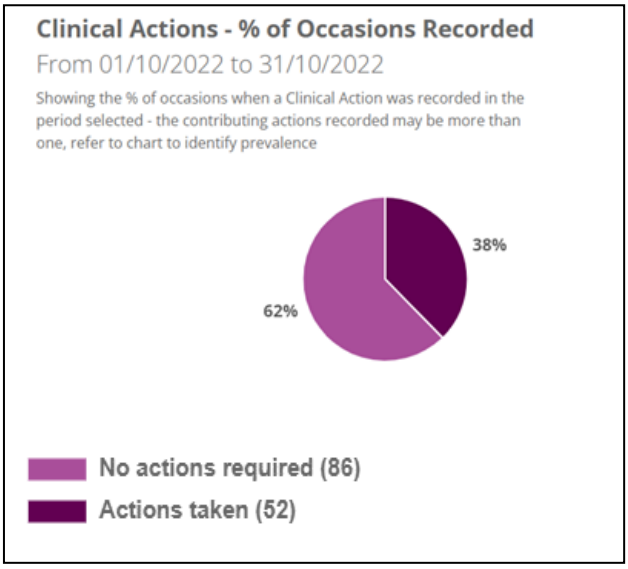
2.4 Acuity

Birth-rate Plus acuity tool is used to monitor the unit's 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 Oct. was 63%. (See Graph 1). Graph 2 outlines that 62% of the time there was no action required and outlines that action was taken 38% of the period. Graph 3 outlines the specific actions taken to maintain safety. The main action taken is delay in induction of labour.

Graph 1



Graph 2



Graph 3

Number & % of Clinical Actions Taken

From 01/10/2022 to 31/10/2022

CA1	Decline in utero transfer	2	4%
CA2	Delay in accepting transfers	0	0%
CA3	Delay in commencing IOL as per trust guidelines	4	7%
CA4	Delay /cancel planned procedures e.g.ECV,Cervical suture	2	4%
CA5	Delay in transfer of cases to theatre e.g. perineal repair, MROP	0	0%
CA6	Delay El. LSCS >24hrs	0	0%
CA7	Delay in continuing IOL as per Trust guideline	46	85%
	Total	54	

2.5 Perinatal Mortality

Perinatal mortality rates continue to be monitored monthly with all loss reviewed by the multidisciplinary team including an external reviewer using the national Perinatal Mortality review tool. Lessons are disseminated to staff. Graph 4 outlines the number and category of fetal losses for Q1 2022/ 23.
Eligible cases have been reviewed in line with the national framework.
One case was also reviewed in line with the current SI framework. This was related to inappropriate plan of care when the woman presented with reduced fetal movement. The patient was seen by a Registrar but was not offered Induction of labour in line with current guidelines. The lady later presented with no fetal heart. Key finding was that the induction guidelines were not followed, and the woman should always be the focus of any management plan.

Graph 4

Walsall Healthcare NHS
NHS Trust

Internal PMRT Cases for Review– Quarter 1 2022

Q1 2022	Late Fetal Loss <22/40	Late Fetal Loss 22-23+6/40	Stillbirth	Neonatal Death <22/40	Neonatal Death >22/40	Termination of Pregnancy	Total Monthly Losses	TOTAL ELIGIBLE FOR REVIEW
April	0	1	1	0	0	2	4	2
May	1	0	0	0	0	0	1	0
June	0	0	1	0	1	2	4	2
Total Loss by type	1	1	2	0	1	4	9	4

= suitable for review using PMRT tool

3.0 QI

Triage

The service continues to audit its triage service quarterly to ensure that women are seen in audit of need. Audit of Q1 2022/ 23 demonstrates that 69% of women were seen within 15 minutes of arrival (graph 5) and 87.5% of women were seen within 30 minutes of arrival (table 3).
Graph 6 is the ethnicity of women attending triage in October.
One of the Key actions for triage is to monitor calls and answer them in a timely fashion to ensure women receive the required care. In October the service introduced a new telephone system to support this. Graph 7 demonstrates a fantastic start for the new process. 87.9% calls were answered, and the average wait time was 2 minutes. The Ockenden business case submitted by the service has included a request for a maternity support worker on every shift which will result in a further improvement.

Graph 5

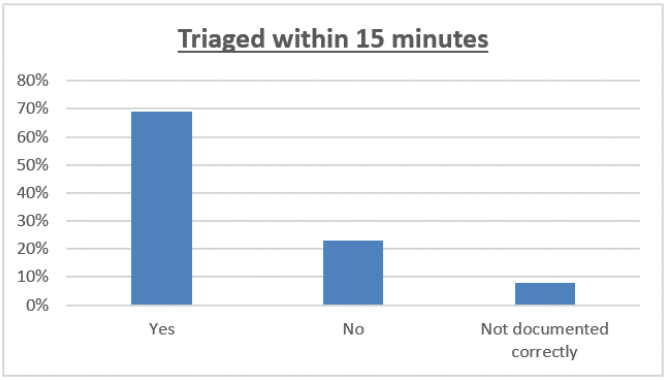
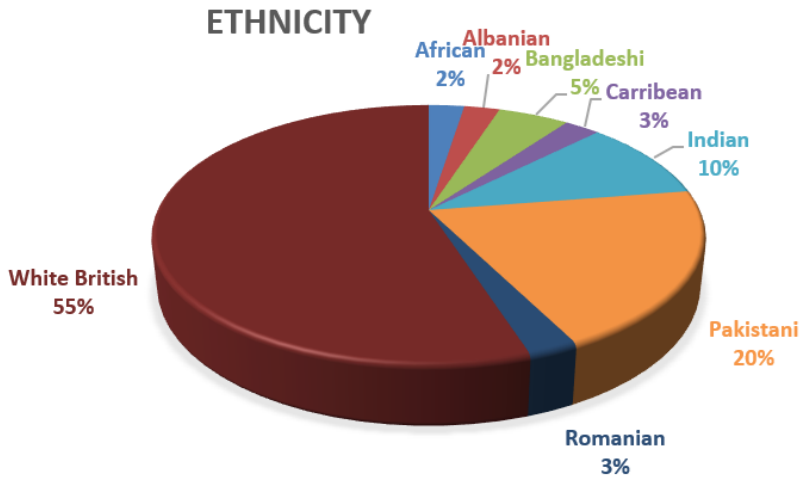


Table 3

Of the 9 women that were not triaged within 15 minutes:

Triage Urgency	Time Triaged within	Outcome
	25 Minutes	All records have been reviewed and no adverse harm has been caused as a result of the delay. On all 9 occasions there were 2 midwives working in Maternity Triage
	23 Minutes	
	21 Minutes	
	53 Minutes	
	40 minutes	
	45 Minutes	
	30 minutes	
	50 Minutes	
	43 minutes	

Graph 6



Staff Feedback

Following the implementation of BSOTS we conducted a qualitative staff survey asking two questions:

1. What could we do to further improve triage?
2. What is working well?

We received 10 responses back and have collated that feedback to present any common themes/trends.

Overall feedback remains positive from staff, and they preferred the new model of working compared to the previous Triage system. They demonstrated both staff improvement and patient improvement. See a few comments below:

Feedback from Women

Women were offered the opportunity to complete a paper survey of their Maternity Triage experience. A total of 10 women participated in the survey.

From the survey, 100% of women felt safe, cared for, treated with compassion in Maternity Triage and that all questions were answered.

Women that phoned triage waited from 1-5 minutes to have their call answered.

Women who attended maternity triage also commented on the service:

"Very happy. Midwives were very nice and welcoming."

"I wasn't sure and not kept in the loop".

Good Practice

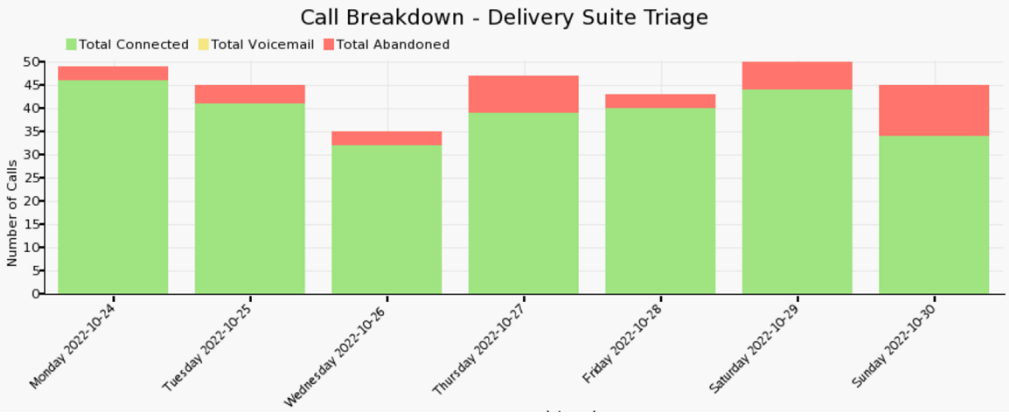
- ✓ 100% felt cared for, safe and treated with compassion in Triage.
- ✓ Positive recognition of how the midwife made women feel
- ✓ 100% of women felt that they were kept informed of the care they were given

Areas for improvement

- ✓ Some women waited longer than others for calls to be answered
- ✓ Waiting times to see a Doctor.
- ✓ Electronic survey to all women following an admission to Maternity Triage to improve data quantity and increase qualitative data

Graph 7

Incoming Call Breakdown By Day
For: Delivery Suite Triage
Dates: From: 2022-10-24, To: 2022-10-30 (Last Week)
Time Filter: between '00:00:00' AND '23:59:59'



		Interval														
		Connected							Voicemail				Abandoned			All
Interval	# Calls	Total	sub 5 sec	Max Wait	Avg Wait	Max Talk	Avg Talk	Total Talk	Total	Max Wait	Avg Wait	Total Talk	Total	Max Wait	Avg Wait	Avg Wait
Monday 2022-10-24	49	46	0	00:12:50	00:00:53	00:07:20	00:03:09	02:25:03	0	00:00:00		00:00:00	3	00:17:29	00:06:51	00:01:15
Tuesday 2022-10-25	45	41	1	00:05:27	00:00:41	00:08:27	00:02:33	01:44:19	0	00:00:00		00:00:00	4	00:02:35	00:01:19	00:00:44
Wednesday 2022-10-26	35	32	0	00:04:41	00:00:59	00:10:19	00:03:04	01:37:59	0	00:00:00		00:00:00	3	00:01:43	00:00:40	00:00:57
Thursday 2022-10-27	47	39	2	00:08:04	00:00:46	00:12:44	00:03:16	02:07:14	0	00:00:00		00:00:00	8	00:07:56	00:02:50	00:01:09
Friday 2022-10-28	43	40	1	00:07:24	00:01:15	00:14:34	00:03:46	02:30:54	0	00:00:00		00:00:00	3	00:00:53	00:00:22	00:01:11
Saturday 2022-10-29	50	44	1	00:11:10	00:02:30	00:11:25	00:04:46	03:29:39	0	00:00:00		00:00:00	6	00:04:20	00:02:42	00:02:31
Sunday 2022-10-30	45	34	1	00:39:39	00:07:39	00:12:07	00:03:31	01:59:18	0	00:00:00		00:00:00	11	00:24:09	00:08:04	00:07:45
	314	276	6	00:39:39	00:02:00	00:14:34	00:03:28	15:54:26	0	00:00:00	00:00:00	00:00:00	38	00:24:09	00:04:07	00:02:15
%		87.9							0				12.1			

4.0 Ockenden - NHSEI Insight visit

The service has had its NHSEI assurance insight visit from the regional maternity team which include representation form the Local Maternity System. The feedback was overwhelmingly positive. The feedback presentation is in the appendix.

5.0 CNST

The service has submitted evidence to demonstrate its compliance with CNST year 4. This has been reviewed by the Director of Nursing and approved. There will be formal submission to the December board for approval. The CNST declaration form is due for submission on the 2nd February 2023.

6.0 Culture Review

There is an on-going review of culture within the unit and a preliminary draft report has been produced. I have highlighted the areas to celebrate as well as the recommendations. The draft report has been shared with the Director of Nursing.

– *What's working well*

Leadership
Significant changes in leadership have had a positive impact on staff experience and engagement. Changes that were regularly noted are summarised below.

- The current Director of midwifery is highly visible, accessible, and receptive and this is highly valued by all staff.

- The senior leadership team are experienced as more visible, stronger, and kinder to each other. The pandemic brought this team closer together. There is a sense of the good rapport within this group and between them and staff, and of greater openness where previously there was a sense of territoriality and a closed in group keeping things in house.

- New ward leadership is having a positive impact. The fact that the ward manager is now permanent should help overcome some of the inconsistencies that may have created a lack of staff containment[1] on the wards.

Delivery Suite
Interviewees described how there has been a huge shift in delivery suite from old school practices to more inclusive MDT working and a commitment to recruiting and developing staff with a focus on soft skills. Like all maternity units there is tension between delivery suite and the wards, with staff being taken from wards to staff delivery suite if needed. Work to bring these two groups of staff closer together and to develop a sense of understanding of each other's respective pressures may reduce this tension and the sense of us and them it has created.

Community
Community staff presented a picture of a staff group with high morale and good job satisfaction.

Medical Culture
Recent years have seen some very significant changes within the medical workforce including the retirement of some older medical consultants and the establishment of a new medical lead. As a result, many felt that medical culture is more equal now with more cohesion and a greater ability to challenge each other. The new CD is seen

to be settling in well and is respected and hardworking. There was a sense of pride and satisfaction that Walsall is seen as somewhere that both trainees and other doctors want to come and work with a cohesive and supportive culture.

Key initial recommendations from the review are -:

- Focus groups with front line staff
- Design and develop for role clarity and role authority
- Invest in clinical leadership development
- Continue to improve the working environment
- Band 7 regular facilitated reflective space (6 weekly)
- Leadership groups regular facilitated reflective space
- MDT team development including opportunities to reflect on impact of work and its difficult contexts
- Develop a co designed induction programme for international midwives

7.0 Serious incidents

There were no serious incidents in October

8.0 RECOMMENDATIONS

The service is requested on-going support for the Ockenden business case. Members of the Committee are asked to review and note the contents of this report.

Appendix 1 - Maternity Services – Overview Findings of Regional and System Insight Visit

Walsall Healthcare NHS Trust

Maternity Services – Overview findings of Regional and System Insight Visit

13th September 2022

NHS England and NHS Improvement

Visit Purpose

An Insight visit to WHT NHS Trust maternity services was completed on the 13th September 2022.

The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Conversations were held with members of the senior leadership team and many front line staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions headings

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Insight Visit Team members: Midlands Perinatal team ;Sandra Smith, Deputy Regional Chief Midwife Chantal Knight, Regional Governance and Assurance Lead Midwife, Susie Al-Samarrai, Regional Lead Obstetrician; ICB: Helen Hurst Director of Midwifery Black Country ICB

Key Headlines

Points for celebration

- The Ockenden report seen as a real opportunity to improve safety and improve care at Walsall by the whole team
- Strong credible leadership team in place both in Trust and division, demonstrating enthusiasm, drive for improvement and succession planning
- loyal, caring and compassionate group of staff who genuinely enjoy working at Walsall and describe their colleagues as ‘family’
- positive picture of recruitment and retention of staff in obstetrics and midwifery with the expectation of full establishment of midwives by December 2022
- Excellent use of staff information boards displaying up to date work already underway, including Ockenden actions and quality safety surveillance model
- Creative remodelling of workforce examples in place for the service
- positive recognition of the support given from the LMNS cross trust working by Walsall staff

Key Headlines

Points for consideration

- Review and increase PA allocation for important and essential additional obstetric roles including; governance lead; SBLCBv2 lead, audit lead, guideline lead, PMRT lead and fetal monitoring lead
- Strengthen audit plan to incorporate all Ockenden actions which are regularly reported throughout the division, utilising Badgernet capability
  - Ensure staff are aware of audit results , Ockenden requirements and professional implications, using variety of communication pathways including information boards in clinical areas, social media and training study days
- strong MVP in place who is maximising the potential to reach minority groups
  - ensure LMNS appropriately remunerate MVP for all work undertaken in timely way
- Ensure link with the NED in place with MVP for regular discussion and feedback
- PMRT meetings should be coordinated by governance team, currently led by the bereavement midwife, in order to prevent any conflict of interest

Summary of Insight Visit Review of Ockenden IEAs Status

IEA	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced safety								
2) Listening to women and families	N/A	N/A						
3) Staff training and working together								
4) Managing complex pregnancy								
5) Risk assessment throughout pregnancy								
6) Monitoring fetal well-being								
7) Informed consent								
Workforce Planning								
Guidelines								

IEA1 Enhanced Safety

- Points for celebration
- Governance methodology was visible and embedded across the division
- SI's and learning are clearly shared at both Trust and LMNS Board
- Good process in place to review PMRT cases including the involvement of external colleagues to fully discuss cases
- 100% of HSIB cases are reported and >95% cases for PMRT are commenced in the timescale required

Points for consideration

- PMRT cases have MDT review and are taken for external review - consider grouping cases into thematic reviews for external clinical opinion to assist with workload e.g. congenital abnormality and severe prematurity
- PMRT meetings should be coordinated by the governance team, currently led by the bereavement midwife to prevent conflict of interest

IEA1	RAG
Q1 - Dashboards	
Q2 – External review of SIs	
Q3 – SIs to Board/LMNS	
Q4 - PMRT	
Q5 - MSDS	
Q6 - HSIB	
Q7 - PCQSM	
Q8 – SIs to Board/LMNS	

IEA2 Listening to Women & Families

Points for celebration

- Monthly meetings of maternity safety champions were well embedded and evidenced
- Posters with details of all maternity safety champions were visible in clinical areas
- A strong MVP in place, maximising potential to reach minority groups – ensure the LMNS renumerate the MVP for work undertaken in a timely way

Points for consideration

- Ensure link with NED is in place with MVP for regular discussion and feedback
- Dates of future meetings of safety champions could be included in posters, along with focus area's for the month

IEA2	RAG
Q9 – Advocate role	N/A
Q10 – Advocate role	N/A
Q11 – NED	
Q12 - PMRT	
Q13 – Service user feedback	
Q14 – Bimonthly safety champ meetings	
Q15 – Service user feedback	
Q16 – NED	

IEA3 Staff Training and Working Together

Points for celebration

- Fully achieved the required standard for MDT training
- Comprehensive understanding of training compliance rates across staff groups
- A daily midday video call in place to discuss workflow and reciprocal patient arrangements in order to share workload across LMNS
- The governance team attend labour ward handover each morning, facilitating shared learning across the division

IEA1	RAG
Q17 – MDT Training	
Q18 – Cons. Ward Rounds	
Q19 – Ring-Fenced Funding	
Q20 -	
Q21 – 90% MDT Training	
Q22 – Cons Ward Rounds	
Q23 – MDT Training Schedule	

IEA4 Managing Complex Pregnancy

Points for celebration

- SBLCBv2 compliance is achieved and embedded
- Maternal Medicine pathways appear effective and well embedded

Points for consideration

- Strengthen the audit plan to incorporate all Ockenden actions which are frequently and regularly reported throughout the division
  - utilise Badgernet capability
  - Ensure staff are aware of audit results , Ockenden requirements and professional implications, using variety of communication pathways including information boards in clinical areas, social media and training study days
- Complete audit to provide evidence for adherence to Maternal Medicine pathway for women and consultant ward rounds twice daily

IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

IEA5 Risk Assessment Throughout Pregnancy

Points for celebration

- Antenatal risk assessment completed on maternity information system - Badgernet - at every visit and audit in place
  - Verbal evidence during staff feedback confirms compliance
- SBLCBv2 compliance is achieved and embedded

IEA5	RAG
Q30 – Risk assessment	
Q31 – Place of Birth RA	
Q32 – SBLCBv2	
Q33 – RA recorded with PCSP	

Points for consideration

- Continue to monitor SBLCBv2 compliance with regular audit processes reported through divisional governance meetings

IEA6 Monitoring Fetal Well-Being

Points for celebration

- Fetal wellbeing leads in post with clinical expertise as described in IEA
- SBLCB2 is implemented and embedded

Points for consideration

- Continue to monitor SBLCBv2 compliance with regular audit processes reported through divisional governance meetings

IEA6	RAG
Q34 – Leads in post	
Q35 – Leads expertise	
Q36 – SBLCBv2	
Q37 – 90% MDT Training	
Q38 – Leads in post	

IEA7 Informed Consent

Points for celebration

- Led by birth centre matron, women are able to access birth options outside of national guidance if requested. This service is well utilised
  - Close collaboration with obstetric colleagues with who understand importance of listening to women, explaining the options and supporting them in their decision making is evident
- birth reflection clinic has been commence by a community midwife in order to support women in understanding their personal birth experience

Points for consideration

- Utilise data from birth reflections clinic and cases discussed with birth centre matron to provide evidence for Ockenden actions
- Understanding that work is already underway with the EDI midwife, a further review with MVP collaboration to assess the quality of the accessible information on the trust website
  - This would help woman to make an informed decision regarding place of birth - consider benchmarking against Birmingham Women's and Children's website, which is fully compliant
  - ensure website can give service users access to pathways of care in any language required and capability of providing information for women and their families who have auditory and visual impairments

IEA7	RAG
Q39 – Accessible Information, Place of Birth	
Q40 – Accessible Information, All Care	
Q41 – Decision making and Informed Consent	
Q42 – Women's Choices Respected	
Q43 – Service User Feedback	
Q44 - Website	

Workforce Planning & Guidelines

Points for celebration

- Visible strong leadership from both t Director (DOM) and Head of Midwifery
  - senior leadership team in place with regular formal operational and informal meetings to discuss current concerns and solutions
- Open and honest organisation ,with shared understanding of issues at all levels
  - Loyal staff who enjoy working for the Trust and appreciate access to career development and progression

Points for consideration

Continue with the recruitment process and appointment of a consultant midwife

- Although internal guidelines are well managed by the governance team consider strengthening the management regarding non evidenced guidance used in the trust e.g. deviations from NICE and SBLCB2
  - SOP should be in place with mitigations and reported on the divisional risk register
  - outcome data to be regularly reviewed in order to substantiate the continued use of non evidenced guidance or propose change of guideline
  - exception reporting to be tabled monthly at divisional governance meetings
  - cross reference to SI's , HSIB and changes in stillbirth rates

WFP & G	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Additional Points for Celebrations / Points for Consideration

- Excellent EDI Lead midwife in place
  - Introducing many innovative QI projects addressing the health inequalities in the demographics of the population
  - Links to senior leadership team and Trust board

- Many new specialist midwifery posts have been created at Walsall which is very much welcomed and needed, providing additional opportunities for career development
  - Consider expanding on roles for succession planning, expanding remit and to cover possible sickness or leave
  - Consider new role of induction of labour coordinator
  - Consider new role of triage coordinator
  - Consider additional role of Bereavement midwife in order to provide 7 day cover

The visiting team would like to express thanks to all the staff who on the day of the visit were very welcoming in sharing their thoughts regarding the maternity services.

Meeting of the Public Trust Board 7th December 2022			
Director of Midwifery Report – CNST Report			
Report Author and Job Title:	**Carla Jones-Charles – 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	• **The service is on track with all CNST safety actions and the evidence has been reviewed by the Director of Nursing.**		
Advise	• **There has been some technical issues with the national data pull for CNST safety action 6. This is a regional issue and the service has completed and action plan for further assurance.**		
Alert	• **There continues to be staffing pressures due to staff absence.**		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• **BAF 1: Safe, high-quality care** • **Risk number 2245: Lack of registered nurses and midwives**		
Resource implications	**This report supports positive steps to achieving CNST.**		

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 ☐	

CNST Incentive Scheme

1. PURPOSE OF REPORT

The purpose of the reports is to inform the Trust Board of our CNST incentive scheme progress for 2022/23

2. BACKGROUND

The Trust currently spends £4m per year for our Maternity department to be a member of the Clinical Negligence Scheme for Trusts (CNST). Maternity safety is an important issue for all members of the CNST. Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend.

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. For a third year CNST have joined forces with the national maternity safety champions to support the delivery of safer maternity care through an incentive element to the contribution to the CNST, rewarding trusts meeting ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.

Provision for the maternity incentive scheme has been built into the CNST maternity pricing for 2022/23. The scheme incentivises ten maternity safety actions (Please see section 3). Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@.nhs.uk) by 12 noon on Thursday 3 February 2023 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing maternity safety actions by the Head of Midwifery and Clinical Director for Maternity Services
- The Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 5 January 2023

3. DETAILS

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Required Standard:
a) All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. b) A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. c) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

d) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated, parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead, ensure that someone takes responsibility for maintaining contact and for taking actions as required.

e) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

Relevant time period: From 6 May 2022 until 5 December 2022

Minimum evidential requirement for trust Board	**Action met? (Y/N)**
Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	**Y**

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required Standard

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

1. By October 2022, Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity

Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme

2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.
3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.
4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.
5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2).
6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).
7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in 19 the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:

Midwifery Continuity of carer (MCoC)

i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.
ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.
iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.

Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.

Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement).

The data for July 2022 will be published in October 2022.

If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information

Minimum evidential requirement for trust Board	Action met? (Y/N)
Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.	**Working on the Digital Strategy. On target to achieve** **Yes**

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required Standard

a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.
c) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.
d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered
e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.
f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need

for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.

h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.

Minimum evidential requirement for trust Board	**Action met? (Y/N)**
Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: Evidence for standard a) to include: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted	**Yes**
Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year.	**Yes**
• Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.	**Yes**

Evidence for standard c) to include: • Data is available (electronic and/or paper based) on all term babies transferred or admitted to the neonatal unit. This will include admission data captured via Badgernet as well as transfer data which may be captured on a separate paper or electronic system. If a data recording process is not already in place to capture all babies transferred or admitted to the NNU this should be in place no later than Monday 18 July 2022	**Yes**
Evidence for standard d) to include: • Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). • Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.	**Yes**
Evidence for standard e) to include: • Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioner	**Yes**
Evidence for standard f) to include: • An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year If not already in place, an audit trail is available which provides evidence that reviews from Monday 18 July 2022, now include all term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there.	

Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting	
Evidence for standard g) and h): • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f).Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter.	**Yes**

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required Standard

a) Obstetric medical workforce

1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-ssues/rolesresponsibilities-consultant-report/

2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS

b) Anaesthetic medical workforce:
A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)

c) Neonatal medical workforce:
The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.

d) Neonatal nursing workforce:
The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.

Minimum evidential requirement for trust Board	Action met? (Y/N)
Obstetric medical workforce Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1 **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing	**Yes**

doreen@crawfordmckenzie.co.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.	

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
Required Standard	
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period	
Minimum evidential requirement for trust Board	**Action met? (Y/N)**
The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio	**Yes**

-The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls	

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required Standard

1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.

2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.

3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.

The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.

Minimum evidential requirement for trust Board	Action met? (Y/N)
Element one Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2	Yes

Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe).

If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition, the Trust board should specifically confirm that within their organisation they:
1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.
2) Have a referral pathway to smoking cessation services (in house or external).
3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.
4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:
• Percentage of women with a CO measurement ≥4ppm at booking.
• Percentage of women with a CO measurement ≥4ppm at 36 weeks.
• Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.

Additional information

If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022.

If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.

Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. Women declining CO testing at booking / 36 weeks Appointment Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching	Yes
Element two Process indicator: 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan. Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in-house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition, the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	Yes

5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.	
Element three Process indicators: A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.**	Yes Yes
Element four There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness.	Yes

The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training.	
Element five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators**.** **The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance.** **A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.** In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on	Yes

https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network	

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	
Required Standard	
Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	
Minimum evidential requirement for trust Board	**Action met? (Y/N)**
• **Evidence should include:** • Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems • Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. • Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed	**Yes** **Yes** **Yes**

work programme. Remuneration should take place in line with agreed Trust processes. • The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it • Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. • Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.	**Yes** **Yes** **Yes** **Yes**

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? **In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?**
Required Standard
Can you evidence that: a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years b) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four c) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your

annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four	
Minimum evidential requirement for trust Board	**Action met? (Y/N)**
Self-certification to NHS Resolution using the Board declaration form.	

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required Standard

a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-qualitysurveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.

b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic /current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.

c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes.

d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

Minimum evidential requirement for trust Board	**Action met? (Y/N)**
Evidence for points a) and b) • Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model.	**Yes**
Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff.	**Yes**

Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	**Yes**
Evidence of bi-monthly engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board.	**Yes**
Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users	**Yes**
Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting.	**Yes**
Evidence for point c): Evidence of an action plan that describes how the maternity service will work towards Midwifery Continuity of Carer (MCoC) being the default model of care offered to all women by March 2024. The plan covers: • The number of women that can be expected to receive MCoC, when offered as the default model of care • A midwifery redeployment plan into MCoC teams, phased alongside the fulfilment of safe staffing levels • How MCoC teams are established in compliance with national principles and standards • How rollout will be prioritised to those most likely to experience poor outcomes, including ensuring rollout to 75% of women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived 10% of neighbourhoods by March 2024. • Developing an enhanced model of MCoC that provides extra support for women from the most deprived 10% of areas. • How care will be monitored locally, and providers ensure accurate and complete reporting on provision of MCoC using the Maternity Services Dataset • Evidence of Board level oversight and discussion of this revised continuity of carer action plan	**Yes**

Evidence for point d): Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement	**Yes**

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	
Required Standard	
1. A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 3. C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: • the family have received information on the role of HSIB and NHS Resolution's EN scheme; and there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	
Minimum evidential requirement for trust Board	**Action met? (Y/N)**
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.	**Yes**

Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.	

Appendix 1 – Saving Babies Lives Element 1

Appendix 2 – CNST Action Plan

Saving Babies Lives Element 1:
A Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.

CNST Guidance:
Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe).
If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator.
If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022.

As per the CNST Guidance above the evidence for Safety Action 6, the data is extracted from BadgerNet and included in MSDS submission.
It is pulled from the Saving Babies Lives Report Within BadgerNet.

The excluding records are excluded for reasons outside of Co monitoring which then changes the numerator of cases but not the denominator.

The table below shows our CO at booking data **according to BadgerNet** this data is then sent to MSDS. There are built in exclusions for data quality so the figures are never like for like because of this. This includes the denominator and numerator.

CO at Booking On BadgerNet

Month	Booking CO % On BadgerNet
Jan	72.7%
Feb	61.1%
March	67.6%
April	63%
May	65.4%
June	71.2%
July	65.4%
August	66.4%
September	73.9%

Please Note: The data above includes those booked out of area.

What We Have Done To Solve The Issue
The Maternity Digital Team reviewed the 83 patients recorded as no CO monitoring at booking in September 2022. If they had a CO monitoring in another trust at booking this information was inputted into our records noting what the result was and where it was taken.

By doing this cleansing we have got the September figure from 73% to 81%. I have asked performance and information team if we can repull the information for the MSDS.
We have also updated 40 records that were excluded from the MSDS this should close the gap between what is on BadgerNet and what gets published for all uploads going forward.

CNST Standard
As CNST is for four consecutive months we may still be able to pass this indicator if the community staff continue to do booking COs

Anyone doing express bookings documents the CO reading from the trust the patient was from. If there is no result, they need to take a CO monitoring.

Evidence
The evidence for CNST is Four Consecutive Months the schedule is below:

Septembers Data is Pulled in November 2022
Octobers Data is Pulled in December 2022
Novembers Data is Pulled in January 2023
Decembers Data is Pulled in February 2023

The evidence for this action is due in February 2023. I am waiting to find out if the December Data Pull is going to be in time to use for evidence.

Next Steps

1) Resend Septembers Data

2) Await confirmation that the February upload of Decembers Data can be included or if we have to accept that August 2022 Data is part of the four months.

3) Saving Babies Lives Lead To Use The Saving Babies Lives Report within BadgerNet.

4) Arrange a meet with SBL and review all the actions that require MSDS upload to ensure we are using the built in reports in BadgerNet.

5) To counteract this going forward we have changed fields in BadgerNet to Mandatory to reduce the number of exclusions.

Walsall Healthcare NHS
NHS Trust

Key:

Complete	On Track	Some Slippage with deadline	Missed target

Action plan in response to CNST Co monitoring

CNST Standard

As CNST is for four consecutive months we may still be able to pass this indicator if the community staff continue to do booking COs

Anyone doing express bookings documents the CO reading from the trust the patient was from. If there is no result, they need to take a CO monitoring.

Evidence:

The evidence for CNST is Four Consecutive Months the schedule is below:

- Septembers Data is Pulled in November 2022
- Octobers Data is Pulled in December 2022
- Novembers Data is Pulled in January 2023
- Decembers Data is Pulled in February 2023

Action	Person Responsible	Deadline	Update
Resend September Data	Fiona Morgan-Lockett	November 2022	
Confirmation that the February upload of Decembers Data can be included or have to accept that August 2022 Data is part of the four months.	Fiona Morgan-Lockett	December 2022	
Saving Babies Lives (SBL) Lead To use The Saving Babies Lives Report within BadgerNet	Karen Scott	November 2022	
Meet with SBL and review all the actions that require MSDS	Fiona Morgan-Lockett	November 2022	

Key:

Complete	On Track	Some Slippage with deadline	Missed target

Action	Person Responsible	Deadline	Update
upload to ensure the reports are built in reports in BadgerNet.			
Change fields in BadgerNet to Mandatory to reduce the amount of exclusions.	Fiona Morgan-Lockett	November 2022	

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 7th December 2022**			
WHT Safeguarding Update Report Q2 (July – Sept 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 expansion to staff within the safeguarding team (as per Safeguarding Business Case 2022) has now concluded. The last post is now in the recruitment stage. • Substantial work has been undertaken regarding the completion of actions outlined in the WHT Safeguarding Development Plan. • Progress has continued in respect of outstanding WHT Safeguarding Case Review work (WHT internal practice review group oversees the partnership DHR, SAR and CSPR work). • The learning disability agenda within the Trust is being scoped via collaboration work across RWT and WHT. A full report is due at the end of 2022. There are plans to have a 'one service model' across WHT and RWT. There is progress with flagging LD patients in records. • DBS compliance reporting has commenced as part of the requirements of the safeguarding dashboard. A working group is meeting across WHT and RWT to oversee this work. The next meeting will be in January 2023. • DoLS applications have increased slightly due to the significant work undertaken by the safeguarding team during this period (due to ward support work)		
Advise	• There are difficulties in securing office space for the safeguarding team at Walsall Manor Hospital. This has been escalated to WHT Directors. The team are required to support ward areas and this is hindering progress. • Significant staff shortages (in the safeguarding children) have had an impact on contributing to Walsall Partnership work during Q2, particularly with contributing to the MASH work. This has been included on the risk register. • Safeguarding Children activity is buoyant. Children's MASH and Domestic Violence activity remains consistently challenging throughout this quarter due to the complexity of cases being discussed. During Q2/Q3, the ICB are reviewing the funding framework around the working model in MASH as a result of activity and following the publication of a national serious case review (Arthur and Star). • There is evidence that further work is required around raising awareness of Mental Capacity Assessments. A revised action plan will be drafted to address this.		

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 to include consideration of sharing training options across RWT and WHT. Continued effort to address staff attendance is in place via briefings, comms and through staff meetings.	
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 Q2 (Jul-Sep 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 monthly to the CCG following scrutiny at the Trust Safeguarding Group. Additional work was progressed during Q2 to complete outstanding areas of reporting on the DASHBOARD template.
- It is noted that during Q2, safeguarding training compliance has fluctuated across the levels. This has been escalated to Divisions for their attention. Additional level 3 training sessions have since been provided over the quarter and staff alerted to non-compliance status. The safeguarding service is currently reviewing the training delivery model to allow staff across WHT and RWT to access each other's training packages.
- The compliance for staff accessing supervision has varied due to staff shortages within the Trust. Additional group supervision sessions have been delivered and continue to be offered to ensure staff are speedily compliant. Compliance will be monitored at the Trust SG Group. The data base for recording safeguarding supervision is being reviewed to ensure accurate reporting is available.
- The safeguarding team have continued to provide a visible presence across the Trust to support staff and teams. At Walsall Manor Hospital, a team office is required to provide the support for the team and to offer space for supervision.
- There is additional safeguarding adult support required for the community teams, this will be addressed following the induction of new members of staff in the adult service during Q3. To note that contact has now been made with respective leads in the community areas to progress this.
- WHT have attended all CCG and LA partnership meetings. There is a JTAI due in November. The focus for this is the early intervention service offer to vulnerable young people and will include oversight of MASH.
- Progress has been noted in completion of actions aligned to the Safeguarding Development Plan. There is further work to be progressed in regard to the development of a safeguarding audit programme. There is additional work to be progressed with safeguarding oversight of incidents, by team attending divisional governance meetings and this work will continue during Q3/4.
- WHT and Walsall Local Authority Adult Service Leads are meeting on a regular basis to discuss S42 cases, and to work together regarding themes for escalation and threshold awareness.
- 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 historical outstanding actions have now been addressed. During 2022 there have been 3 SAR referrals, and in Q2, 1 safeguarding child case review was escalated.

- During Q2, 5 notifications were made by the Trust as part of the 'Learning from the lives and deaths' programme regarding persons who died (with LD/Autism diagnosis).
- 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. Accessing information from case records is a lengthy process. The health commissioning of staff within MASH is under review by ICB.
- The number of DoLS applications submitted during Q2 was 113 which demonstrates a slight increase from 112 submitted during Q1. The safeguarding adult team have provided robust ward support during this period which has clearly impacted on the number of applications being progressed.
- 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.
- WHT have secured funding (from the Walsall Safer Partnership) for a Band 7 practitioner to work in ED to raise awareness of domestic violence. This is in progress and the practitioner will start in post December 2022.
- 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 Q2 2022/2023 report seeks to provide information and evidence of the Trust's continued commitment to good safeguarding measures. It refers to the standards outlined in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) 2021-2022 and is aligned to national and local safeguarding standards including the requirements from CQC, NHS Learning Disability Standards and Walsall Safeguarding Partnership.

1	a. Health providers are required to demonstrate clear governance arrangements and that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, the Safeguarding Partnerships/and SABs priorities, and in regular monitoring meetings with commissioners.

b. Health providers are required to demonstrate that there is a Board Level Executive Director who holds accountability within the organisation for safeguarding (including Children and Young People in Care) and Prevent in line with Intercollegiate Documents and National Guidance

c. Health providers are required to demonstrate that the organisation complies fully with information requests and safeguarding informatics returns to NHSE/I and Commissioning organisations.

Annual Submission

Q2 Update:

Annual report completed and presented to Trust in July 2022. Data provided accordingly.

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

Q2 Update

- There is a current review of all safeguarding policies. Full data has been provided within the Safeguarding Department Annual Report (July 22). WHT and RWT are working collaboratively to complete outstanding policy work. The policy tracker is discussed at the Trust Safeguarding Group. Joint policy work is being progressed between WHT and RWT.
- The safeguarding team has expanded during Q2 to include the new Deputy Head of Safeguarding (commenced in post 3rd October 2022) and a new Safeguarding Adult Team Lead (commenced 12th September 2022). The outstanding post cited within the previous business case (the Safeguarding Business Support Manager) is currently in recruitment stage (November 2022). It is expected that this post will be finalised for start date Feb 2023.

- During Q1, there was a request for WHT to provide assurance against the DBS recording process (evidence of compliance required for the monthly safeguarding dashboard). This was escalated to the Director of Nursing and HR. Further joint work across WHT and RWT commenced during Q1/Q2, and the reporting of the DBS for new starters has since improved (Data = 90.87% in April 22 to 92.17% by September). There is ongoing work to review the staff groups aligned to the 'standard and enhanced' element of this work and to ensure existing staff who require repeat DBS checks have these completed. The working group will reconvene in January 2023 and will refer to national guidance that has been disseminated during Q2 which outlines staff groups that require DBS checks.

Actions:

- To complete to the recruitment of the business support manager.
- To work collaboratively with RWT to ensure all policies are updated by end of Q4.

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

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

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

Q2 Update

- The WHT safeguarding training staff level groups were reviewed during March 2022 to ensure that competencies required for healthcare staff remain in line with the Intercollegiate Document for Children (2019) and Adults (2018). This will be reviewed again during Q4. The WHT/RWT training package content is currently under review (eLearning and face to face delivery options) with both safeguarding services considering the content and ability to let staff access both training programmes. The national training package for children at level 3 is being considered for roll out at WHT as an additional option.
- All safeguarding training compliance is reported monthly at the Trust Safeguarding Group (for each Division) and via the Safeguarding Dashboard presented to CQRM monthly.
- During Q2 Safeguarding Children Training Level 1 and 2 compliance was over 95% and 93.1% respectively. Level 3 compliance has reduced slightly down to 83% in September, possibly due to staff sickness and annual leave. However, additional training delivery options have been sought (utilising national e learning packages) to

assist staff who have not been able to access the training sessions (2—3 dates currently offered per month). WHT training and development department have been contacted to assist with this process. All staff have been individually contacted to complete their training.

- During Q2 the compliance for Safeguarding Adult Level 1 and 2 training remained consistent with over 94.5% for Level 1 and 96% for Level 2. Level 3 training compliance has reduced to 80.2% (September) and this has been raised at Trust Safeguarding Group for all staff to prioritise the training. Additional L3 training dates have been provided and all staff presented with the dates via Trust Comms and divisional meetings.
- Attendance at the Mental Capacity Act training has remained at over 93.4%. To note that additional ward training has also been provided by the safeguarding team to raise awareness of the subject area as part of the continued work in preparation for the forthcoming Liberty Protection Safeguard processes due to be launched during 2024.
- The Safeguarding Team training compliance has varied. Adult Level 4 training (2 x Named Nurses) is 100%, whereas 75% for children (6 out of 8) due to significant staff sickness. L4 training has been sought during Q3 for those staff outstanding. This will be completed by 2.12.22.
- The Safeguarding Team have continued to provide bespoke training for ward and community staff as required and on request. Additional support and/or bespoke training is required for the community services and will commence from Q4. This will give the new safeguarding adult team sufficient time to become appropriately inducted into the organisation.
- Learning Disability Training has been disseminated as part of the Level 3 Adult training programme. The Trust is awaiting further guidance on the plan to roll out the Oliver McGowan LD Training programme. This is expected to be mandatory across health trusts by Q3/Q4.
- Domestic Violence Training is included in both Adult and Children Safeguarding Level 3. Additional training has been offered during Q2 via the Walsall Partnership.
- The attendance at Prevent Training has been excellent during Q2 at over 95% predominantly.
- WHT Board training is currently being scoped for delivery from 3rd November 2022.

Actions:

- Safeguarding Training compliance will continue to be monitored during Q3 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 Q2, the Safeguarding Team specialists, including Named Doctors have been offered or have had access to safeguarding supervision including the Named Safeguarding Midwife. It is noted that for most safeguarding professionals this supervision is provided externally by the CCG or other professional experts.

Total number of children community Staff/midwives identified to receive safeguarding supervision within Q2	**Q2 Compliance**
Health Visitors: 17 (10 not eligible for supervision)	14 = **53%** (3 cancelled, 3 long term sick, 1 Mat Leave, 6 commenced university)
School Nurses: 13	10 = **76%**
Community Midwives (Group)	**92%**

Health Visitor and School Nurse supervision compliance has varied over Q1 and Q2 due to staff shortages and team changes. All outstanding supervision has been a key priority, and staff have been offered follow up supervision quickly.
Midwives have received a range of one to one, group supervision during the time period and compliance has remained good.
Over Q2, the Safeguarding Service has had additional support from the 0-19 service with the delivery of supervision to community staff. To note, that staff (2 x Band 7 Named Nurses) had been recruited to the team during Q2, but due to unprecedented circumstances the posts have subsequently been re advertised (November).
Throughout July to September, ED and Acute Paediatrics have had access to the monthly drop-in safeguarding supervision sessions. The safeguarding team (children and adult service) have also undertaken floor walks which provides additional opportunistic case reflection and discussions.
General support is also provided to key areas within the Trust including Maternity, Children Ward, Sexual Health and community teams.

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 Q2, 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 continues to meet on a bi-monthly basis to review and update all actions aligned to the organisation. Three adult referrals have been submitted to Walsall Practice Review Group during 2022 known as SAR 7,8 & 9. The referrals have generated chronology responses and are being progressed as part of the Walsall Partnership action plan. One review has concluded, the others are in progress. A CSPR referral was made to Walsall Practice Review Group during Q2, which has not progressed to a formal safeguarding review During Q2, 5 notifications were made by the Trust 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. The Trust is represented at the regional LeDeR Strategic Group. To note that during Q2, the national review into the murders of Arthur Labinjo-Hughes and Star Hobson was published. The initial reaction for the partnership board was to review MASH and partnership arrangements. During Q2 the ICB commissioned an external consultant to review arrangements within Walsall MASH including health arrangements and governance. The findings of this report are to be expected in October 2022.

Actions:

- To ensure any action plans are completed within timescale
- To attend Walsall Practice Review Group (PRG)
- To attend the WHT PRG meeting and ensure learning disseminated
- To receive the findings of the commissioned MASH review and participate in any subsequent work as outlined for WHT.

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 Q2 WHT has ensured that learning from all types of reviews has been disseminated Trust wide via:

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

Recommendations are also embedded within mandatory and bespoke safeguarding training.

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

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

Learning from reviews is 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

5. a. Health providers are required to provide evidence that staff are aware of the importance of listening to children, young people and adults with care and support needs. b. Evidence that the organisation ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding. **Annual Submission**
Annual report completed and presented to Trust in July 2022. Data provided accordingly.

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.
<u>Safeguarding Adults Activity</u> • 113 DoLS applications were submitted during Q2 (July = 35, Aug = 41, Sep = 37) which is an increase on the 112 submitted in Q1. To note that the safeguarding team have provided regular ward support in completion of applications and offered bespoke training regarding mental capacity assessment processes throughout Q2. • No Prevent referrals have been made during Q2. 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 Q2, (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). To note that WHT safeguarding adult team and Walsall Local Authority adult social care services met in September to progress joint work around the S42 threshold processes. There will be bi monthly meetings convened from Q4 between WHT and WLA to review outstanding cases and to ensure the escalation process is robust. • During Q2, WHT were asked to look at the impact of the forthcoming implementation of Liberty Protection Safeguards (LPS) with RWT. As part of this work, WHT will be looking at scoping a range of opportunities to contribute to this work stream which Walsall ICB will lead on across the Black Country.

Joint work is in progress with RWT and the ICB. A MCA/DoLS action plan is to be drafted to support this work. This will be reported on from Q3.

- The safeguarding team continue to offer support, training and guidance on the Mental Capacity Act, assessing mental capacity, and completing DoLS. WHT Safeguarding Adult Team undertake a monthly audit regarding RESPECT and MCA compliance. The outcome of this is reported to each Division. The focus remains on raising awareness of appropriate documentation and ensuring that relatives are informed of the process and outcome of decision making. The RESPECT work is being reviewed in November 2022.
- During Q2, the Learning Disability and Autism Lead (from RWT) has worked across both Trusts to review service provision. To note that there will be a business case presented to both Trusts to outline potential future requirements. Progress has been made with LD case record flagging at WHT and the future delivery of mandatory training (Oliver McGowan course) is in review. Progress has been reported to Trust Safeguarding Group monthly. The business case will be prepared and presented at the end of 2022.

Safeguarding Children Activity

- During Q2, it was noted that there continued to be significant staffing shortages due to sickness, maternity leave, and vacancy factors within the team. This prompted the service to be placed on the Trust Risk Register. To note that there has been a slight improvement (in November) mainly due to the return of staff and the continued support from the 0-19 service in respect of supporting with the roll out of supervision.
- The Safeguarding Children Team have provided support via face to face 'floor walks' to Ward 21, ED, Maternity and Fracture Clinic. Extended support to other areas will be scoped during Q3/Q4.
- Safeguarding Supervision has been delivered to the Health Visiting, Maternity and School Nursing Teams via a mixture of remote and face to face sessions. This remains a key priority.
- Group supervision has also been offered to Ward 21, Maternity and ED. Attendance has varied due to operational pressures.
- During Q2 the safeguarding children team have commenced recording 16 and 17 year olds placed on adult ward areas within the Trust. This is monitored at the Trust Group.
- During Q2, the activity for undertaking MASH checks and strategy meetings remained consistently high. There was a total of 2106 MASH checks completed within the time period which is a significant increase compared to 1910 checks undertaken during Q1. There will be a review of the team resource during Q3/4.
- 141 MARAC cases were discussed in Q2 involving 246 child records being sourced. This has increased from 115 during Q1.
- Advice call activity has fluctuated due to the increase in team visibility across the Trust.
- Virtual Safeguarding Children Level 3 training and face to face training has been delivered to all staff.

- During Q2, the Safeguarding Children Team supported staff with 24 statements for court. 35% of the statements completed were from the health visiting service (8 cases).
- Virtual Safeguarding Children Level 3 training and face to face training has been delivered to all staff.
- The Children in Care Team (Q2 report presented separately)

Action:

- For Safeguarding to continue to provide appropriate support to all key areas within the Trust including adult ward areas where 16/17 year olds are placed.
- To review the resource required within MASH to ensure that there is sufficient staff capacity to undertake the safeguarding information checks (within the timescale) as required.

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.

- Throughout Q2, WHT, Walsall Local Authority and Walsall CCG agreed 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. 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.
- The safeguarding service requested attendance at Divisional Governance meetings regarding oversight of risks that were being presented. This work has since progressed.
- The safeguarding team continued to undertake the Trust audit around RESPECT 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. The work around RESPECT is being reviewed within the Trust.
- In Q2, in preparation for transition to Liberty Protection Safeguards (LPS) the safeguarding adult team worked collaboratively with RWT as part of a trust wide MCA audit undertaken during June/July reviewing 731 patients notes (at RWT). There was an increase in compliance noted around compliance to the MCA and completion of DoLS applications often because of enhanced support offered by the safeguarding team. The focus on MCA and DoLS will continue during 2023, and a refreshed action plan will be drafted.

8. Health providers are required to provide evidence and assurance that they are responding to National Reports and Inquiries.
• From April, the WHT Safeguarding Team commenced collaborative work with RWT regarding the response to the LPS national report. • There are no outstanding CQC actions from previous inspections • During Q2, WHT will be participating in the JTAI inspection which will focus on the early intervention services that support vulnerable young people. • WHT will be working with Walsall Local Authority and ICB in response to the national report following Arthur and Star • WHT are awaiting guidance on the Oliver McGowan learning disability training requirements for the Trust (expected Q4). Action: • To attend any partnership meetings in response to the planned JTAI inspection in November 2022

9 a. Health providers are required to demonstrate they have effective arrangements for engaging and working in partnership with other agencies. b. Health providers are required to demonstrate that they actively engage with all aspects of the work of the local safeguarding partnerships, strategic groups and sub groups (including Channel, MAPPA, MARAC, CSP, CJB and Modern Slavery Partnerships)
During Q2 the Safeguarding team have attended all requested partnership and safeguarding meetings with Walsall Local Authority (LA), ICB and all care planning operational meetings. This includes MARAC and Practice Review Group (PRG) WHT have submitted the completed monthly CCG dashboard. WHT do not attend MAPPA meetings.

3. RECOMMENDATIONS

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

MEETING OF THE PRIVATE TRUST BOARD - Wednesday 7th December 2022			
Risk Management Report covering Bi-Monthly 3, August and September 2022			
Report Author and Job Title:	Vicky Haddock - Head of Risk Management and Compliance	**Responsible Director:**	Kevin Bostock - Group Director of Assurance
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• The report ensures that the Trust Board receives summary information on the improvements being made to the Trust's Risk Management process, tools, and templates. • The Board Assurance Framework (BAF) risks that form the Strategic Objective (SO) risk register of the Trust which have been raised and accepted by the Trust Board to determine adequacy of assurance and controls measured to effectively minimise these risks to acceptable levels. • Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable the Trust Board to maintain effective oversight of SO risks through a regular process of formal review. • Each Lead Director meets monthly with the Head of Risk Management and Compliance to review risks that sit on the corporate level element of the Trust's risk register (CRR) and bi-monthly to review the BAF SO's.		
Advise	• Three of the eight identified Board Assurance Framework Strategic Objective risks have a current **High** rated risk score (15-25), an increase from two in Bi-Monthly 2, June and July 2022. • 20 of the 29 Corporate Risks have a current **High** rated risk score, 15-25 (a reduction from 21 of the 25 Bi-Monthly 2, June and July 2022).		
Alert	• Some actions of the BAF and CRR are passed target completion dates, these have been discussed with the Lead Director at the confirm and challenge meetings, as well as at Risk Management Executive Group, with support offered to enable the risks to be updated at the earliest opportunity. See below additional detail: ○ Of the eight identified Board Assurance Framework Strategic Objectives: ▪ Progress narrative has not been provided on two of the SO's within the specified review timescale:- • Strategic Objective 01 - Safe, High-Quality Care, • Strategic Objective 05 - Use Resources Well. ▪ Seven actions are overdue from the target completion dates (up from six in Bi-Monthly 2, June and July 2022) - • Five of the actions are within Strategic Objective 01 - Safe, High-Quality Care, • Two of the actions are within Strategic Objective 05 - Use Resources Well. ○ Of the 29 Corporate Risks, there are: ▪ Five actions that have passed their target date for action delivery (down from 11 in Bi-Monthly 2, June and July 2022) - • Two actions in Digital Services, • Two actions in MLTC, • One action in EPRR. ▪ One risk within Estates and Facilities has had no progress narrative update within the specified review timescales (no change since Bi-Monthly 2, June and July 2022).		
Does this report mitigate risk included in the BAF or TRR?	Risk implications are outlined within the document.		
Resource implications	Risk implications are outlined within the document.		
Legal and/or Equality and Diversity implications	The BAF and indeed elements of the attached risks form part of our registration and licence requirements to both NHSI and CQC, which may result in regulatory or legal action under the Health and Social Care Act. There is clear evidence[1] of unequal and differential impact of COVID-19 on sections of our society including differential impact associated with levels of deprivation, occupations, and ethnicity. 1. https://www.health.org.uk/sites/default/files/upload/publications/2020/Build-back-fairer-the-COVID-19-Marmot-review.pdf#:~:text=Building%20back%20fairer%20will%20require%20fundamental%20thinking%20about,must%20be%20dealt%20with%20at%20the%20same%20time		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Risk Management Report

1. PURPOSE OF REPORT

The purpose of the report is to provide the Trust Board with a status update in relation to; 1) the Board Assurance Framework (BAF) Strategic Objectives (SO) and those risks that site on the corporate level of the Trust's risks register (CRR), noting the actions in place to support mitigating these risks; 2) the improvement being made to the Trust's Risk Management process, tools, and templates.

2. BACKGROUND

These BAF form the Strategic Objective (SO) risk register of this organisation which have been raised and accepted by the Trust Board to determine adequacy of assurance and controls measured to effectively minimise these risks to acceptable levels.

Each principal risk in the BAF is assigned to a Lead Director and a Lead Sub Committee of the Board, to enable the Trust Board to maintain effective oversight of SO risks through a regular process of formal review. Each Lead Director meets monthly with the Head of Risk Management and Compliance to review the risks that sit on the corporate level element of the Trust's risk register (CRR) and bi-monthly to review the BAF SO's.

3. DETAILS

3.1 Board Assurance Framework (BAF)

There are currently eight identified SO risks included within the BAF which have been approved by the Trust Board.

3.1.1 Current BAF Risks

- BAF SO 01 - Safe, High-Quality Care,
- BAF SO 02 - Care at Home,
- BAF SO 03 - Work with Partners,
- BAF SO 04a - Leadership Culture and Organisation Development,
- BAF SO 04b - Organisation Effectiveness,
- BAF SO 04c - Making Walsall (and the Black Country) the best place to work,
- BAF SO 05 - Use Resources Well,
- BAF SO 06 - COVID.

3.1.2 BAF Movement

The table below shows the movement of the BAF risk documents from Bi-Monthly 2 (June and July 2022) to Bi-Monthly 3 (August and September 2022):

Summary Risk Title	SO Under Threat	Change in Current Risk Score							
		2021/22				2022/23			Change Direction
		Q1	Q2	Q3	Q4	Bi-M1	Bi-M2	Bi-M3	
BAF SO 01 - Safe, High-Quality Care	Safe, high quality care	15 High	25 High	25 High	20 High	20 High	20 High	20 High	↔
BAF SO 02 - Care at Home	Care at home	9 Moderate	12 Moderate	16 High	16 High	12 Moderate	12 Moderate	12 Moderate	↔
BAF SO 03 - Working with Partners	Partners	6 Low	6 Low	6 Low	6 Low	6 Low	6 Low	3 Very Low	↓
BAF SO 04 - Value our Colleagues 04a - Leadership Culture & OD	Value colleagues	20 High	16 High	16 High	12 Moderate	12 Moderate	12 Moderate	12 Moderate	↔
04b - Organisational Effectiveness		20 High	16 High	16 High	12 Moderate	12 Moderate	12 Moderate	16 High	↑
04c - Making Walsall & BC BPTW		20 High	16 High	16 High	12 Moderate	12 Moderate	12 Moderate	12 Moderate	↔
BAF SO 05 - Use Resources Well	Resources	15 High	15 High	15 High	15 High	15 High	20 High	20 High	↔
BAF SO - 06 COVID	All	6 Low	12 Moderate	15 High	12 Moderate	9 Moderate	9 Moderate	9 Moderate	↔

A summary of the BAF SO; title, risk description, current risk score movement, forecasted risk score movement for the next bi-monthly review** (Bi-Monthly-4, October, and November 2022) and risk review details over the last bi-monthly review** (Bi-Monthly-3, August, and September 2022), is shown below (in risk number order):

- **BAF SO 01 - *Safe, High-Quality Care;*** *we will deliver the best quality of care evidenced by patient experience feedback and good clinical outcomes.*
  - **Risk Description** - *The Trust fails to deliver best care outcomes, and/or patient/public experience, which impacts on the Trust's ability to deliver services which are safe and meet the needs of our local population.*
    - **Current Risk Score Movement** - Has not been confirmed within the specified review timescale, and progress narrative remains outstanding, to cover the third bi-monthly period of 2022/23 financial year. In the second bi-monthly period it had remained as a **20 High** (Severity 4 x Likelihood 5), and the Director of Nursing verbal confirmation that the score had not changed for this period at Risk Management Executive Group (RMEG).
    - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to reduce.

- **BAF SO 02 - *Care at Home****; we will work with partners in addressing health inequalities and delivering care closer to home through integration as the host of Walsall Together.*
  - **Risk Description** - *Failure to deliver care closer to home and reduce health inequalities.*
    - **Current Risk Score Movement** - Has remained the same to cover the third bi-monthly period of 2022/23 financial year, as a **12 Moderate** (Severity 4 x Likelihood 3).
    - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory of risk reduction now being confirmed in the fourth bi-monthly period of 2022/23 financial year.

- **BAF SO 03 - *Work with Partners;*** we will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.
  - **Risk Description** - *Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high-quality care.*

- **Current Risk Score Movement** - Has reduced in the third bi-monthly period of 2022/23 financial year, from a 6 Low (Severity 3 x Likelihood 2) to a **3 Very Low** (Severity 3 x Likelihood 1).
- **Forecasted Risk Score Movement for the next Bi-Monthly Review** - Is expected to remain as a 3 Very Low (Severity 3 x Likelihood 1).

➢ **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times.* ***04a*** *- Leadership Culture & Organisational Development.*
- **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention, and patient care.*
  - **Current Risk Score Movement** - Has remained the same to cover for the third bi-monthly period of 2022/23 financial year, as a **12 Moderate** (Severity 4 x Likelihood 3).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory for risk reduction being confirmed in the fourth bi-monthly period of 2022/23 financial year.

➢ **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times.* ***04b*** *- Organisational Effectiveness.*
- **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention, and patient care.*
  - **Current Risk Score Movement** - Has increased in the third bi-monthly period of 2022/23 financial year, from a 12 Moderate (Severity 4 x Likelihood 3) to a **16 High** (Severity 4 x Likelihood 4).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory for risk reduction being confirmed in the fourth bi-monthly period of 2022/23 financial year.

➢ **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times.* ***04c*** *- Making Walsall (and the Black Country) the Best Place to Work.*
- **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention, and patient care.*
  - **Current Risk Score Movement** - Has remained the same to cover the third bi-monthly period of 2022/23 financial year, as a **12 Moderate** (Severity 4 x Likelihood 3).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory for risk reduction being confirmed in the fourth bi-monthly period of 2022/23 financial year.

➢ **BAF SO 05 - *Use Resources Well;*** *we will deliver optimum value by using our resources efficiently and responsibly.*
- **Risk Description** - *The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets & technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.*
  - **Current Risk Score Movement** - Has not been confirmed to cover the third bi-monthly period of 2022/23 financial year. In the second bi-monthly period it had increased from a 15 High (Severity 5 x Likelihood 3) to a **20 High** (Severity 4 x Likelihood 5).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Has not been confirmed.

➢ **BAF SO 06 - *Covid;*** *this risk has the potential to impact on all of the Trust's Strategic Objectives.*
- **Risk Description** - *The impact of Covid-19 and recovering from the initial wave of the pandemic on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.*
  - **Current Risk Score Movement** - Has not been confirmed to cover the third bi-monthly period of 2022/23 financial year. In the second bi-monthly period it had remained the same as a **9 Moderate** (Severity 3 x Likelihood 3).
  - **Forecasted Risk Score Movement for the next Bi-Monthly Review** - Has not been confirmed.

3.2 Corporate level of the Trust's risk register (CRR)

There are currently 29 risks that sit on the corporate level of the Trust's risk register (Level 4). Not all risk review meeting were completed this month and not all the updates provided within the review timescale to complete Bi-Monthly 3 (August

and September 2022) updates. The risks were discussed and minuted at the Risk Management Executive Group (RMEG) meeting, with support offered to enable the risk to be updated at the earliest opportunity.

3.2.1 Current Risks

Details of the 29 Corporate Risks (in risk number order) are shown on the relevant dashboards in addition to the controls, assurances and actions to be undertaken that will help to mitigate the risk by resolving control and assurance gaps.

3.2.2 CRR Heat Map

The table below shows the current risk score of our Corporate Risks to complete Bi-Monthly 3 (August and September 2022) and any movement since the last report in Bi-Monthly 2 (June and July 2022):

Likelihood	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5:	10:	15:	20: • 2081 ↑ • 2245 ↔ • 2394 ↔ • 2430 ↔ • 2439 ↔ • 2581 ↔ • 2664 ↔ • 2917 ↔	25:
Likely 4	4:	8:	12: • 3031 *	16: • 208 ↔ • 2072 ↔ • 2082 ↔ • 2325 ↔ • 2737 ↔ • 3002 ↔ • 3012 ↔ • 3057 *	20: • 2066 ↑ • 2370 ↔
Possible 3	3:	6: • 3058 *	9: • 2587 ↔	12: • 2489 ↔ • 2540 ↔ • 2601 ↓ • 3036 *	15: • 665 ↔ • 1005 ↔
Unlikely 2	2:	4:	6:	8: • 1528 ↓	10: • 2464 ↔
Rare 1	1:	2:	3:	4:	5:
	Severity				

Symbols Key:	Amendment since the previous report:
*	New Corporate Risk.
↓LRR	Risk de-escalated from the Corporate Risk Register (CRR, Level 4) to Local Risk Registers (LRR, Level 1-3).
↑	Increased risk score.
↔	No change to the risk score.
↓	Reduced risk score.

3.3 Risk Movement

The table below focuses on the movement of the top 10 risks from Bi-Monthly 2 (June and July 2022) to Bi-Monthly 3 (August and September 2022):

Risk ID	Risk Title	Change in Current Risk Score							
		2021/22				2022/23			Change Direction
		Q1	Q2	Q3	Q4	Bi-M1	Bi-M2	Bi-M3	
1528	*Potential delay in patient care and patient results.*				20 High	20 High	20 High	8 Moderate	↓
2066	*Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels.*							20 High	↑
2081	*Delivery Operational Financial Plan.*							20 High	↑
2245	*Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.*	20 High	20 High	20 High	20 High	20 High	20 High	20 High	↔
2370	*Delays in presentations for other, non-COVID conditions may further exacerbate health inequalities and increase the risk of premature mortality.*			20 High	20 High	20 High	20 High	20 High	↔
2394	*Reduced Capacity in Health Visiting due to Recruitment and Retention Challenges.*						20 High	20 High	↔
2430	*Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record.*	20 High	20 High	20 High	20 High	20 High	20 High	20 High	↔
2439	*Unable to provide specialist care, treatment or meet social care requirements for complex CAMHS patients.*	20 High	20 High	20 High	20 High	20 High	20 High	20 High	↔
2581	*Internal risk for patients awaiting Tier 4 hospital admission.*		15 High	20 High	20 High	20 High	20 High	20 High	↔
2601	*Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment, and treatment of the sepsis 6.*		12 Moderate	20 High	20 High	20 High	20 High	12 Moderate	↓
2664	*Patient Safety and Training Issues in Medicine /ED.*		20 High	20 High	20 High	20 High	20 High	20 High	↔
2917	*In appropriate use of SCALE2 within NEWS2.*				20 High	20 High	20 High	20 High	↔

3.4 Reporting and Assurance

The Board Assurance Framework (BAF) and corporate level of the Trust's risk register (CRR) reports will be presented to provide assurance and mitigation where appropriate.

The Head of Risk Management and Compliance will provide expert support to risk owners and assessors in further reviewing and updating risks, to provide an accurate position statement.

All risks on the CRR will be reviewed in a timely manner to ensure robust actions are agreed, achieved and timescales adhered to. Overdue reviews and actions will be highlighted and escalated.

To ensure the CRR is actively monitored and updated with progress to maintain its current position; the schedule for reviewing corporate risks has been revised allow sufficient time to facilitate confirm and challenge sessions with view to strengthening the quality of risk evaluation, articulation, action planning and progress. These updates then feed into a Risk Management Executive Group (RMEG) meeting, where all Executive Directors have the opportunity to discuss and challenge their peers BAF SO's and CRR risks.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the BAF SO's and CRR risks documented and their respective progress. Note the summary information on the improvements being made to the Trust's Risk Management process, tools, and templates.

End of Report

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 7th December 2022**			
Infection Prevention and Control Update			
Report Author and Job Title:	Amy Boden Head of Infection Prevention and Control, Deputy DIPC	**Responsible Director:**	Lisa Carroll, Director of Infection Prevention and Control and Director of Nursing.
Recommendation & Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• 0 Acute Acquired MRSA bacteraemias for the financial year at time of report (November 2022) • The Trust are achieving targets with all Gram-negative bacteraemias		
Advise	• The IPC Team have been delivering education in preparedness for winter on seasonal circulating viruses.		
Alert	• There has been an increase in C.*difficile* toxin acute acquired cases. The Trust are currently over trajectory for the financial year. • Elements of the IPC BAF have been updated to reflect new risks in quarter 3 that has heightened risk scores from previous quarter.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Findings and gaps in assurance are included on the IPC BAF assurance tool.		
Resource implications	None		
Legal and Equality and Diversity implications	None		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Board Assurance Framework Summary

Action	Required action	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23 current	Change in level of risk
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other services users.	12	6	6	6	→
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections	8	6	8	8	→
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	4	4	4	4	→
4	Provide suitable accurate information on infections to services users, their visitors and any person concerned with providing further support or nursing/medical care, in a timely fashion	3	3	3	6	↑
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	8	6	6	8	↑
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	6	6	9	9	→
7	Provide or secure adequate isolation facilities	20	12	9	12	↑
8	Secure adequate access to laboratory support as appropriate	8	6	6	6	→
9	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections	6	6	6	6	→
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	6	8	8	12	↑

Details of updates captured in IPC BAF

Infection Prevention in the healthcare environment

Further refurbishment work has been completed for Wards 16 and 17; this has demonstrated an improvement in the overall environment and ability to clean surfaces effectively. Bay occupancy has changed from 6 beds to 5, increasing bed spacing and including bathrooms within the bay to reduce risk of transmission of pathogens.

The IPCT continue to support capital projects including at snagging stages of the new Urgent Emergency Centre.

Recent sustainability activity including a campaign to reduce use of gloves in clinical practice is taking place at the Trust, with a launch at Walsall Healthcare and Royal Wolverhampton Sustainability Lunch hour via a Webinar from Deputy DIPC at Walsall Healthcare. Environments are being reviewed to support reduction of glove usage.

Staff uptake of seasonal Influenza and COVID-19 booster vaccinations

Overall Trust staff percentage data for uptake of seasonal vaccinations is lower than anticipated during this year's campaign; 19.6% for flu and 18.8% for COVID (at 23.11.22). Education has been provided via three Trust webinars from Deputy DIPC and Consultant Microbiologist as part of a preparedness for winter series, including promotion and myth busting for seasonal and booster vaccinations. Themes are being closely monitored via the Trust vaccination group and promotion is being encouraged through senior Trust colleagues during the back to floor Friday model.

Ability to isolate patients

The Manor Hospital now has nine Bioquell isolation pods installed to improve available segregation facilities. This improved opportunities to isolate patients but with limitations due to no en-suite facilities. Incident reports submitted demonstrate an increase in "failure to isolate" reports due to side room demand increasing; 39 incident reports were completed for this in October versus 30 submitted in September. Most incidents are due to patients who have developed symptoms of diarrhoea. The IPC team are liaising with Black Country Pathology Services for additional routes for rapid stool testing to ensure prompt isolation can take place when needed.

MRSA admission screening

There has been a declining trend in compliance to MRSA admission screening at the Trust; this has been escalated at Infection Prevention and Control Committee with a request from MLTC and Surgical Divisions to support areas in increasing compliance in screening, including a review of handover documentation and education from IPCT at safety huddles.

Infection Prevention advice for visitors

The Welcome Hub continue to support visitors in booking appointments to Walsall Healthcare inpatient areas. During booking, visitors are checked for any symptoms of respiratory tract infection. Recent outbreaks have indicated that visitors have attended the ward despite having symptoms of infection; the IPC team are working with the Welcome Hub to update infection

prevention guidance and the phone switchboard has been updated to capture this advice when a member of the public calls the Trust.

Performance: Infection Prevention and Control Alert Organisms

***Clotridioides difficile* infection**

The Trust has a target set for 27 acute acquired cases of C.difficile. This is a target reduction of 6 cases following achievements in 2021/22. The Trust is now over trajectory due to a significant increase in C.difficile cases in September and October. Initial review of these cases have identified justified antibiotics and recent typing demonstrates different isolates, providing assurance that there are no hospital outbreaks associated with the cases. Surveillance across the Midlands indicates C.difficile has increased across multiple settings.

2022/23	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Max Cases per Month	2	2	2	2	2	2	2	2	3	3	2	3
Actual acute cases	0	1	4	1	2	6	7					
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	27
Acute Cumulative actual	0	1	5	6	8	14	21					

The IPC Team are going to undertake a cluster review meeting to identify further learning and are working closely with the antimicrobial stewardship pharamacist to support antimicrobial stewardship across the Trust, including use of the Microguide app. The Team are also looking to recruit a Nurse Associate into the Team with a clinical focus on stool management and antibiotic prescribing as interventions to reduce the incidence of C.difficile.

MRSA Bacteraemia

There have been 0 MRSA bacteraemias to report for the financial year at time of report (23.11.22).

MSSA Bacteraemia

There is no National target set for MSSA bacteraemias; in the absence of a target, the Trust have a locally set target of 11 cases, based on reducing from previous financial year surveillance data. To date, there have been three MSSA bacteraemias reported for the financial year. One case has been upgraded to a serious incident and is currently under investigation. Initial findings have demonstrated an improvement needed in the Trust with meeting the frequency standard of visual infusion phlebitis (VIP) scores. The team have prepared an updated VIP chart for educational purposes across the Trust to support improvements in this standard.

Gram-negative Bacteraemias

National target for E.coli bacteraemias at the Trust are 50 for the year. 20 acute acquired cases have been reported for the financial year to date.

National target for Klebsiella bacteraemias at the Trust is 27 for the year. 4 acute acquired cases have been reported for the financial year to date, with no new cases since July 2022.

National target for Pseudomonas bacteraemias at the Trust is 10 for the year. 1 acute acquired case has been reported for the financial year to date, with no new cases since July 2022.

The Infection Prevention Team are participating in a Gram-negative steering group across the Midlands and work on Quality Improvement projects locally to prevent different system infections, including pneumonia and urinary tract infections. A business case is currently being prepared for the introduction of a mouth care team with an aim to reduce the incidence of hospital acquired pneumonia, the most prevalent health care associated infection at the Trust. The team are also working on a project to standardise approaches to urinary catherisation through the introduction of a new product and education.

Carbapenemase producing Enterobacteriaceae (CPE)

0 cases of acute acquired CPE to report. There has been an increase seen in patients admitted with CPE; staff are undertaking screening as per Trust policy and isolating patients accordingly.

Outbreaks and Incidents

COVID-19: There have been 45 cases of HCAI COVID-19 in September and 82 cases in October 2022. The majority of cases are categorised in ongoing outbreaks at the Trust, which are being monitored for a 20 day period from last positive case, as agreed with NHSE. HCAI COVID-19 reporting and monitoring for harm is monitored via the IPCT and reported to the division as per NHSE guidance. There have been no recent changes to COVID-19 guidance and outbreak meetings have not identified any new findings.

MRSA: An MRSA outbreak is ongoing on Ward 3 at time of report. There are a total of 5 MRSA cases (colonisation, no infections identified). Outbreak control measures are in place and weekly screening of ward inpatients underway until decision to step down by the outbreak management team.

The Team have provided a range of winter preparedness sessions to provide education on COVID-19, Influenza and Norovirus to support with potential viruses presenting to the Trust. Influenza A and Norovirus have been managed by the Trust in October and November but all were identified on admission and managed appropriately.

The IPC team have provided communication to the Trust on Diptheria following reports from UKHSA associated in the South West region. The Infectious Diseases manual produced by the Trust Consultant Microbiologist and IPCT has been shared with guidance on this disease and has been a utilised resource at regional level.

Promotional Activity

Walsall Healthcare were recently showcased at the National Infection Prevention Society Conference in October with poster presentations and a talk in the main conference hall. The talk was delivered by Deputy DIPC on balancing compassion with infection prevention, focusing on inpatient visiting and poster presentations were on improving indoor air quality and the respiratory IPC schematic to aid decision making in clinical practice.

End of Report.

MEETING OF THE PUBLIC TRUST BOARD – WEDNESDAY 7TH DECEMBER 2022			
Medicines Management Report			
Report Author and Job Title:	Gary Fletcher Director of Pharmacy	**Responsible Director:**	Dr Manjeet Shehmar Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• Following a Section 29a Notice in MLTC, actions have been developed to address the concerns raised by CQC led by the Deputy CEO • It is through the Medicines Management Group (MMG) that compliance and assurance will be monitored chaired by the CMO • Measures have been put in place to strengthen the effectiveness of medicines management through Divisional and Care Group engagement and the risk register • Immediate action has been taken with communication to all prescribers around standards of prescribing according to their professional regulatory bodies • Education has been delivered and a training with competency assessment plan has been agreed via the Trust Education team • External Chief Pharmacy Consultancy has been recruited to support the Trust and Trust Chief Pharmacist • The MMG Agenda has been reviewed and aligned with RWT • Medicines Safety Reporting has been prioritised on MMG and Patient Safety Group agendas • The risk around Controlled drugs continues to be monitored via patient safety group • A review of the prescriptions in the section 29a letter has been completed to assess harm and any immediate actions		
Advise	• The known risks regarding medicines storage and CD record keeping compliance continues to be monitored. Controlled drug improvements are seen in some areas. • Ward level medicines storage, administration and prescribing audits are now built into Tenable • Pharmacy drugs issues logs are to include individual staff level data • The Governance and escalation of medicines management issues is being reviewed • Electronic drug storage units have been purchased for Ward 5/6, Wards 14-17, Maternity & Ward 24/25. The installation of electronic drug storage units which will address some of the storage issues. The implementation of these is being prioritised by estates. Pharmacy are also purchasing a new controlled drug storage unit for the main dispensary. • Consideration of an electronic prescribing system with a demonstration last week		

	• Localised accountability and praise will be enabled once audit data captures individual level data.	
Alert	• There has been progress against the Section 29a Notice actions but assurance is not yet gained to show improved practice and adherence to medicines management. • The Trust is at risk of prosecution if the Section 29a Notice is not complied with by 31st December	
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. All risks around medicines management are being reviewed across all Divisions and a new corporate risk is being developed from this risk assessment.	
Resource implications	Resources will be required for purchase of further electronic drug storage units, an electronic prescribing system and Controlled Drug management software which will be taken via the usual investment routes. A review of pharmacy establishment and resource may also require investment	
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper apart from the Section 29a Notice and its implications.	
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, alert 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. CQC SECTION 29A NOTICE

Following a CQC inspection of MLTC Division between 4th and 5th October 2022, concerns were raised regarding the management of medicines, specifically, that prescribing, administration, recording and storage was not safe and put patients at risk of harm. This was fed back to the Trust in a Section 29a notice on 17th October. Examples of poor practice included:

- Amendments to drug orders on charts not compliant with the Medicines Policy
- Medicines not available for patients, resulting in missed doses
- Patients weights not recorded when weight dependent dosage prescribed
- Poor diabetes management
- Expired medicines found in ward stock
- Ambient temperatures above the upper limit of 25°C recorded regularly

The Trust is required to make significant improvements relating to the above by 31st December 2022.

An immediate action was to provide assurance that the patient identified in the notice were subsequently discharged safely or still an inpatient. This has been completed and a full review of each case to evaluate if the patients had come to harm has been completed, with no patient having an adverse event as a result.

An executive level action plan has been developed, and weekly meeting stood up to oversee the completion of the action plan. The plan includes:

- A full review of the Medicines Management Group ToR, agenda and reporting flows
- A review of the Medicine Policy and medicines related policies
- Review of accountability framework within the Divisions regarding medicines management
- A review of prescriber training and competency assessment
- Implementation of an electronic prescribing system
- Review of the clinical practice for the administration of medicines
- Review of paper prescription chart to ensure fit for purpose
- Review of medicines management audit plan
- Review of pharmacy establishment and resource
- Electronic prescribing and storage

Progress has been made with all the above in preparation for the revisit on 31st December, and to assist in the improvement process the Trust has engaged an external Pharmacist Consultant. Whilst the Section 29a Notice refers specifically to MLTC, the actions will be generalisable across the Trust.

3. MEDICINES MANAGEMENT

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

The Medicines Management Group (MMG) is the group which has oversight of medicines management and usage. The MMG is chaired by the Chief Medical Officer or by the Director of Pharmacy in the absence of the Medical Director. This has been amended so that there will be executive chairing of the MMG.

The MMG reports directly into the Clinical Effectiveness Group on a quarterly basis.
The MMG receives reports from a number of sub-groups.
The agenda for the MMG has been reviewed and aligned with RWT
Divisional accountability has been incorporated by monthly Divisional reports to MMG responding to medicines management reports from Divisional Pharmacists to the Divisional Quality Group

Audits of Compliance

The ward Tenable audits have been amended to include the issues raised in the Section 29a Notice, including prescribing.

The ward pharmacist medicines issues reports will include data at an individual level as well as ward level so that feedback can be given.

Based on these audits, accountability will be set at ward level through Divisional Governance structures and at individual level through professional regulatory and standards.

Controlled drugs

Areas which stock controlled drugs are subject to a 12 point audit on a 3 monthly basis, or a shorter time period at the request of the CDAO where there are concerns with compliance based on the most recent audit. Areas are scored with regard to the number of non-compliant audit points and the degree of non-compliance within each criterion (ie quantity and quality). The table below ranks this areas with the highest Q scores and which require immediate remedial actions.

Area	Quantity	Quality	Score
AMU	6	4	24
Gynae Theatre 12	4	4	16
Gynae Theatre 14	4	3	12
Ward 14	5	2	10
Ward 11	4	2	8
Stroke Rehab Unit	3	2	6
Ward 29	4	1	4
DTC Theatre 5	3	1	3
DTC Theatre 8	3	1	3
Ward 10	3	1	3
Ward 12	3	1	3
Ward 17	3	1	3

The CDAO is reviewing the CD audits at a weekly CD meeting in pharmacy where action to be taken around non-compliant audit standards is discussed i.e.re-audit of the specific non-compliant standards and, where these continue to be non-compliant, ensuring a Safeguard incident is raised to prompt an action plan. The results of each CD audit, and where necessary, the re-audit and logged Safeguard incident are being added to the relevant risk in the risk register.

The Lead Pharmacist for each Division provides audit data to the Divisional Boards for discussion and actions. The pharmacy auditor provides audit outcome data information locally to the Senior Sisters and Matrons.

Pharmacy have been working with nursing staff to produce a short (6 mins) video recording of good practice around controlled drugs. The content has now been reviewed and finalised and is available to all staff via the Trust Intranet in July. If this proves to be successful, it will be taken forward as an addition to mandatory training for nursing and medical staff.

An AMU Improvement Board has been established. It is a multidisciplinary group and is chaired by the Chief Medical Officer. The Group meets monthly and includes controlled drug compliance and medicines management as part of its remit.

As part of the QI work on ED the move to SAD type registers has resulted in an improvement in record keeping. These registers will now be implemented on all wards and will replace to old style record books. Whereas ED and ED Resus were significantly non-compliant – it is evident that from the most recent audits, progress had been made with respect to the number of audit criteria non-compliant, as well as the degree to which they are non-compliant. ED will need to maintain efforts to get to 100%.

Those areas which have a 100% compliance against the most recent audit are

- DTC Recovery
- DTC Theatre 10
- DTC Theatre 2
- DTC Theatre 3
- DTC Theatre 6
- DTC Theatre 7

- Integrated Assessment Hub
- OPD Dental Clinic
- Ward 15
- Ward 2

These areas are congratulated for their efforts.

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. The Corporate risk was reviewed in June and has now been reduced from 20 to 16.
Divisions and Care Groups continue to manage their own risks based on audit results. These are reviewed regularly and can be reduced based on improvements based on audit data.

All Divisions are drafting their risks relating to the Section 29a Notice so that a Corporate Risk can be escalated to the CRR.

Ward storage

Ward storage compliance July to September 2022

Wards are required to use the Tendable app to complete ward storage audits (medicines management (medicine room) inspection report) which provide evidence towards divisional care group medicines management risk.

July 2022

22 areas completed a medicines management (ward storage) audit in July 2022 which was uploaded to Tendable; 1 area completed an additional audit (AMU x2). However, 10 areas (Ward1, Ward 2, Ward 3, Ward 4, Ward 15, Ward 24, Ward 24, Ward 27 and Ward 29) did not complete and upload a ward storage audit (medicines management (medicine room) inspection report) in July 2022.

Overall, standards above 80% compliance except for:

- 79% compliance with Drug Trolley(s) fixed to the wall when not in use
- 73% compliance with open liquids in the Drug Trolley(s) have a 'date opened' label
- 77% compliance with all vials of insulin that are in use have a 'date opened' label

Main areas of non-compliance with ward storage standards are:

- MLTC: medicines locked away & left unattended, open liquids in drug trolley have ‘date opened’, all vials of insulin that are in use have a 'date

- opened' label, errors in the CD Register correctly amended as per the Medicines Policy (in the last 7 days)
- Surgery: medicines locked away & left unattended, drug room free of clutter, drug Trolley(s) fixed to the wall when not in use, all open liquids in the drug trolley(s) have a 'date opened' label, all vials of insulin that are in use have a 'date opened' label, room and fridge temperatures checked and recorded daily, drug room temperature above 25 degrees C, errors in the CD Register correctly amended as per the Medicines Policy (in the last 7 days), signatures in CD order book to demonstrate receipt
- WCCSS: none in areas audited
- Community: none in areas audited

August 2022

25 areas completed a medicines management (ward storage) audit in August 2022 which was uploaded to Tendable; 4 areas completed additional audits (Ward 10 x5; Ward 11 x3; Ward 12 x2; PAU x3). However, 5 areas (Ward 4, Ward 24, Ward 25, Ward 27 and Ward 29) did not complete and upload a ward storage audit (medicines management (medicine room) inspection report) in August 2022

Overall, standards above 80% compliance except for:

- 70% compliance with open liquids in the Drug Trolley(s) have a 'date opened' label

Main areas of non-compliance with ward storage standards are:

- MLTC: Drugs Room free of clutter, all open liquids in the Drug Trolley(s) have a 'date opened' label, errors in the CD Register are correctly amended as per the Medicines Policy (in the last 7 days) and there are signatures and dates in the Ward Controlled Drugs Order Book to demonstrate receipt of Controlled Drugs from the Pharmacy (in the last 7 days)?
- Surgery: medicines stored and locked away, all open liquids in the drug trolley(s) have a 'date opened' label, drug room temperature above 25 degrees C, there are signatures and dates in the Ward Controlled Drugs Order Book to demonstrate receipt of Controlled Drugs from the Pharmacy (in the last 7 days) and CD Reconciliation and stock checks have been completed and recorded twice daily (in the last seven days)
- WCCSS: Drug Trolley(s) fixed to the wall when not in use
- Community: none in areas audited

September 2022

19 areas completed a medicines management (ward storage) audit in September 2022 which was uploaded to Tendable; 2 areas completed additional audits (Ward 21 x2; PAU x3). However, 10 ward areas (Ward 1, Ward 2, AMU, ICU, Ward 20B, SACU, Ward 23, Ward 24, Ward 25, and Ward 27) did not complete and upload a ward storage audit (medicines management (medicine room) inspection report) in August 2022

Overall, standards above 80% compliance except for:

- 74% compliance with open liquids in the Drug Trolley(s) have a 'date opened' label.
- 77% compliance with signatures and dates in the Ward Controlled Drugs Order Book to demonstrate receipt of Controlled Drugs from the Pharmacy (in the last 7 days).

Main areas of non-compliance with ward storage standards are:

- MLTC: medicines locked away and not left out unattended, drugs Room free of clutter, all open liquids in the Drug Trolley(s) have a 'date opened' label, and there are signatures and dates in the Ward Controlled Drugs Order Book to demonstrate receipt of Controlled Drugs from the Pharmacy (in the last 7 days)?
- Surgery: all open liquids in the drug trolley(s) have a 'date opened' label, room temperatures and fridge temperatures where medicines are stored are checked and recorded daily, errors in the CD Register correctly amended as per the Medicines Policy (in the last 7 days) and there are signatures and dates in the Ward Controlled Drugs Order Book to demonstrate receipt of Controlled Drugs from the Pharmacy (in the last 7 days).
- WCCSS: none in areas audited
- Community: none in areas audited

Actions to address:

- A short training video has been developed which sets out the key requirements with regard to the management of controlled drugs. Alongside the Medicines Management handbook, is will be key piece of educational material.
- Funding secured to purchase automated ward storage cabinets across Wards 14-17 and Ward 5 as part of the refurbishment programme. The projects also include swipe card access to drug storage areas, electronic temperature monitoring and air temperature control., this will allow for the above standard to be achieved consistently across these ward areas. The refurbishment of Wards 16 &17 is nearing completion and the pyxis units are on site awaiting installation.
- WCCSS 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.
- The new build ED will include air temperature monitoring, swipe card access to drug areas and electronic drug storage units in four locations – ED, PAU, AMU and ED Resus.
- Pharmacy has installed an electronic cabinet for controlled drugs. This will enhance security within pharmacy and has allowed the audit trail to become paperless There are also options being explored with the pharmacy collaboration with BD to extend the electronic stock control system into ward areas which will provide an opportunity to replace paper based audit trails.
- Pharmacy has begun some work with Corporate Quality Nurses to set up workshops for nursing staff to focus on discussions around NMC professional accountability & responsibility, and legal aspects of practice and medicines. Initially the work will focus on Divisions, but potentially will be expanded and become part of regular professional updates.

Further projects and work

Pharmacy Quality Improvements

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

- Controlled drugs management- as part of a wider QI project this aims to improve controlled drugs compliance across ward 27 and accident and emergency
- Discharge Medication Service (DMS), which is a CQUIN to improve the communication to community pharmacies on the electronic discharge summary around medication changes. In Q2 this CQUIN target has been exceeded and the expectation is that it will be met by year end.
- Environmental sustainability. Pharmacy is part of the joint RWT/WHT “Greener NHS” group and is focussing initially on reduction I the use of anaesthetic gases.

Antimicrobial Stewardship

- AMS pharmacists have completed two submissions for the UTI CQUIN, compliance for the maximum payment has been achieved for both submissions (60%). This is a labour-intensive audit, being a paper-based Trust, however both submissions have been submitted when due.
- Following on from this audit a UTI working group has been put together to learn from the areas where we could improve and achieve 100% compliance, this team feeds into the continence team and IPC. The team have been completing ward-based UTI reviews and educational sessions planned for different staff groups.
- OPAT multidisciplinary ward rounds continue weekly, the service has been consultant led since January 2022, the monthly cost saving from this service has been calculated as £58,950 for September. Our aim in the next 12 months is to increase the referrals from the acute Trust to free up beds and allow patients to be treated at home.
- A new pharmacist will be starting in the team December 2022 - bringing the staffing allocation for pharmacists to 1.0 WTE
- Total IV antibiotic consumption has decreased by 4% since last quarterly report (May 2022). There has also been a reduction in co-amoxiclav consumption, there is currently a QSIR project running to reduce consumption of Tazocin and co-amoxiclav on AMU.

Medical Gases

- The Medical Gases Group last met on 30th September 2022.
- VIE replacement – initial works have commenced, with a view to completion in September.
- Training for nurses acting as Designated Nursing Officers was completed on 14th September. Ten matrons are now signed off as DNOs and can authorise any permit to work requests. Skanska have been supplied the names and contacts of the DNO matrons.
- Following a survey of nitrous oxide use by the consultant anaesthetists, it has been agreed with the Anaesthetic lead consultant and Surgery DD that the piped N_2O outlets can be blanked off and the piped system and manifold to West Wing theatres can be decommissioned. Approval for this will be sought from the Theatre Management Group.
- E&F have (in July) implemented a bar code tracking system provided by our gas supplier Air Liquide. This will allow full audit trail of bottled gases and identification of location. This will be particularly helpful with the security of nitrous oxide cylinders.
- “Greener NHS” – WHT is success story with regard to nitrous oxide and desfluorane usage – Trust was one of the top users in the country.

Policies and procedures

The following Pharmacy policies have been reviewed and approved:

- Antimicrobial policy
- Medicines Reconciliation Policy

- Immunoglobulin Policy

.

CQUIN Update

There are two CQUIN relating to medicines.

- DMS – 1.5% of all discharges to be referred to community pharmacy for medicines review via Pharmoutcomes. Continues on target at 1.7%.
- Antibiotic usage in UTI – 60% compliance with set standards required. On target at end of Q2.

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

4. 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 completed in March 2023.

5. RECOMMENDATIONS

Note the Section 29a Notice and risk

Note and seek assurance against the plan for the improvement required under the Section 29a notice is in place and being progressed with the assistance of an external Pharmacist Consultant. The oversight group is executive led.

Note that whilst there remain some areas where compliance to the Medicines Policy regarding drug storage and CD record keeping requires improvement, there has been a general improvement in awareness and engagement.

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – Wednesday 7th December 2022			
Health Inequalities Strategy		**AGENDA ITEM:**	
Report Author and Job Title:	Matthew Dodd, Director of Integration	**Responsible Director:**	Matthew Dodd, Director of Integration
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☒		
Assure	• There is recognition of the need for a Strategy in common with RWT delivering a shared approach to communications, education, training and monitoring of outcomes. The Tactical & Operational implementation will vary as this is dependent on local requirements and relationships / resources. • WHT has established a Health Inequalities Steering Group. A work programme is being developed, which builds on existing good practice within the Trust		
Advise	• Within Walsall 56% of the population live with the most deprived 20% of the national population as identified by the Index of Multiple Deprivation		
Alert	• The Covid pandemic has exacerbated health inequalities. There is now a unique opportunity to address these, although it must be recognised that there is significant pressure on services as part of the process of restoration and recovery. In the short term there is a requirement to be pragmatic about where efforts are focused for maximum benefit.		
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 the Black Country ICB around initiatives to address health inequalities		
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 Walsall Together partnership and the associated BAF risk for Walsall Healthcare.		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☒	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

Walsall Healthcare Trust

Strategy for addressing Health Inequalities

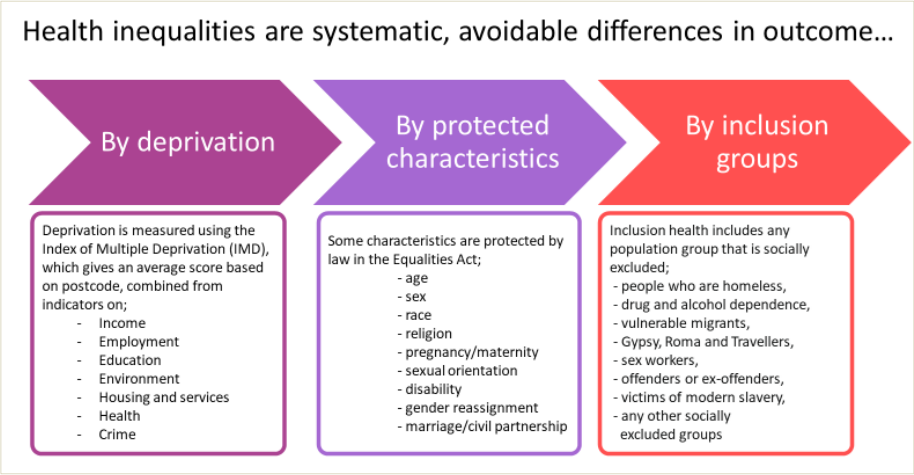
1.0 Overview: What do we mean by Health Inequalities

Health inequalities are differences in health between different groups of people. These differences are seen in

- Outcomes for people (life expectancy; healthy life expectancy)
- The care and support people receive (access; quality and experience)
- Opportunities to lead healthy lives (behaviours; wider determinants of health)

Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health and this shapes our mental health, physical health and wellbeing (Figure 1).

Figure 1: Health Inequalities



Everyone and every organisation have a role to play in tackling health inequalities. The experiences, outcomes and opportunities to lead healthy lives for the population we serve are well within the scope of NHS organisations to improve. The care we deliver needs to be equitable, fair and proportionate to the recognised needs of the whole population.

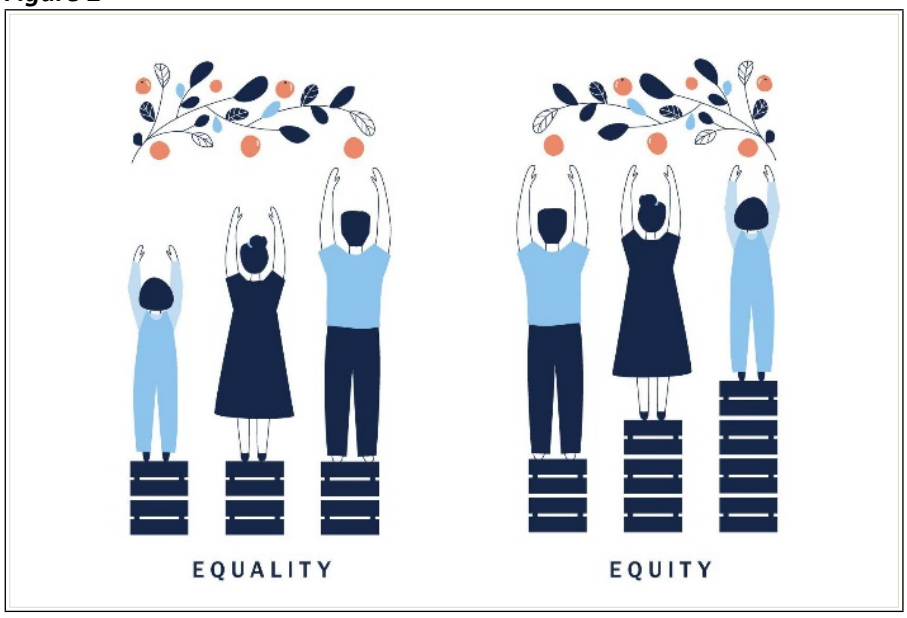
The Covid pandemic has exacerbated health inequalities. There is now a unique opportunity to address these, although it must be recognised that there is significant pressure on services as part of the process of restoration and recovery. In the short term there is a requirement to be pragmatic about where efforts are focused for maximum benefit.

2.0 What do we aspire to?

We will strive to improve the outcomes, experiences and opportunities to lead healthy lives for everyone we serve. We will strive to deliver equitable care proportionate to the needs of people (Figure 2). We seek to narrow the gap in access, experience and outcomes of care in our services.

In acknowledging that people have different opportunities in life, we must be careful not to make matters worse by offering care in a way that compounds these differences.

Figure 2



For our patients, carers and families this equates to:

- **Assess Equity**: Use data and insight to systematically assess whether services are provided in a fair way, in a way that addresses levels of need in our populations.
- **Anticipate Problems:** Consider barriers such as literacy, income, digital access and language in the design of our services. Listen to people to ensure that we aren't making it harder for some groups to benefit.
- **Act Earlier:** Investing in prevention, such as tobacco dependency treatment, and improving services that ensure children get the best start in life, such as maternity and health visiting. These interventions are evidence based to achieve the best long-term impact for our population.

Additionally, as employers, offering career opportunities to local residents, looking after the wellbeing of our staff, and making sure staff have equal opportunities for training and promotion.

3.0 What is the position within Walsall?

Within Walsall 56% of the population live with the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (**Figure 3**)

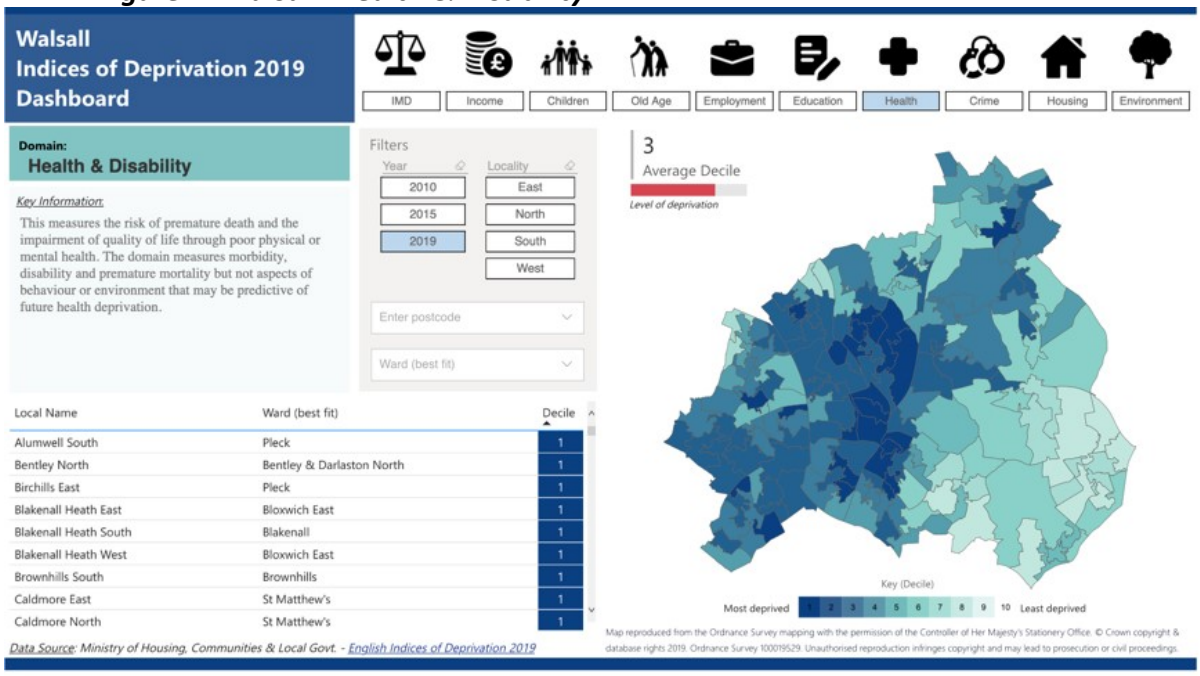
Figure 3: Black Country Deprived Communities

CORE 20	50%

Dudley	31%	Sandwell	60%	Walsall	56%	Wolverhampton	53%
Brierley Hill	41%	Caritas	59%	Walsall East 1	24%	North Network	59%
Dudley & Netherton	64%	Central Health Partnership	58%	Walsall East 2	13%	RWT	41%
Halesowen	14%	Citrus Health	56%	Walsall North	78%	South East	67%
Kingswinford & Wordsley	8%	Newcomen & Health	56%	Walsall South 1	79%	Total Health	64%
Sedgely, Coseley & Gornal	27%	Oldbury & Smethwick	61%	Walsall South 2	57%	Unity East	62%
		Together4Healthcare	70%	Walsall West 1	65%	Unity West	20%
Stourbridge, Wollescote & Lye	23%	Vision Health	59%	Walsall West 2	67%		
		Your Health Partnership	61%				

This manifests in the following distribution of risk of premature death and impairment of quality of life (through poor physical or mental health) as outlined in **Figure 4**

Figure 4: Walsall: Health & Disability



Appendix 1 provides more data relating to Walsall

4.0 Health Inequalities Strategy

4.1 Joint approach with RWT

There is recognition of the need for a Strategy in common with a shared approach to communications, education, training and monitoring of outcomes. The Tactical & Operational implementation will vary as this is dependent on local requirements and relationships / resources.

4.2 Joint Focus on Access and Quality of care

For both organisations, the starting point for the health inequalities strategy lies in the national priorities as outlined in **Table 1**

Table 1: Five National Priorities:

- Restoring NHS services inclusively, breaking down performance reports by patient ethnicity and indices of multiple deprivation (IMD) quintile.
- Mitigating against digital exclusion, identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile.
- Ensuring datasets are complete and timely, improving data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning.
- Accelerating preventative programmes: flu and COVID-19 vaccinations, annual health checks for those with severe mental illness and learning disabilities, continuity of carers for maternity services, targeting long-term condition diagnosis and management.
- Strengthening leadership and accountability, which is the bedrock underpinning the four priorities above, with system and provider health inequality leads having access to Health Equity Partnership Programme training, as well as the wider support offer, including utilising the new Health Inequalities Leadership Framework.

These translate into a key set of actions as outlined in **Table 2**

Table 2: Key Areas for Action

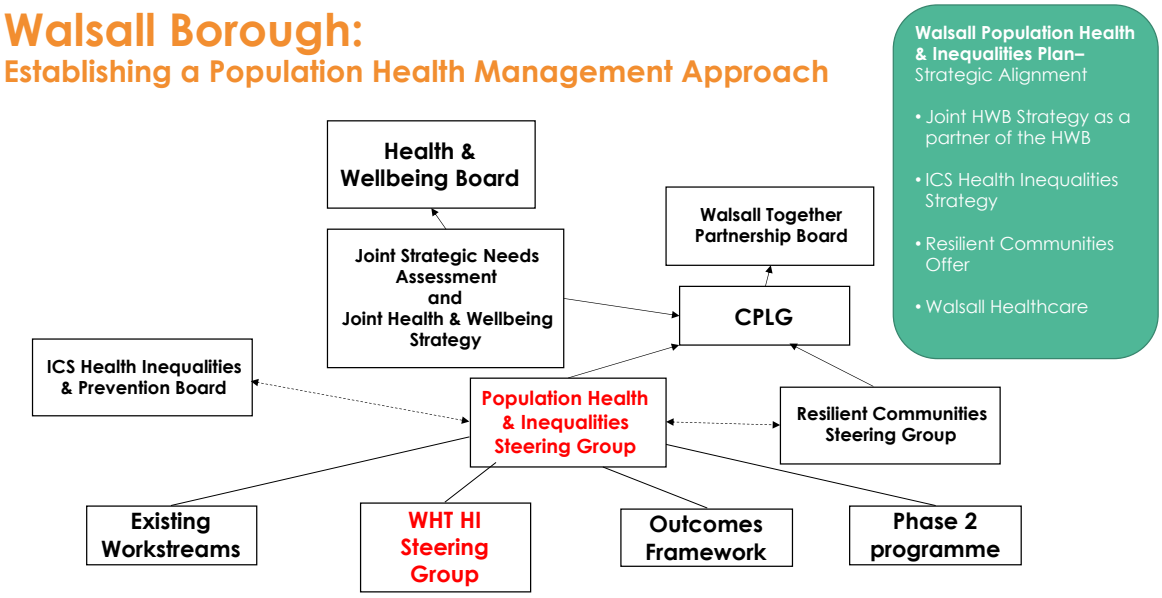
Dimension	Focus
Restoring NHS services inclusively	Maternity 0-19 years' service Elective Recovery: Planned Care Urgent & Emergency Care
Digital Exclusion	Implementation of use of digital services to improve access to health care (at home) Monitoring impact & ensuring face to face options available
Data Quality	Improving the quality of coding within the Trust for ethnicity and deprivation Monitoring systems for impact of health inequality work
Accelerating Prevention	Primary Care / Community: screening programmes; refugees Secondary Care: smoking cessation Self-Care: health literacy; shared decision-making skills for patients & staff; patient activation & empowerment
Leadership & Accountability	Review all service developments to ensure a focus on reducing health inequality Education & Training for medical staff & senior leaders Use of Health Equity Assessment Tool (HEAT)

4.3 Acknowledging the Importance of Place

There are differences between the two trusts based on starting point with regards to infrastructure and place-based partnership arrangements. RWT has comprehensive data analysis for its local population with Public Health capacity rooted within the Trust. The RWT Health Inequalities approach is embedded in its 'Place' work programme and is linked to the Wolverhampton Health & Well Being Board.

For WHT the data is less robust on Trust activity from a Health Inequality perspective, but it is possible to plan around existing data and extrapolate RWT data. The WHT Health Inequalities approach is embedded in Walsall Together work programme and Walsall Health & Well Being Board (**Figure 5**)

Figure 5: Walsall Place Structure for addressing Population Health & Inequalities



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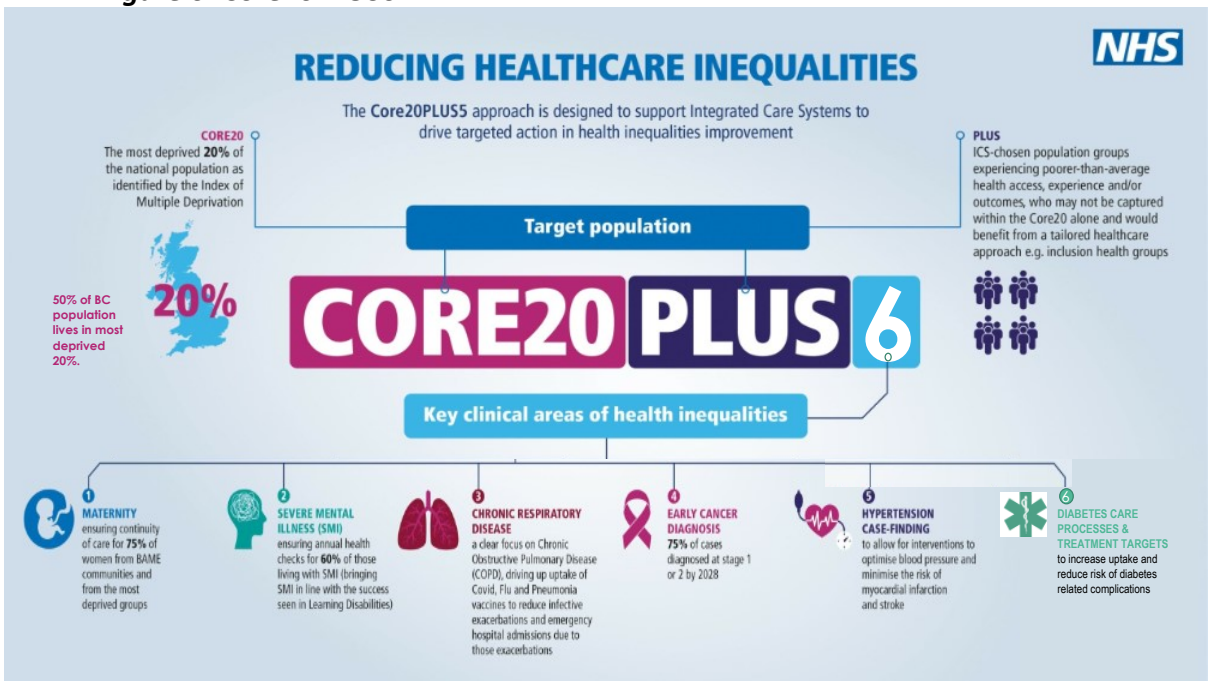
The approach within place is driven by the Core20PLUS5 approach with an additional focus on Diabetes as a 6th key clinical area (**Figure 6**)

Figure 6: Core20PLUS6



4.4 Governance

4.4.1 **Structure:** A Trust Health Inequalities Steering Group has been established with representation from Clinical Divisions. This has an Executive lead (Director of Integration) with a clinical lead (Dr Simon Harlin) and a managerial lead (Director of Transformation & Place Development). It is proposed that this reports into the Trust Quality & Patient Experience Committee.

4.4.2 **Strategy & Implementation Plan:** The plan is detailed in **Appendix 2**. It focuses on two phases:

Phase 1: Plausibility & Pragmatism

- Build on existing programmes of work which address health inequalities
- Focus on additional areas that 'make sense' [ease; opportunity; interest; requirement; funds; literature]
- Prepare the infrastructure for a more systematic approach

Phase 2: Certainty & Analysis

- Based on activity / outcomes data relating to people we see at WHT & (un)met need in the community
- Evidence-based approach
- Clear criteria to identify areas for intervention; projected / actual impact of initiatives

5.0 Delivery

The Trust Health Inequalities Group seeks to make links between the work that is Trust-centred with the wider Inequalities work being undertaken at partnership level.

Table 3 summarises the status of the workstreams within the Trust strategy

Table 3: Phase 1 Implementation

Dimension	Description / Rationale	Status
Build on the existing programme of work		
Accelerating prevention	Smoking Cessation	Tobacco Dependency Coordinator and Advisors are being recruited This work is now being coordinated with the Walsall Together Population Health & Inequality Group to address broader support needs to cease smoking long term
	Refugee Health	A bid has been submitted to the Population Health and Inequalities (PH&I) Grant to fund maternity outreach workers

	Outreach Support Team: Cancer, Palliative & End of Life Care	Increased interventions with general practice around the uptake of screening
Restoring NHS services inclusively	Maternity	Extensive work undertaken by Midwife for Health Inequalities A bid has been submitted to the Population Health and Inequalities (PH&I) Grant to fund maternity outreach workers
	Pre-operative optimisation	Proof of concept undertaken around Gynae patients who were not fit for surgery. This focused on interventions and aimed to consider whether deprivation or other protected characteristics are linked to being unfit for surgery. This is now being rolled out to further specialities and a bid has been submitted to the Population Health and Inequalities (PH&I) Grant
	National focus on Excess deaths post-Covid	**Cardiovascular:** Development of heart failure pathway within community with Consultant support **Diabetes:** work being undertaken with primary care to reconfigure the existing community diabetes service
Additional areas that 'make sense'		
Accelerating Prevention	Physical inactivity and unhealthy diet	This is being considered by the WT Population Health & Inequalities Group with a view to submitting a future bid to the Population Health and Inequalities (PH&I) Grant
	Alcohol Service	The Trust is linking in with the WT Population Health & Inequalities Group to ensure that any Trust service links in with holistic community-based plans to support people in reducing / ceasing their alcohol consumption
Restoring NHS services inclusively	Ethnic disparity in prostate cancer	Initial work on publicising screening campaigns highlighted the existing pressures on Urology services across the Black Country. It also highlighted that mortality outcomes within Walsall are poor for white males from deprived communities. This is now to be raised by the Trust cancer team with the Black Country ICB Cancer Health Inequalities group to agree a system-wide approach
	Waiting List: management of Neuro Rehab waiting list	Community Services is reviewing the waiting list management process to ensure

		that this group of patients is not disadvantaged [consideration to text reminder service / telephone reminders as more appropriate]
	Waiting List validation	The Data Task & Finish Group will consider means of measuring the impact of validation to ensure that an equitable approach is adopted
Phase 1: Prepare the infrastructure for a more systematic approach		
Data	Collection & Recording: Are we collecting the data we need?	Dashboard is being developed which looks at protected characteristics and waiting / activity data A Data task & finish group is being established to quality assure the data being produced
Data Interpretation & Analysis	Do we know how to interpret this data?	The Data Task & Finish Group will also focus on how best to interpret this data and translate this into a set of priorities for action
Communications & Engagement	**Communications** Ensuring access to health information material that is relevant to target groups? **Engagement** Ensuring our engagement strategies are appropriate for 'marginalised' groups	The Trust is linking in with Walsall Together to learn from the engagement work already undertaken within the Partnership A bid has been submitted to the Population Health and Inequalities (PH&I) Grant to fund health education material in a variety of languages / media to support the outreach work by the maternity health inequalities team
Leadership	What behaviours do we expect from leaders within the organisation?	The Trust Steering Group is to look at training for clinical staff which reflects the neds of the local population [e.g. Mind the Gap]
Governance	Ensuring that health inequalities are addressed in Business cases, Trust policies, Performance monitoring, Quality improvements	The Trust Equality Impact Assessment tool has been updated

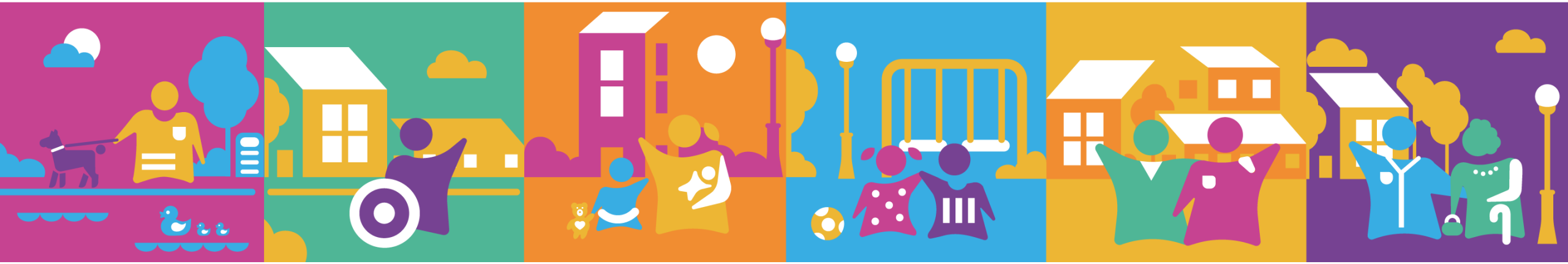
6.0 Recommendations

The Trust Board is recommended to note the actions being taken around the Trust Health Inequalities Strategy.

Walsall Together

Walsall Healthcare Trust
Population Health & Inequalities Strategy
Data Overview

2022/23



Collaborating for happier communities

Walsall Together

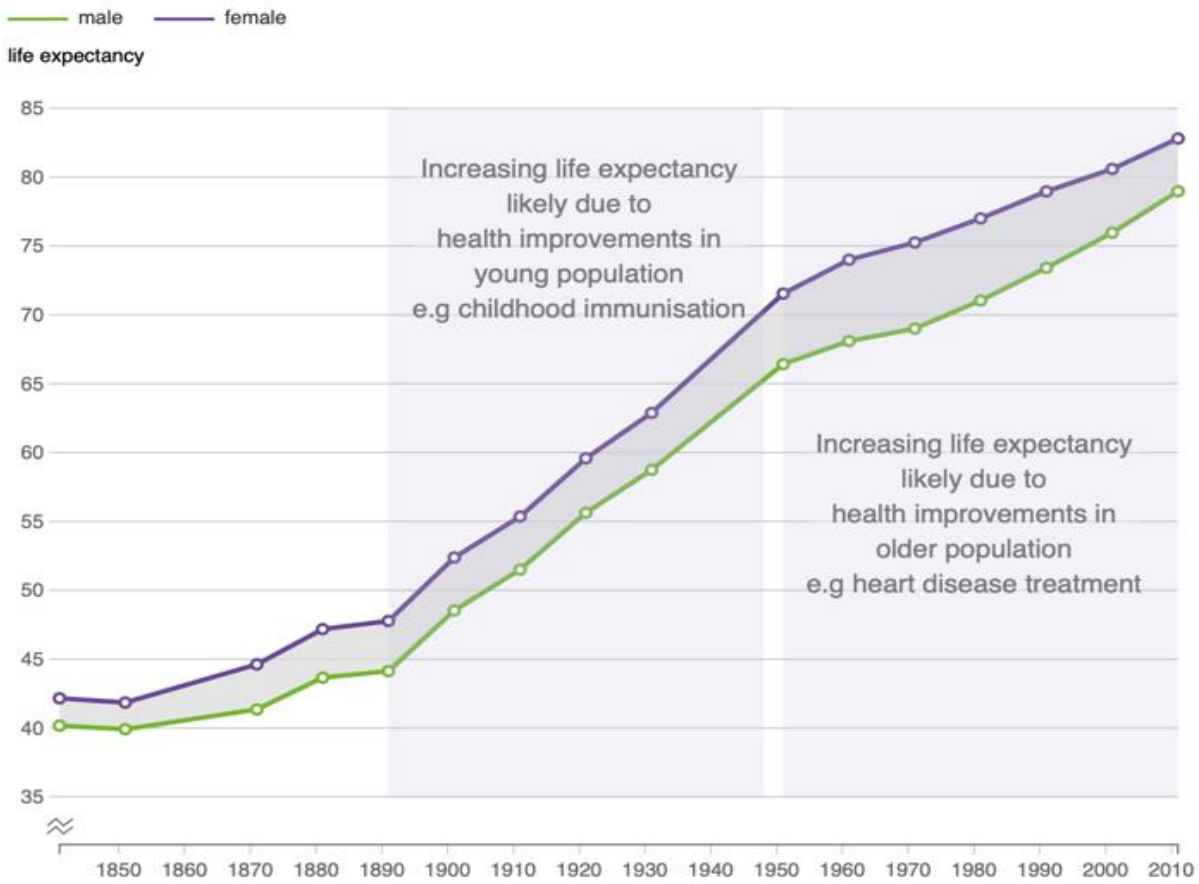
What do we mean by Health Inequalities?

- **Health inequalities are differences in health between different groups of people**

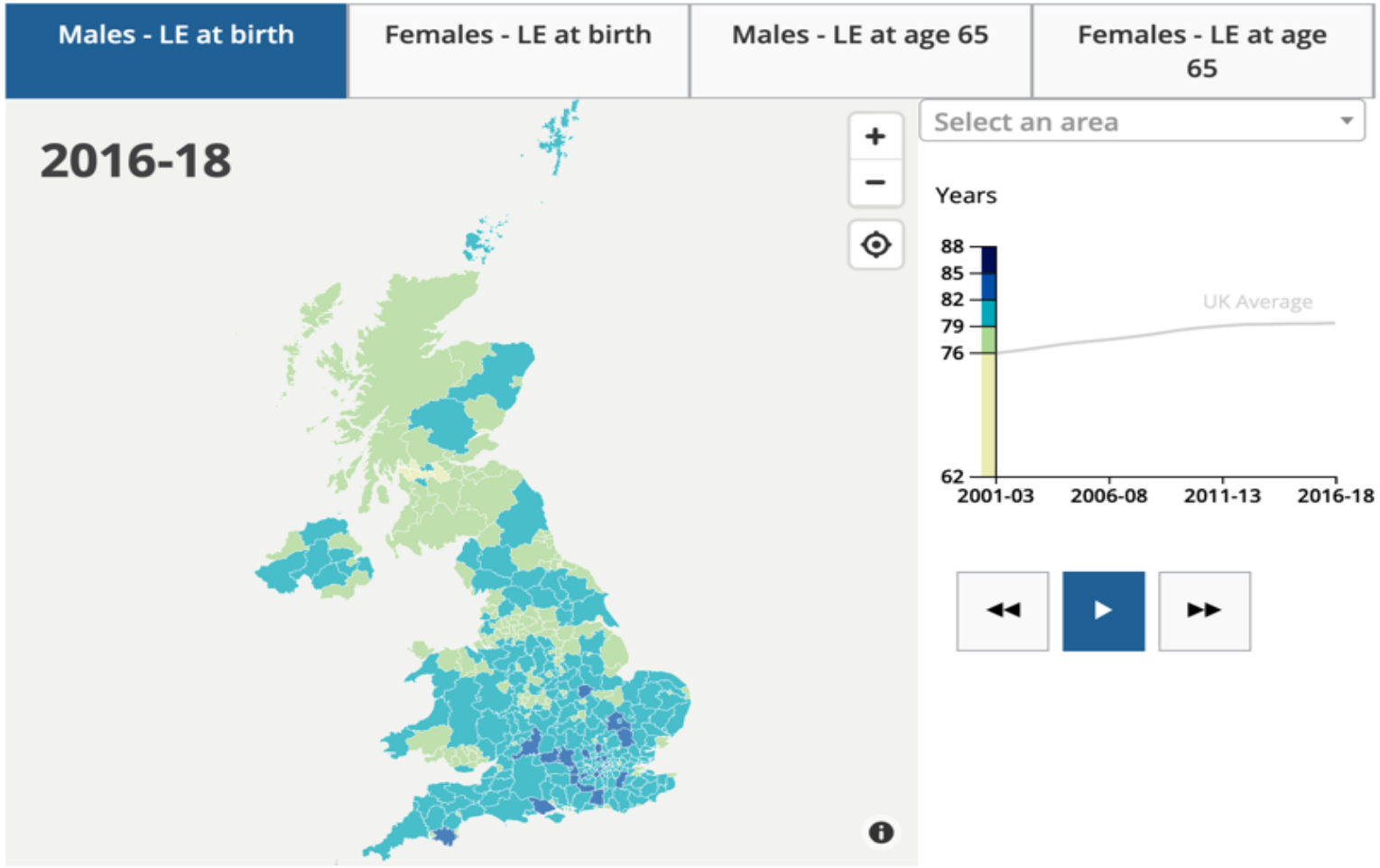
- These differences are seen in
  1. Outcomes for people
     - life expectancy
     - healthy life expectancy
  2. The care and support people receive
     - access
     - quality and experience
  3. Opportunities to lead healthy lives
     - behaviours
     - wider determinants of health

Walsall Together

Life expectancy at birth, England and Wales, 1841 to 2011



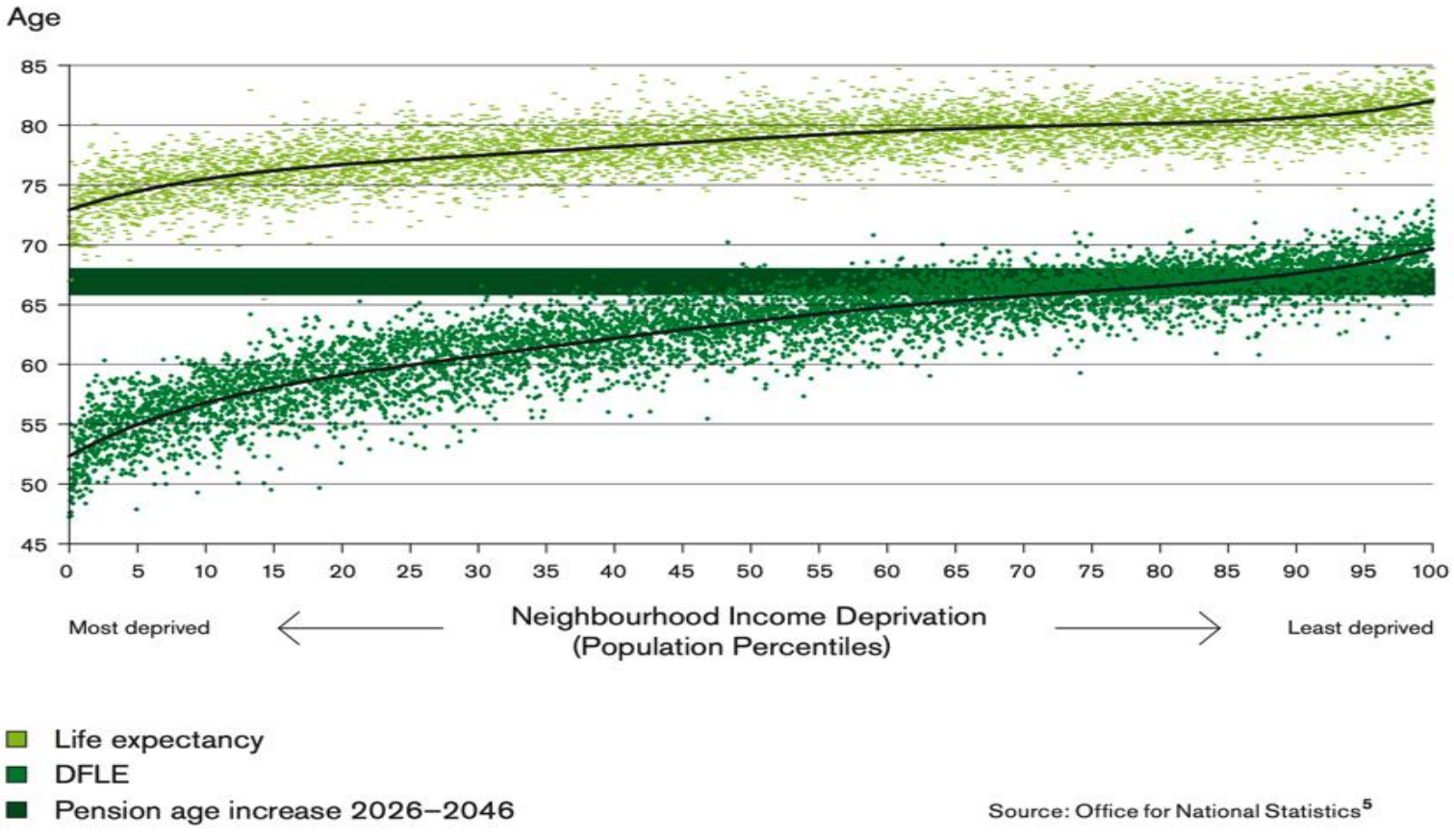
Walsall Together



Source: Office for National Statistics

Walsall Together

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[5]

Walsall Together

Table 44: Neonatal mortality rates by baby's ethnicity, mother's age and mother's socio-economic deprivation quintile of residence: United Kingdom and Crown Dependencies, for births in 2015 to 2019

Baby's ethnicity	Mother's age	Rate per 1,000 live births					
		Socio-economic deprivation quintile*					
		1 - Least deprived	2	3	4	5 - Most deprived	All quintiles
White	<25	1.81	1.92	2.00	2.31	2.44	2.17
	25-29	1.24	1.43	1.41	1.86	2.02	1.59
	30-34	1.26	1.21	1.31	1.64	1.96	1.41
	35+	1.33	1.69	1.86	1.80	2.43	1.70
	All ages	**1.33**	**1.49**	**1.58**	**1.90**	**2.19**	
Mixed	<25	0.68	0.65	1.60	1.56	1.75	1.44
	25-29	1.55	1.58	1.11	1.71	1.40	1.46
	30-34	1.14	0.92	1.80	1.42	2.10	1.47
	35+	1.24	0.79	2.00	2.65	1.68	1.64
	All ages	**1.22**	**1.00**	**1.65**	**1.81**	**1.73**	
Asian	<25	2.19	4.38	4.61	2.89	3.00	3.40
	25-29	1.76	2.32	2.22	2.60	2.78	2.46
	30-34	2.07	1.97	2.38	2.69	3.07	2.52
	35+	2.22	2.21	2.38	3.74	3.45	2.92
	All ages	**2.05**	**2.30**	**2.54**	**2.90**	**3.04**	
Black	<25	4.65	0.00	2.74	1.31	3.75	2.60
	25-29	2.04	2.02	1.87	2.26	2.05	2.08
	30-34	3.01	2.83	1.91	2.06	3.06	2.53
	35+	3.60	2.03	2.46	2.75	3.10	2.81
	All ages	**3.10**	**2.11**	**2.17**	**2.22**	**2.89**	
All 4 ethnicities	<25	1.80	1.92	2.17	2.26	2.49	
	25-29	1.29	1.52	1.51	2.00	2.09	
	30-34	1.33	1.29	1.52	1.84	2.28	
	35+	1.40	1.68	1.97	2.29	2.65	

Rate
0 to 0.49
0.5 to 0.99
1 to 1.49
1.5 to 1.99
2 to 2.49
2.5 to 2.99
3 to .49
3.5 to 3.99
4 to 4.49
4.5 to 4.99

§ excluding terminations of pregnancy and births <24^{+0} weeks gestational age
* based on mothers' postcodes at time of birth, using the Children in Low-Income Families Local Measure
Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey

Health Inequalities

Walsall Together

Health inequalities are systematic, avoidable differences in outcome…

By deprivation

Deprivation is measured using the Index of Multiple Deprivation (IMD), which gives an average score based on postcode, combined from indicators on;

- Income
- Employment
- Education
- Environment
- Housing and services
- Health
- Crime

By protected characteristics

Some characteristics are protected by law in the Equalities Act;

- age
- sex
- race
- religion
- pregnancy/maternity
- sexual orientation
- disability
- gender reassignment
- marriage/civil partnership

By inclusion groups

Inclusion health includes any population group that is socially excluded;

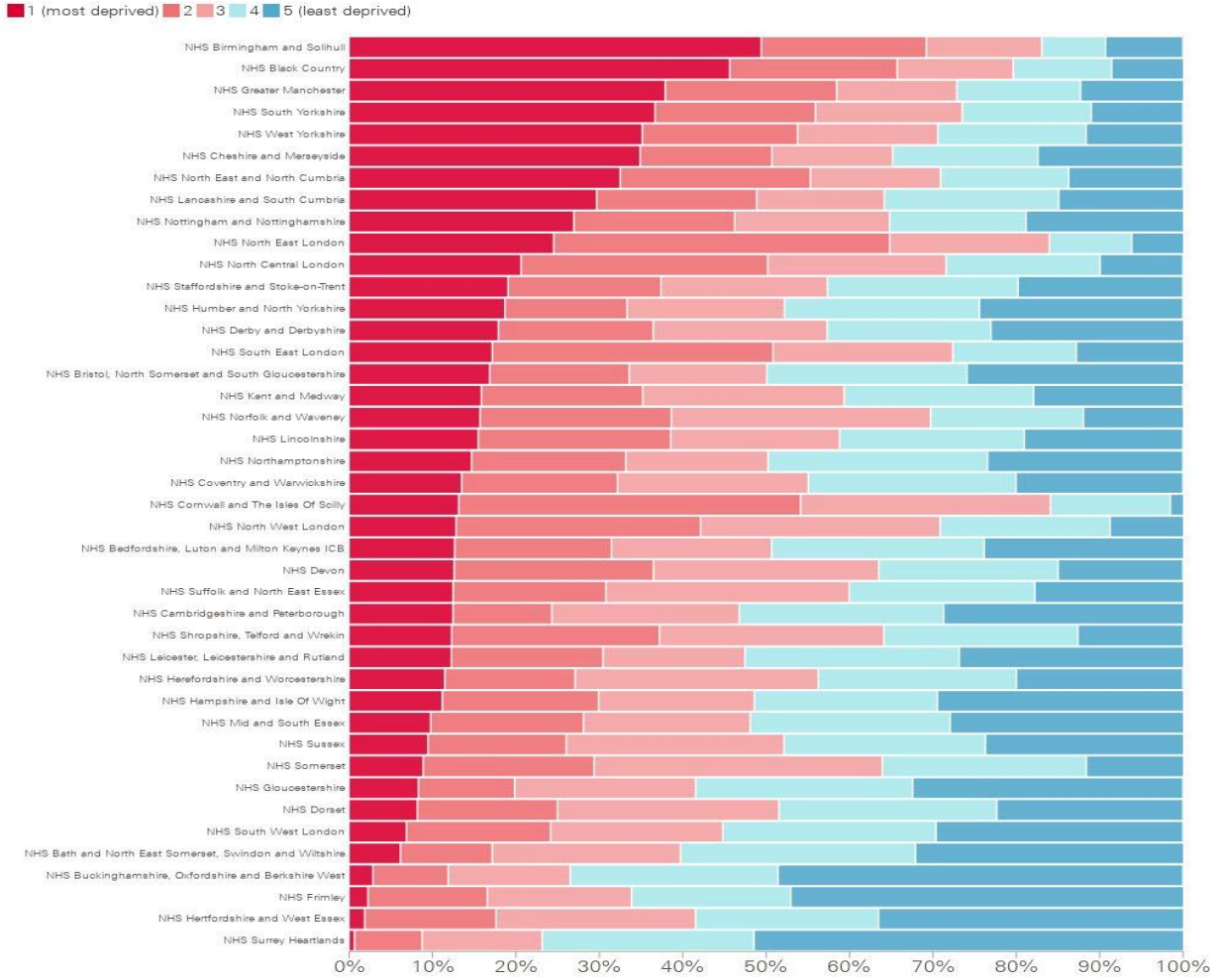
- people who are homeless,
- drug and alcohol dependence,
- vulnerable migrants,
- Gypsy, Roma and Travellers,
- sex workers,
- offenders or ex-offenders,
- victims of modern slavery,
- any other socially excluded groups

Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health and this shapes our mental health, physical health and wellbeing.

Walsall Together

ICSs cover areas with varying levels of deprivation

The percentage of neighbourhoods (LSOAs) in each deprivation quintile in each ICS



Walsall Together

Life expectancy and causes of death

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)
1 Life expectancy at birth (male)	All ages	2016 - 18	n/a	77.5	78.9	79.6
2 Life expectancy at birth (female)	All ages	2016 - 18	n/a	82.0	82.7	83.2
3 Under 75 mortality rate from all causes	<75 yrs	2016 - 18	2788	401.6	354.4	330.5
4 Mortality rate from all cardiovascular diseases	<75 yrs	2016 - 18	661	96.8	78.4	71.7
5 Mortality rate from cancer	<75 yrs	2016 - 18	1025	150.5	138.3	132.3

Walsall
Indices of Deprivation 2019
Dashboard

IMD | Income | Children | Old Age | Employment | Education | Health | Crime | Housing | Environment

Domain:
Index Multiple Deprivation

Key Information:

The Index of Multiple Deprivation is the official measure of relative deprivation in England. It is comprised of 7 main domains: Income (of which there are sub-domains for children & the elderly), Employment, Education, Health, Crime, Barriers to Housing & Living Environment. The overall rank is used to determine the relative deprivation for each area.

Filters

Year: 2010 | 2015 | 2019

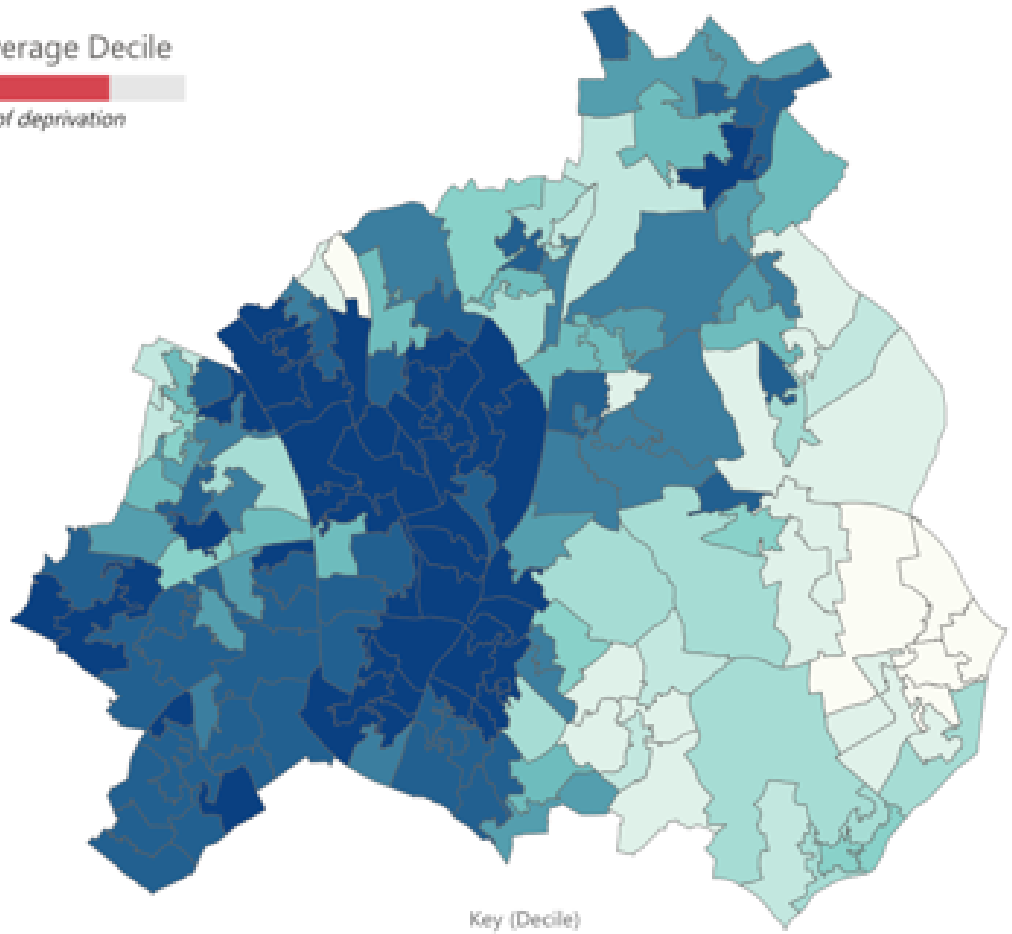
Locality: East | North | South | West

Enter postcode

Ward (best fit)

4
Average Decile

Level of deprivation



Local Name	Ward (best fit)	Decile
Alumwell East	Pleck	1
Alumwell South	Pleck	1
Beechdale East	Birchills Leamore	1
Beechdale West	Birchills Leamore	1
Bentley North	Bentley & Darlaston North	1
Birchills East	Pleck	1
Blakenall Heath East	Bloxwich East	1
Blakenall Heath South	Blakenall	1
Blakenall Heath West	Bloxwich East	1

Data Source: Ministry of Housing, Communities & Local Govt. - English Indices of Deprivation 2019

Walsall
Indices of Deprivation 2019 Dashboard

IMD | Income | Children | Old Age | Employment | Education | Health | Crime | Housing | Environment

Domain:
Health & Disability

Key Information

This measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.

Filters

Year: 2010 | 2015 | 2019

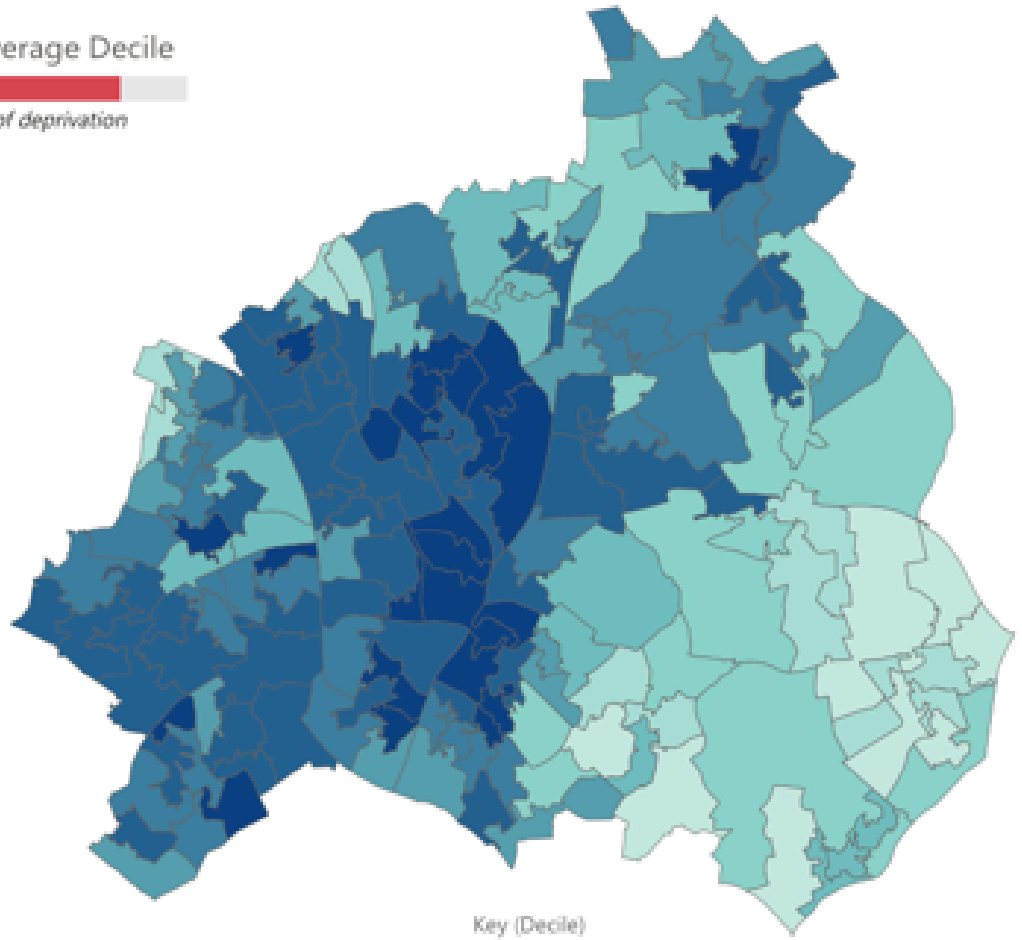
Locality: East | North | South | West

Enter postcode

Ward (best fit)

3
Average Decile

Level of deprivation



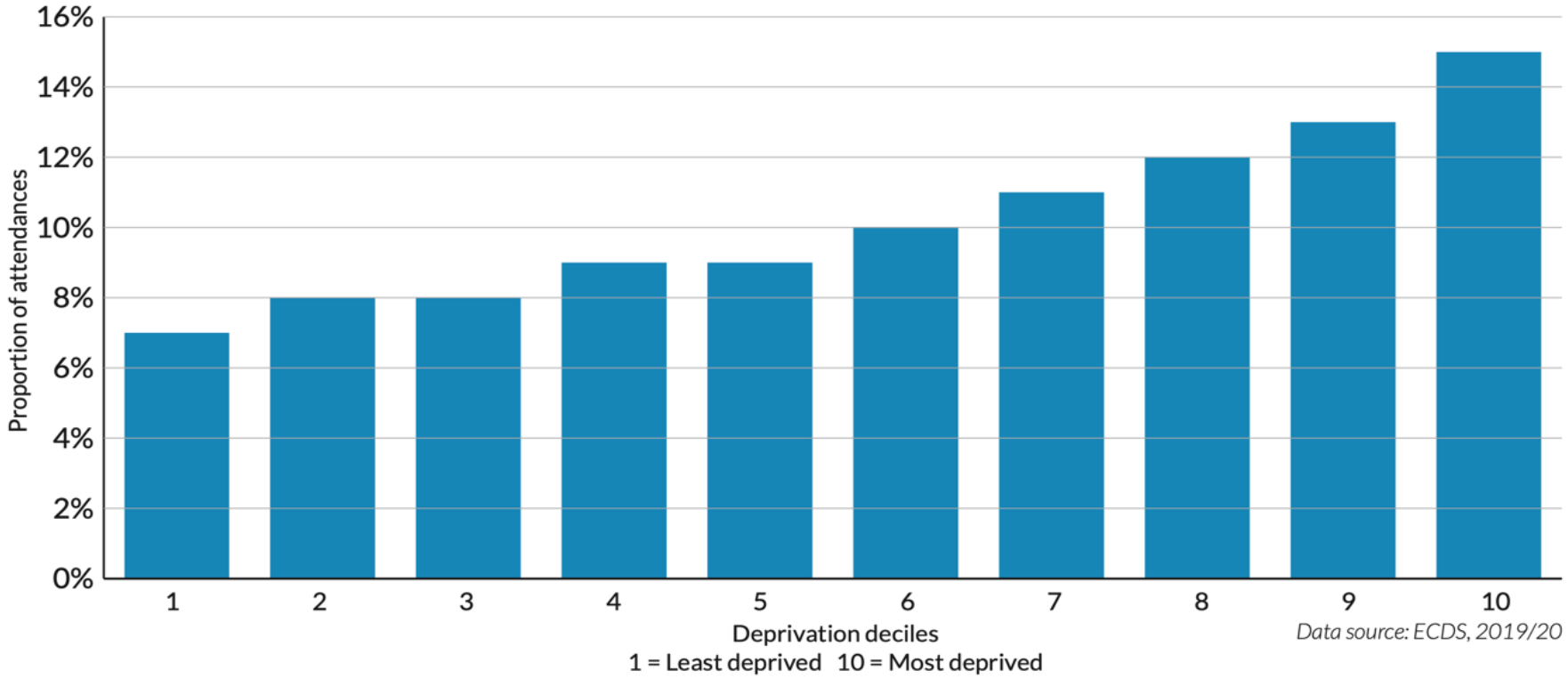
Local Name	Ward (best fit)	Decile
Alumwell South	Pleck	1
Bentley North	Bentley & Darlaston North	1
Birchills East	Pleck	1
Blakenall Heath East	Bloxwich East	1
Blakenall Heath South	Blakenall	1
Blakenall Heath West	Bloxwich East	1
Brownhills South	Brownhills	1
Caldmore East	St Matthew's	1
Caldmore North	St Matthew's	1

Data Source: Ministry of Housing, Communities & Local Govt. - English Indices of Deprivation 2019

MLTC

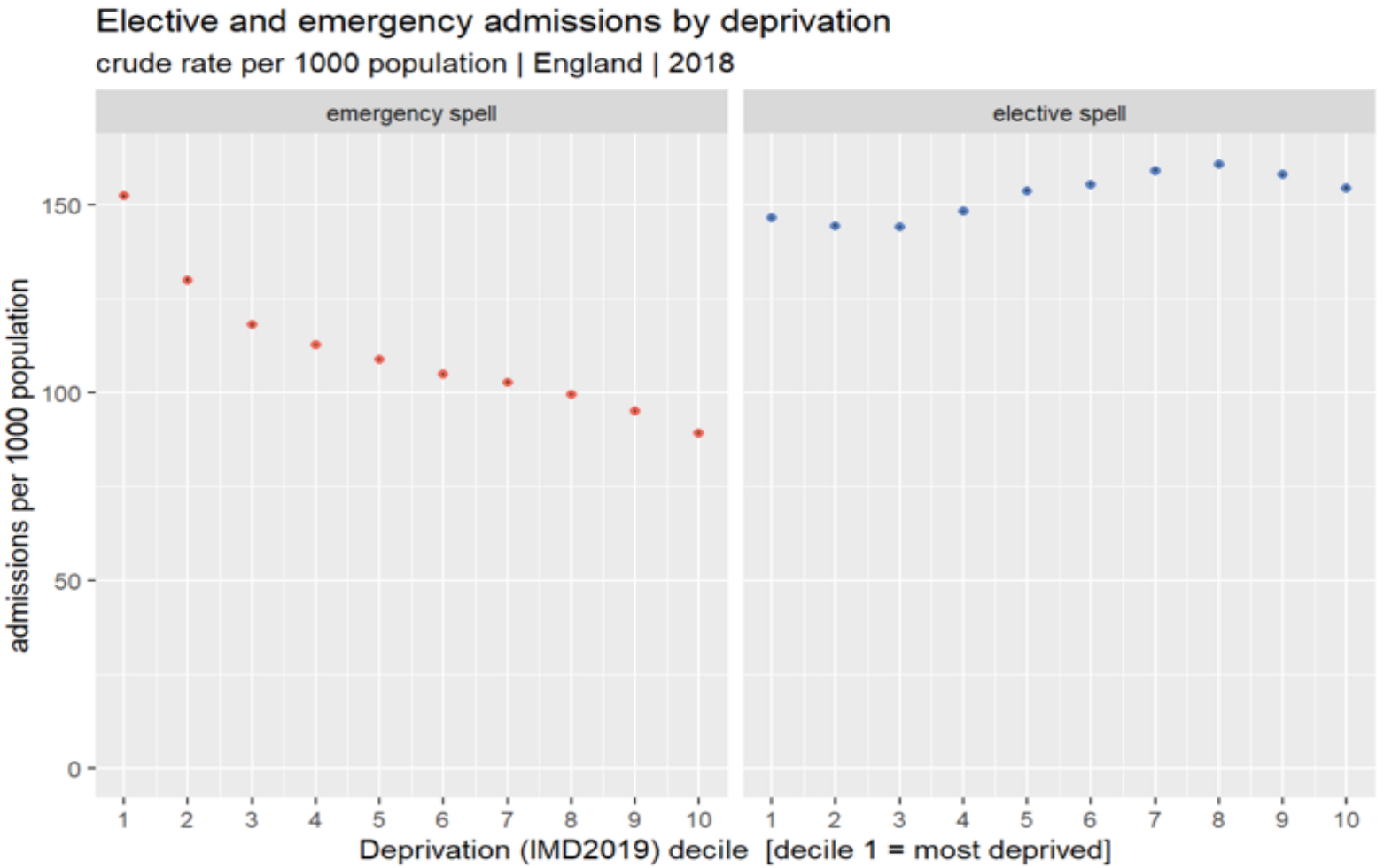
Walsall Together

Figure 12: Proportion of ED attendances by level of deprivation

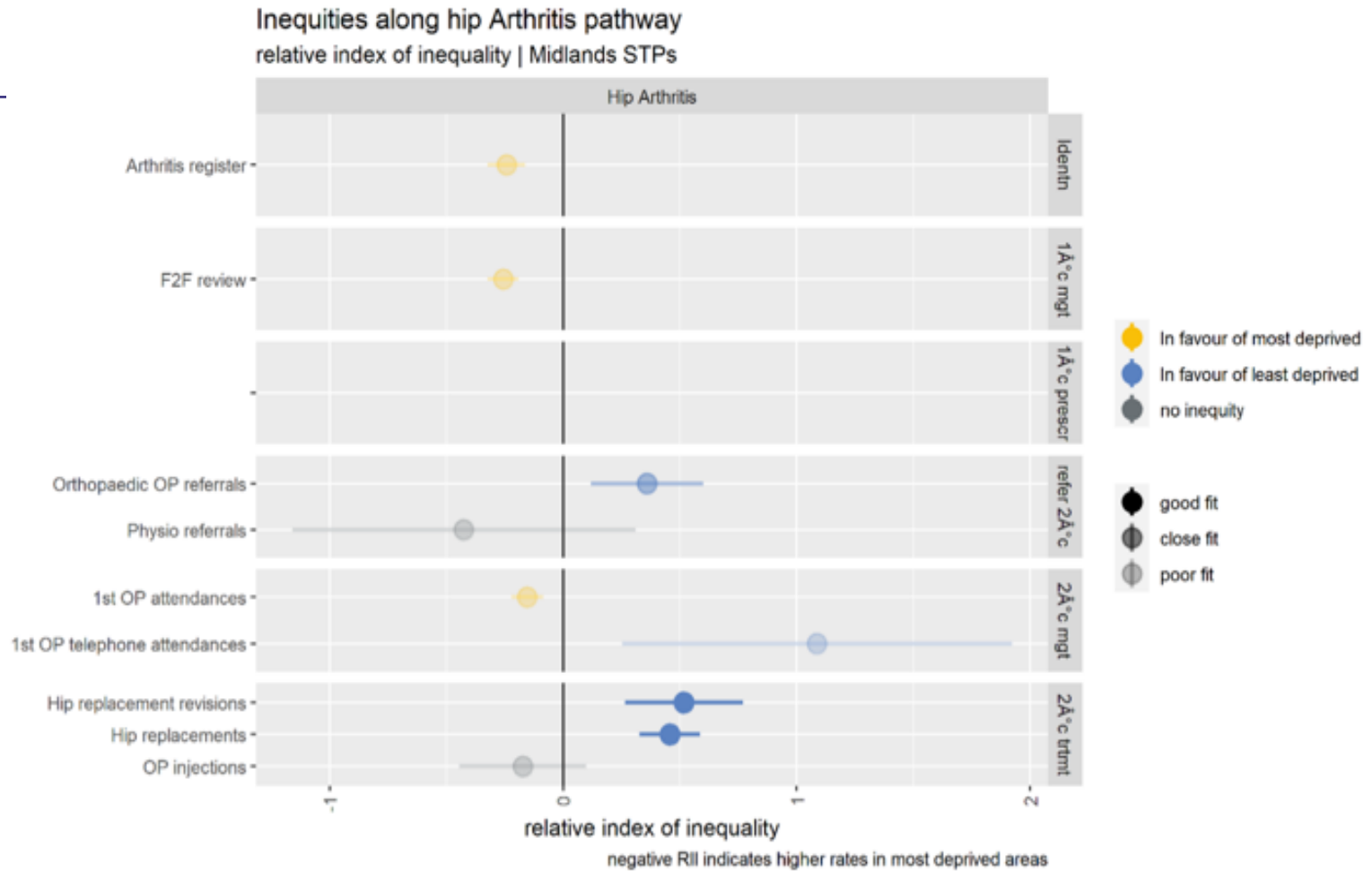


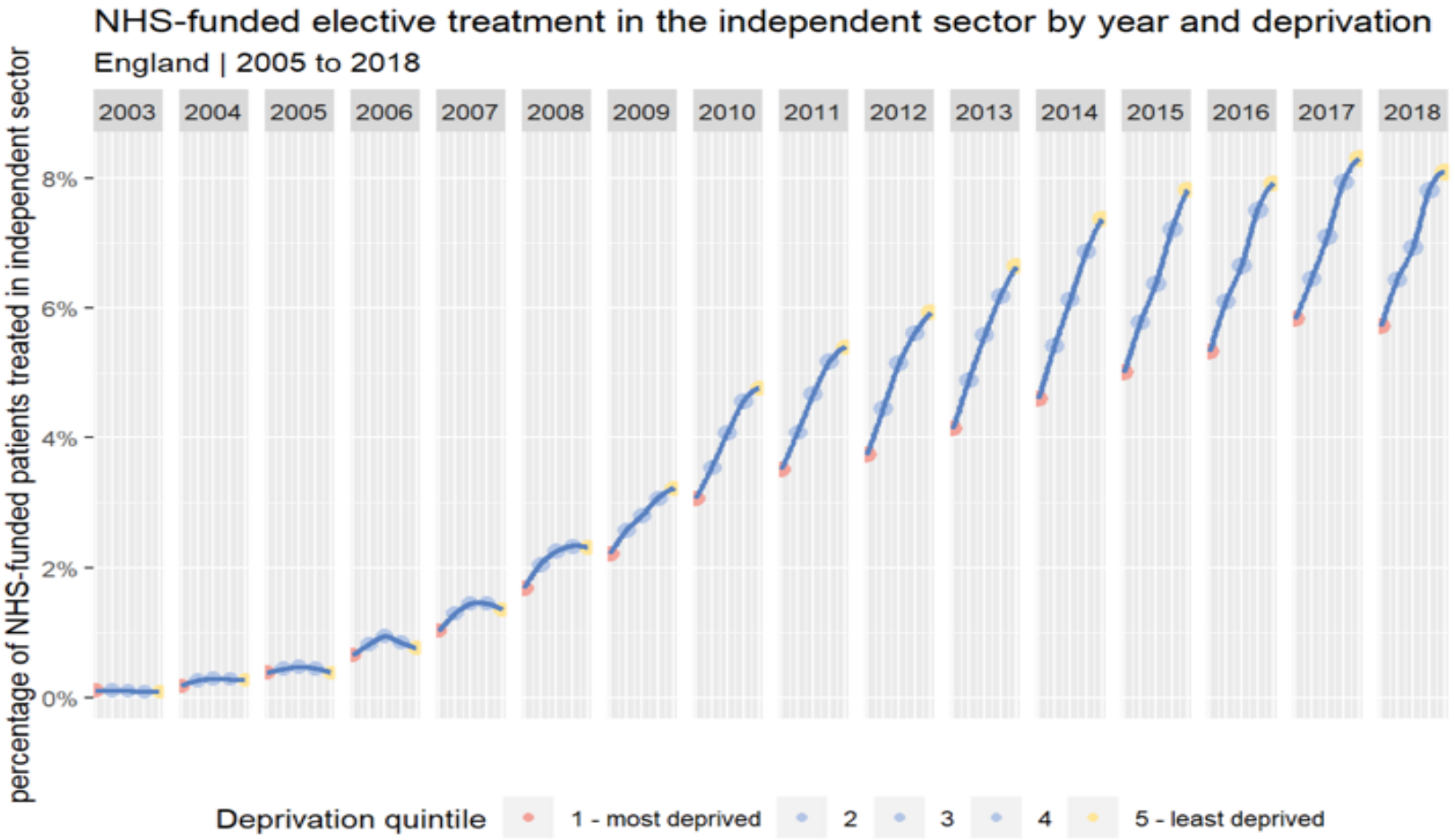
Data source: ECDS, 2019/20

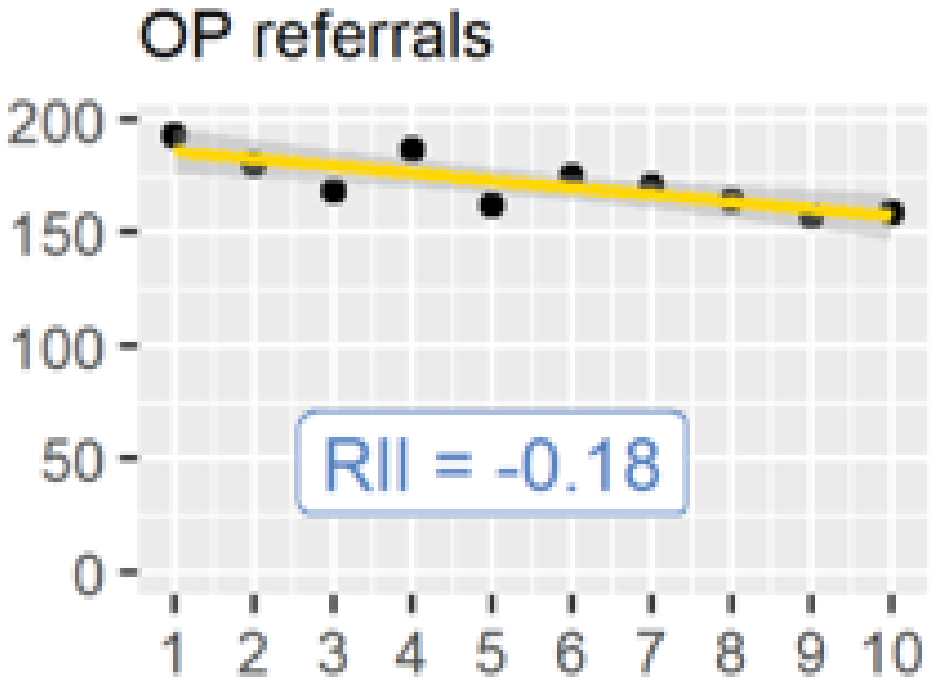
Walsall Together



Surgery


Inequities along hip Arthritis pathway
relative index of inequality | Midlands STPs
Hip Arthritis
Arthritis register
F2F review
Orthopaedic OP referrals
Physio referrals
1st OP attendances
1st OP telephone attendances
Hip replacement revisions
Hip replacements
OP injections
IdentIn
1Â°c mgt
1Â°c prescr
refer 2Â°c
2Â°c mgt
2Â°c trtmt
-1
0
1
2
relative index of inequality
negative RII indicates higher rates in most deprived areas
In favour of most deprived
In favour of least deprived
no inequity
good fit
close fit
poor fit


NHS-funded elective treatment in the independent sector by year and deprivation
England | 2005 to 2018
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
percentage of NHS-funded patients treated in independent sector
8%
6%
4%
2%
0%
Deprivation quintile
1 - most deprived
2
3
4
5 - least deprived



1=Least Deprived
10=Most Deprived

DNAs

DNA rates % of all appointments (excludes cancelled appointments)

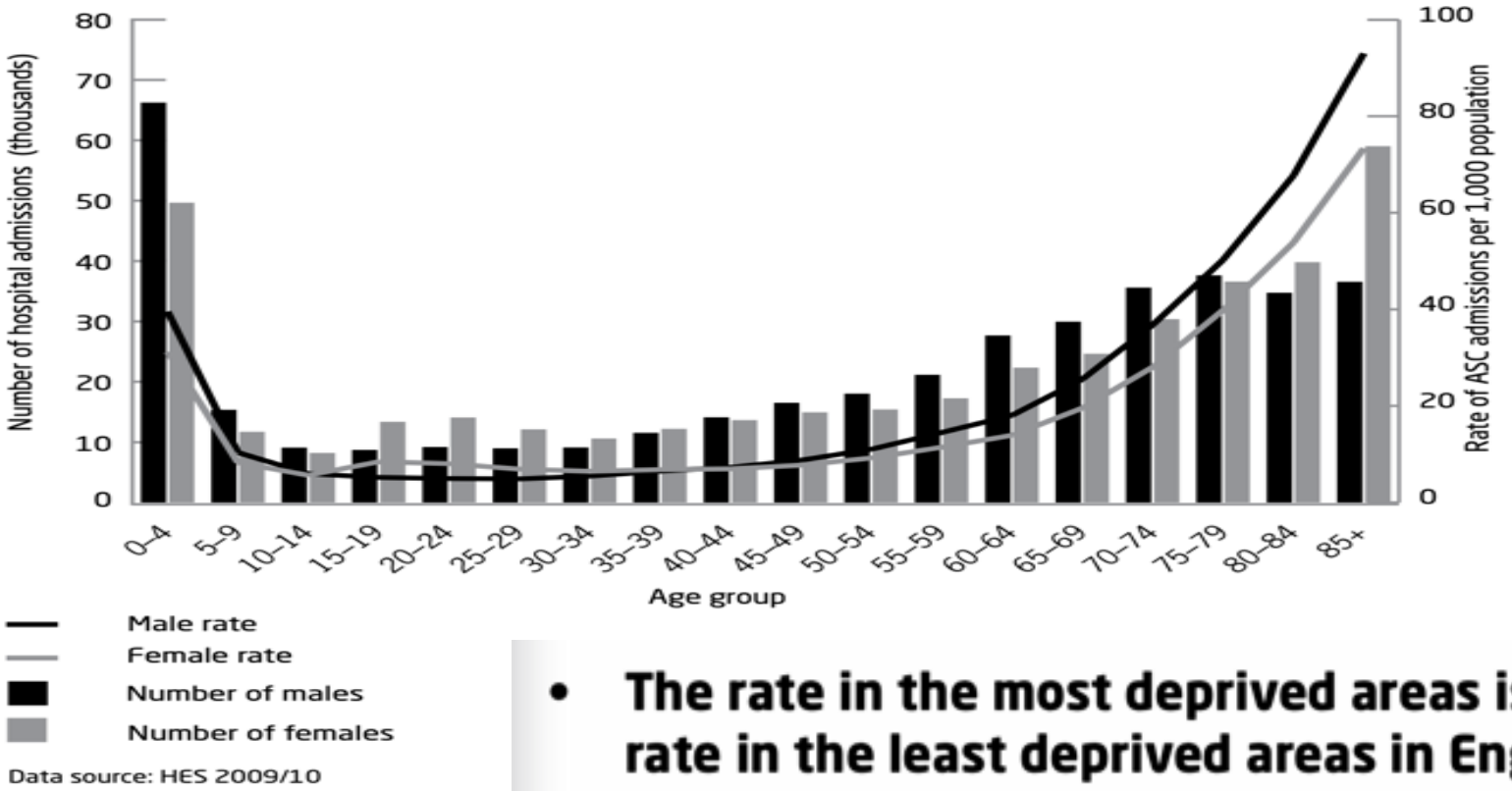
	Age								
IMD decile	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
0-19.9	21%	20%	22%	20%	15%	11%	9%	7%	9%
20-39.9	16%	17%	19%	15%	12%	9%	5%	6%	7%
40-59.9	14%	16%	17%	18%	13%	8%	4%	5%	6%
60-79.9	13%	12%	13%	13%	8%	7%	5%	3%	5%
80-100	12%	11%	13%	13%	9%	6%	3%	3%	4%

	Ethnicity						
IMD decile	Black	Asian	Mixed	Other	White	Missing	Not stated
0-19.9	16%	12%	23%	18%	11%	27%	22%
20-39.9	13%	9%	17%	12%	8%	19%	15%
40-59.9	11%	8%	14%	14%	7%	24%	21%
60-79.9	11%	9%	20%	8%	5%	15%	7%
80-100	18%	5%	9%	6%	5%	13%	7%

Walsall Together

Women & Children's

Figure 1: Age and sex distribution of patients admitted for ACSCs, England, 2009/10



Data source: HES 2009/10

- **The rate in the most deprived areas is more than twice the rate in the least deprived areas in England.**

Walsall Together

Figure 2.25 Percentage of pupils achieving 5+ A*–C grades including English and Maths at GCSE by income deprivation of area of residence, England, 2008/9

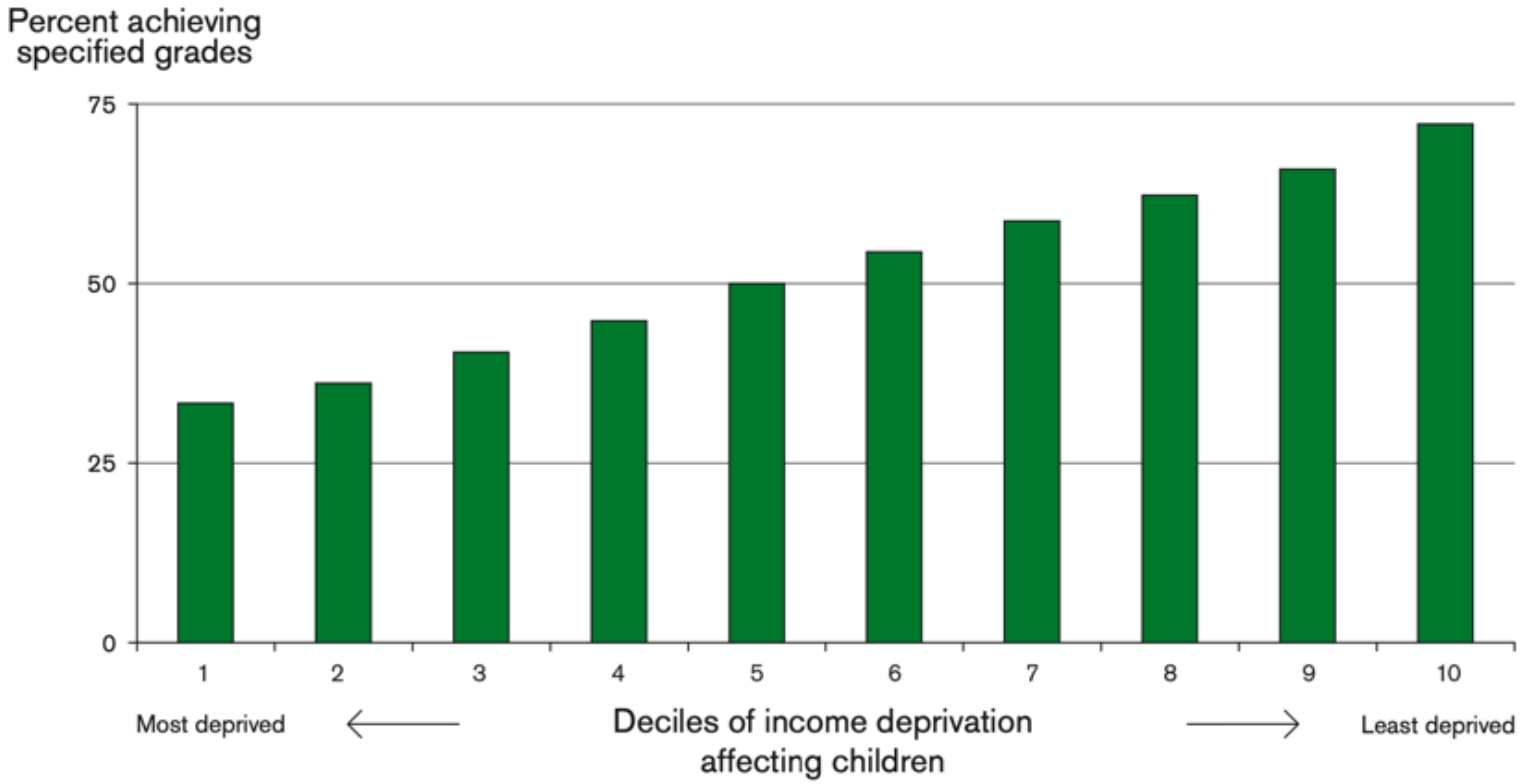
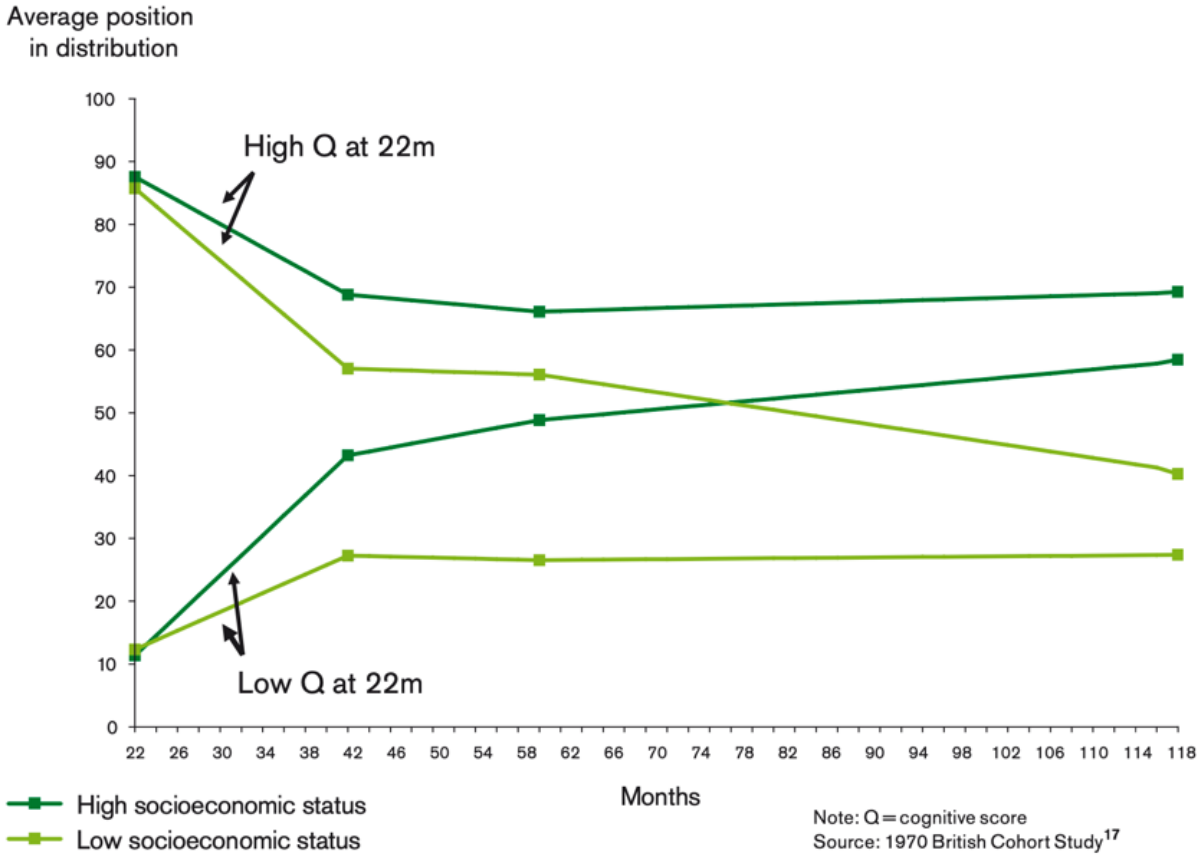
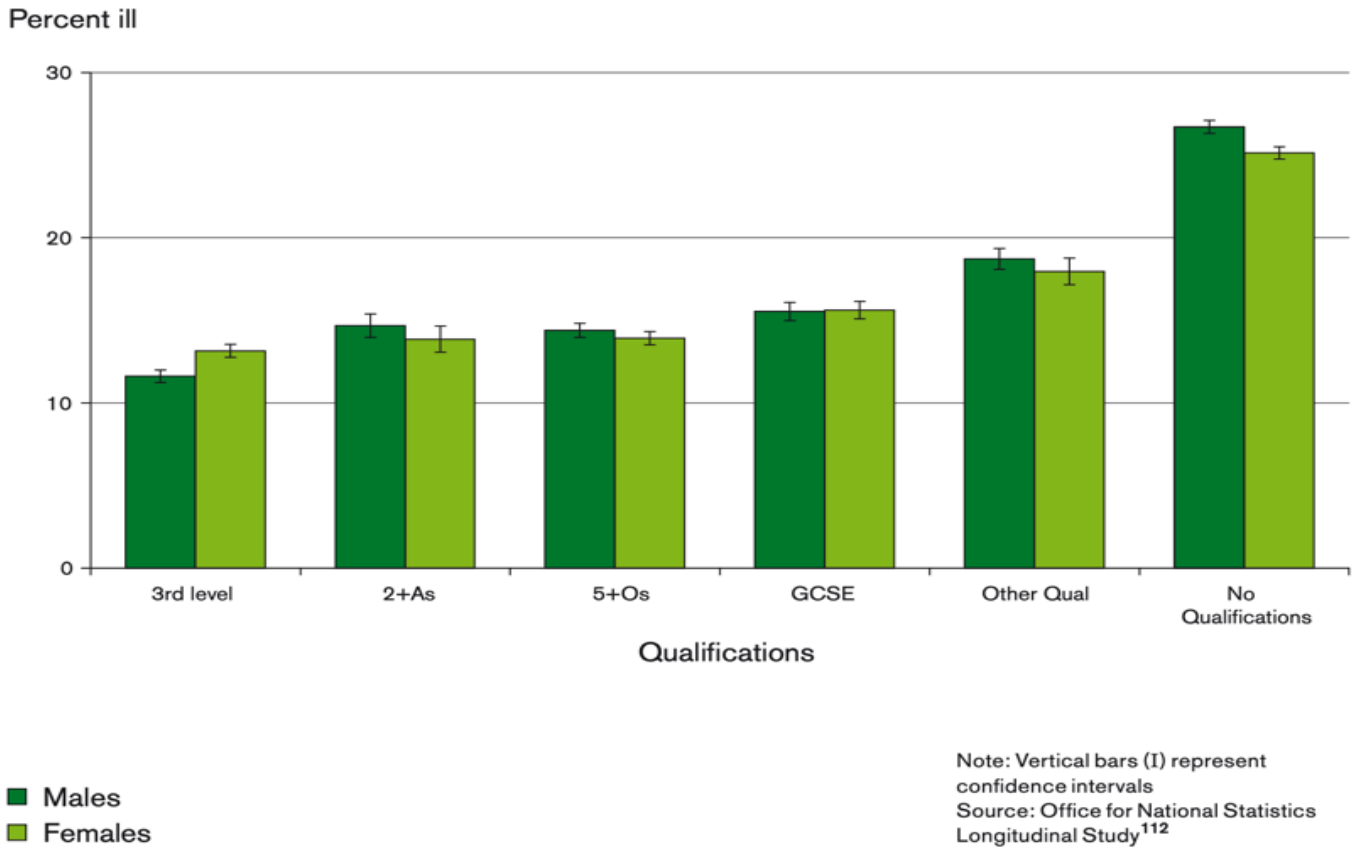


Figure 6 Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



Note: Q = cognitive score
Source: 1970 British Cohort Study[17]

Figure 2.26 Standardised limiting illness rates in 2001 at ages 16–74, by education level recorded in 2001



Note: Vertical bars (I) represent confidence intervals
Source: Office for National Statistics Longitudinal Study[112]

Walsall Together

Wider determinants of health

Indicator	Age	Period	Count	Value (Local)	Value (Region)
25 Percentage of children in low income families	<16 yrs	2016	15070	25.8	20.3
26 Average GCSE attainment (average attainment 8 score)	15-16 yrs	2018/19	140532	43.5	45.7
27 Percentage of people in employment	16-64 yrs	2018/19	121200	70.8	73.8
28 Statutory homelessness rate - eligible homeless people not in priority need	Not applicable	2017/18	13	0.12	1.08

Walsall Together

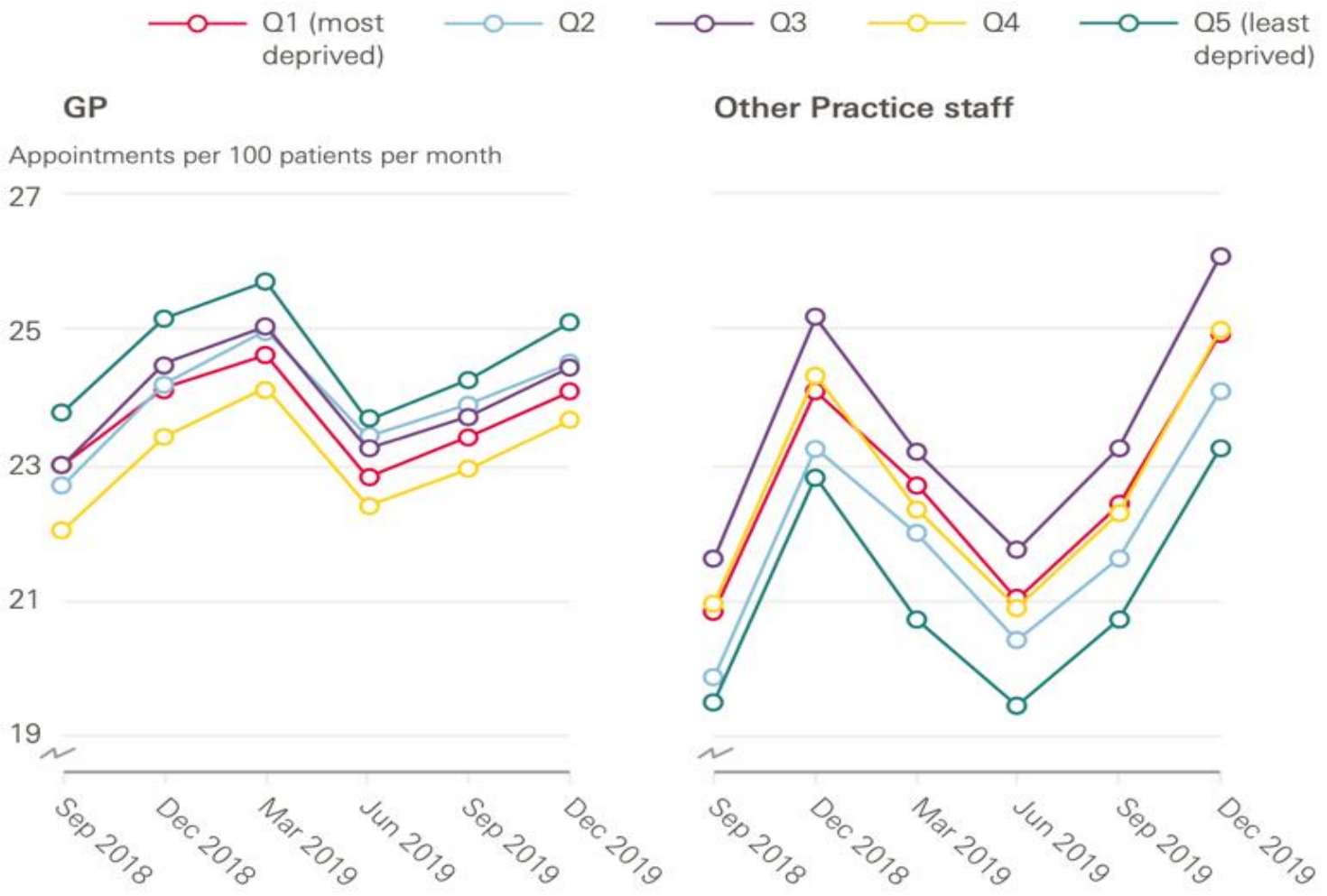
Table 44: Neonatal mortality rates by baby's ethnicity, mother's age and mother's socio-economic deprivation quintile of residence: United Kingdom and Crown Dependencies, for births in 2015 to 2019

Baby's ethnicity	Mother's age	Rate per 1,000 live births					
		Socio-economic deprivation quintile*					
		1 - Least deprived	2	3	4	5 - Most deprived	All quintiles
White	<25	1.81	1.92	2.00	2.31	2.44	2.17
	25-29	1.24	1.43	1.41	1.86	2.02	1.59
	30-34	1.26	1.21	1.31	1.64	1.96	1.41
	35+	1.33	1.69	1.86	1.80	2.43	1.70
	All ages	**1.33**	**1.49**	**1.58**	**1.90**	**2.19**	
Mixed	<25	0.68	0.65	1.60	1.56	1.75	1.44
	25-29	1.55	1.58	1.11	1.71	1.40	1.46
	30-34	1.14	0.92	1.80	1.42	2.10	1.47
	35+	1.24	0.79	2.00	2.65	1.68	1.64
	All ages	**1.22**	**1.00**	**1.65**	**1.81**	**1.73**	
Asian	<25	2.19	4.38	4.61	2.89	3.00	3.40
	25-29	1.76	2.32	2.22	2.60	2.78	2.46
	30-34	2.07	1.97	2.38	2.69	3.07	2.52
	35+	2.22	2.21	2.38	3.74	3.45	2.92
	All ages	**2.05**	**2.30**	**2.54**	**2.90**	**3.04**	
Black	<25	4.65	0.00	2.74	1.31	3.75	2.60
	25-29	2.04	2.02	1.87	2.26	2.05	2.08
	30-34	3.01	2.83	1.91	2.06	3.06	2.53
	35+	3.60	2.03	2.46	2.75	3.10	2.81
	All ages	**3.10**	**2.11**	**2.17**	**2.22**	**2.89**	
All 4 ethnicities	<25	1.80	1.92	2.17	2.26	2.49	
	25-29	1.29	1.52	1.51	2.00	2.09	
	30-34	1.33	1.29	1.52	1.84	2.28	
	35+	1.40	1.68	1.97	2.29	2.65	

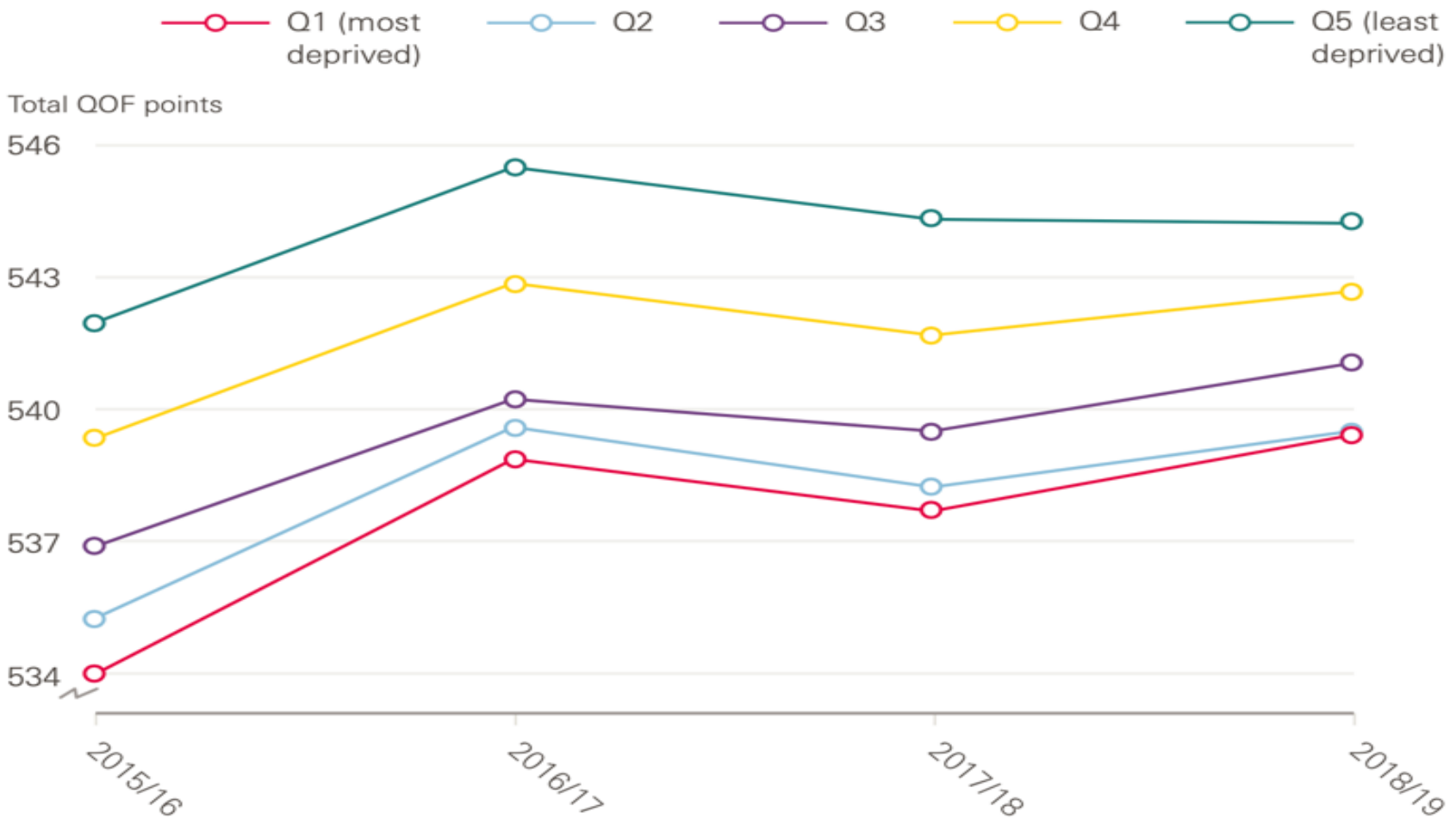
Rate
- 0 to 0.49
- 0.5 to 0.99
- 1 to 1.49
- 1.5 to 1.99
- 2 to 2.49
- 2.5 to 2.99
- 3 to .49
- 3.5 to 3.99
- 4 to 4.49
- 4.5 to 4.99

§ excluding terminations of pregnancy and births <24+0 weeks gestational age
• based on mothers' postcodes at time of birth, using the Children in Low-Income Families Local Measure
Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey

Access

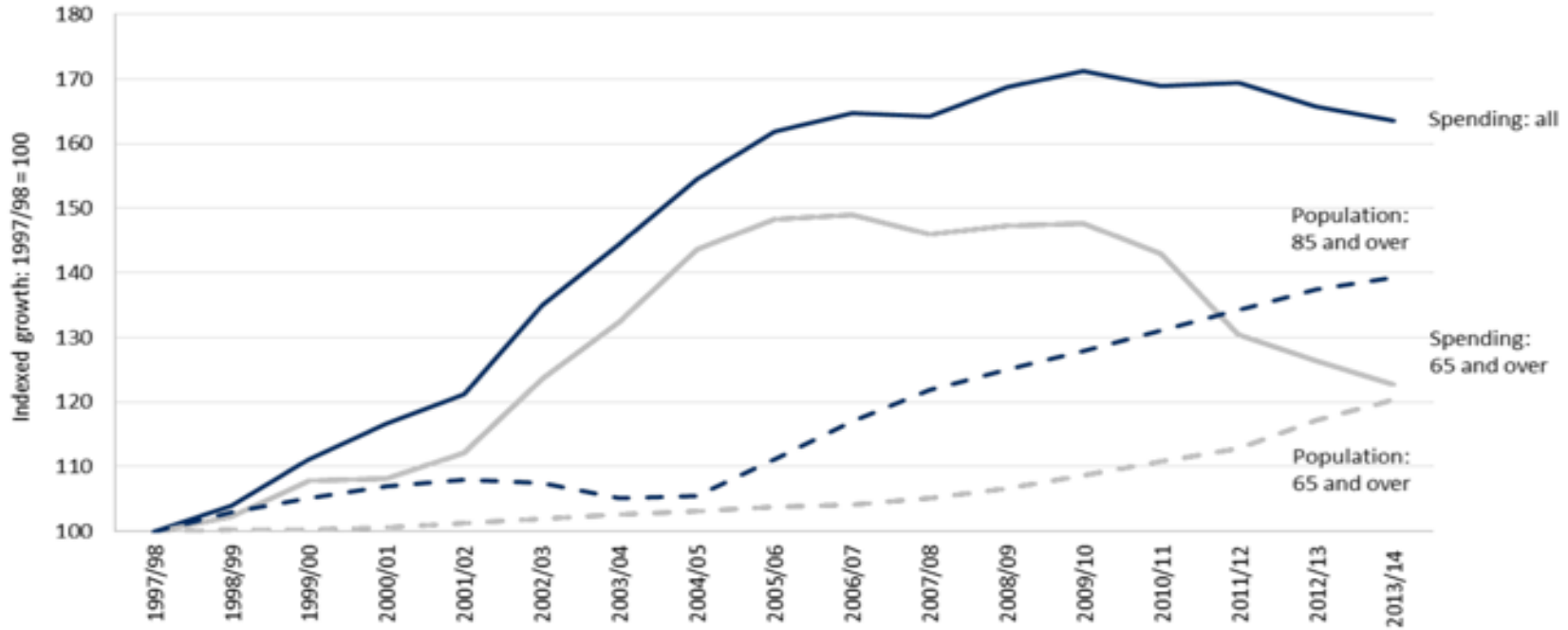

Q1 (most deprived)
Q2
Q3
Q4
Q5 (least deprived)
GP
Other Practice staff
Appointments per 100 patients per month
27
25
23
21
19
Sep 2018
Dec 2018
Mar 2019
Jun 2019
Sep 2019
Dec 2019

Quality


Q1 (most deprived)
Q2
Q3
Q4
Q5 (least deprived)
Total QOF points
546
543
540
537
534
2015/16
2016/17
2017/18
2018/19

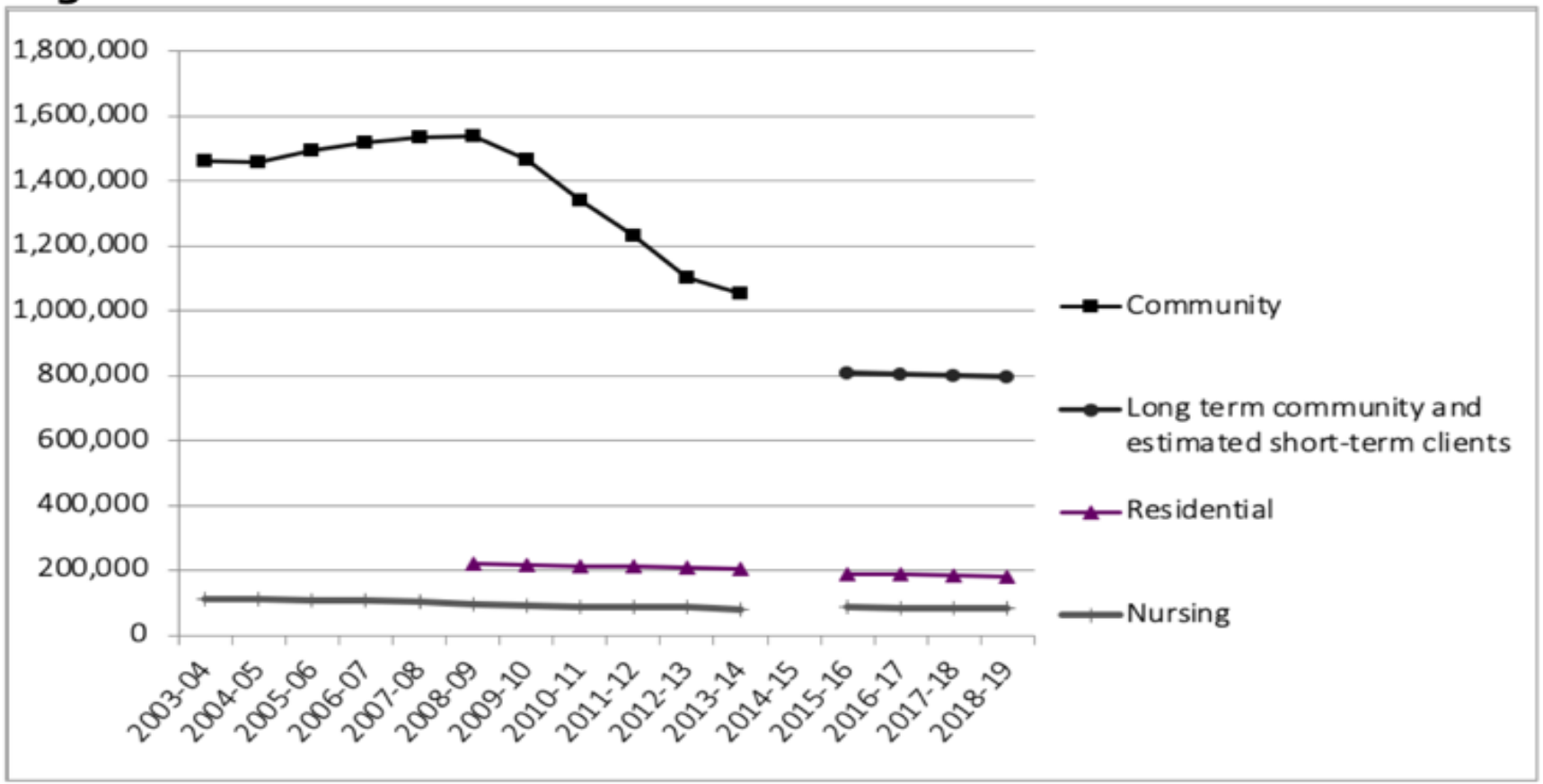
Social Care

Figure 2 Growth in real net current spending and population estimates by age group, England, 1997/98 to 2013/14



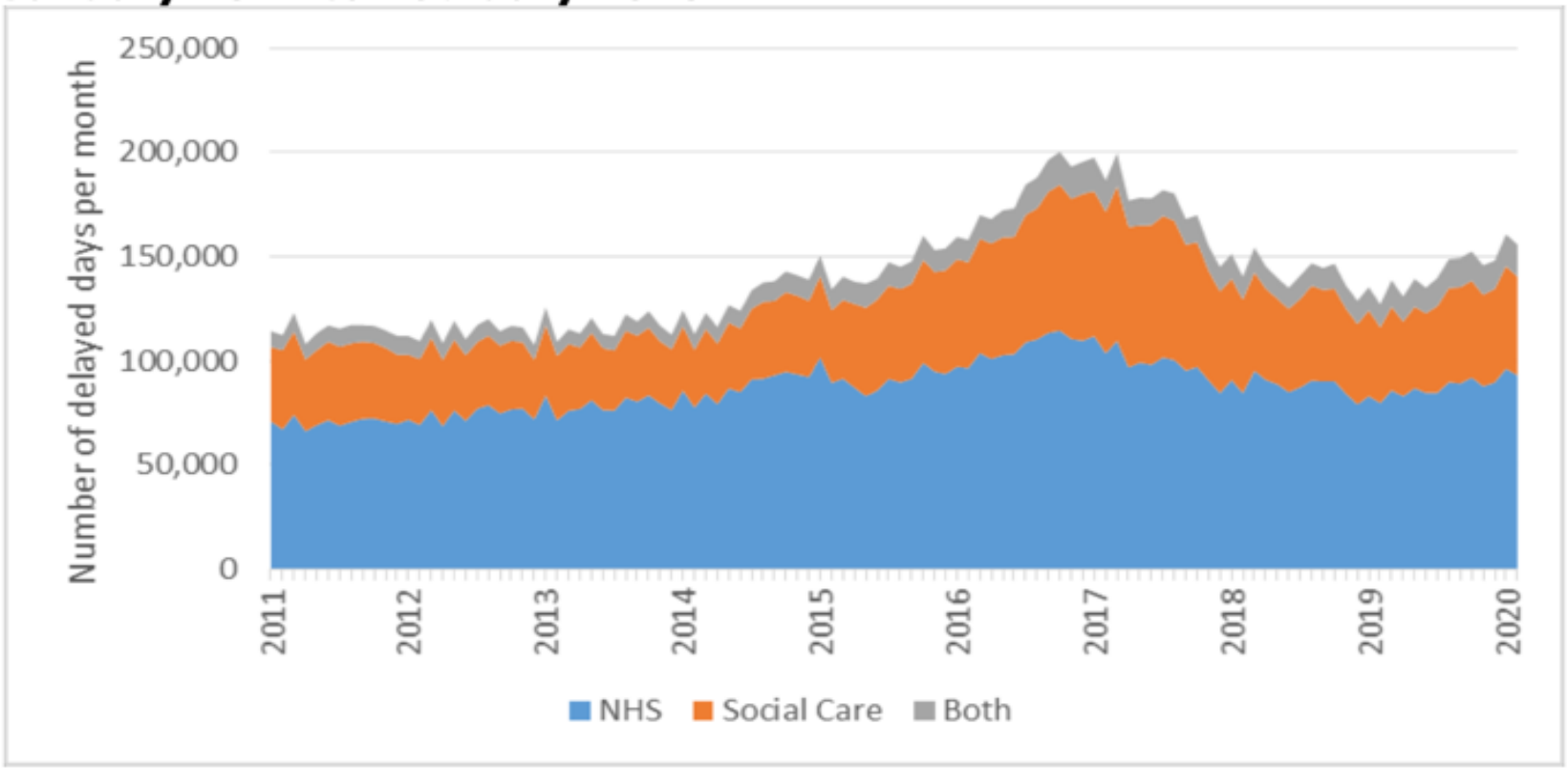
Walsall Together

Figure 14 Number of clients receiving adult social care support from local authorities within a year, by type of setting, 2003-04 to 2018-19, England



Walsall Together

Figure 22 Delayed transfers of care by responsible organisation, January 2011 to February 2020

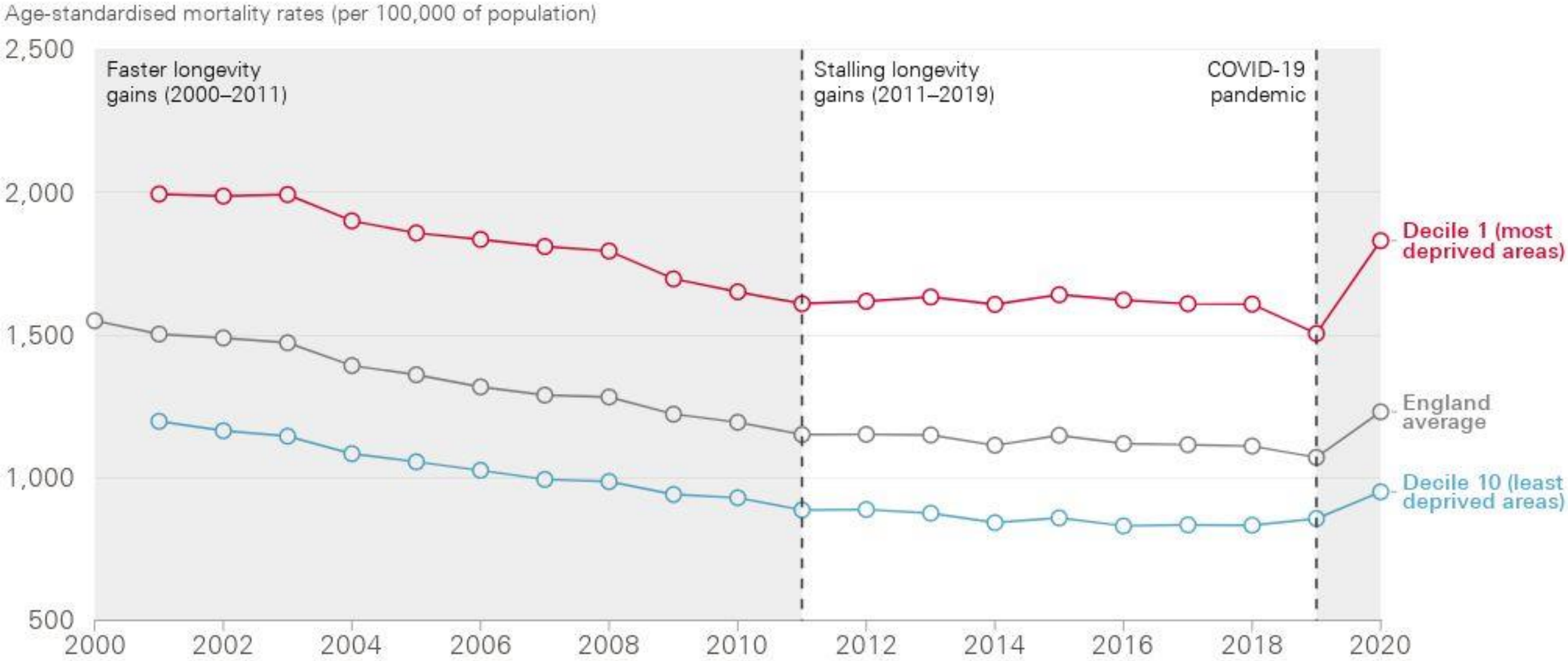


Source: Delayed transfers of care (NHS England, 2020)

There are stark and longstanding socioeconomic inequalities in mortality rates

Age-standardised mortality rates per 100,000 of population, by deprivation decile: England, 2000–2020

Male | Female



REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement

Target population

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

50% of BC population lives in most deprived 20%.

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

CORE20PLUS6

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for **75%** of women from BAME communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

6. **DIABETES CARE PROCESSES & TREATMENT TARGETS**
to increase uptake and reduce risk of diabetes related complications

Black Country Deprived Communities

CORE 20	50%

Dudley	31%	Sandwell	60%	Walsall	56%	Wolverhampton	53%
Brierley Hill	41%	Caritas	59%	Walsall East 1	24%	North Network	59%
Dudley & Netherton	64%	Central Health Partnership	58%	Walsall East 2	13%	RWT	41%
Halesowen	14%	Citrus Health	56%	Walsall North	78%	South East	67%
Kingswinford & Wordsley	8%	Newcomen & Health	56%	Walsall South 1	79%	Total Health	64%
Sedgely, Coseley & Gornal	27%	Oldbury & Smethwick	61%	Walsall South 2	57%	Unity East	62%
		Together4Healthcare	70%	Walsall West 1	65%	Unity West	20%
Stourbridge, Wollescote & Lye	23%	Vision Health	59%	Walsall West 2	67%		
		Your Health Partnership	61%				

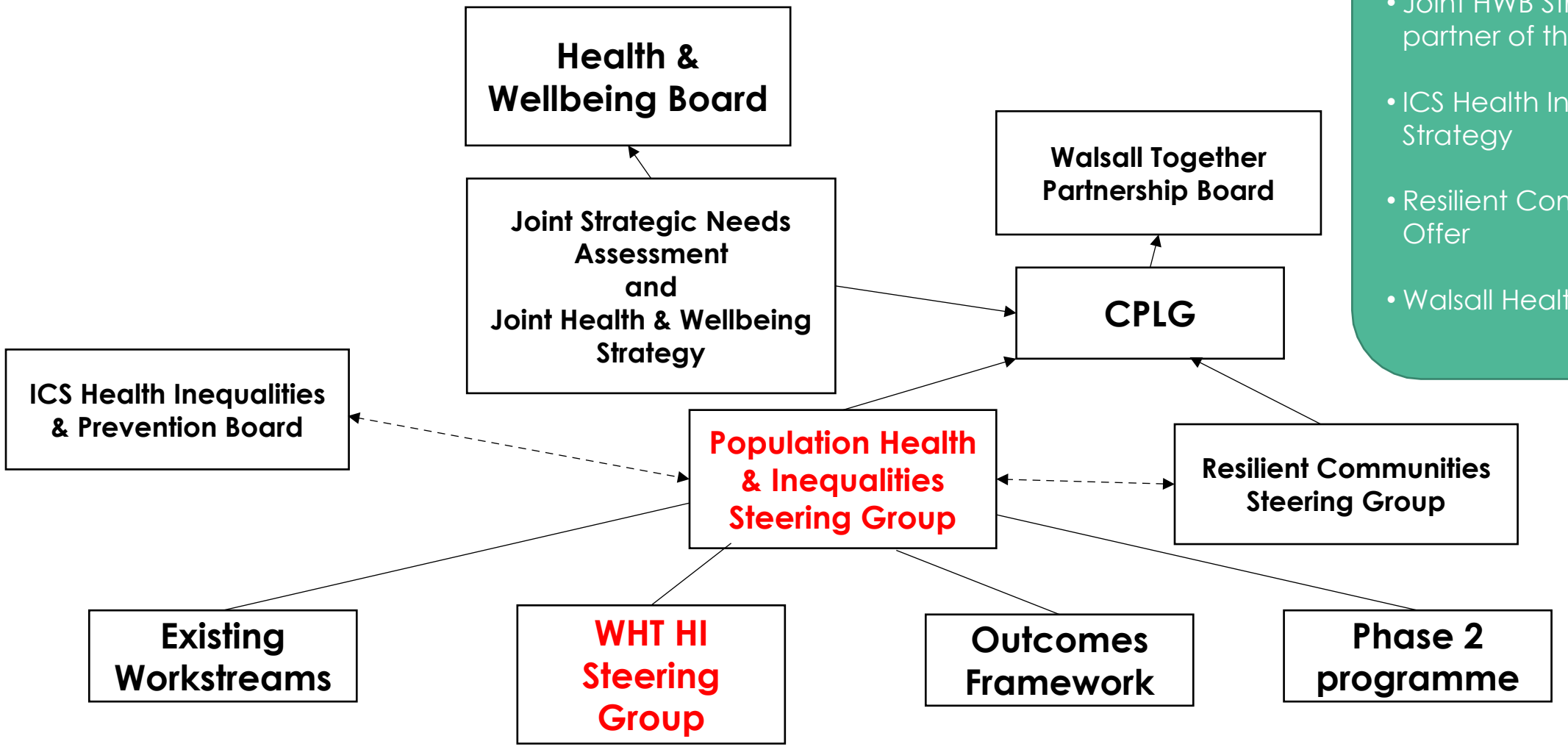
Walsall Together

Walsall Healthcare Trust
Developing a Population Health & Inequalities Strategy

2022/23

Collaborating for happier communities

Walsall Borough:
Establishing a Population Health Management Approach



Walsall Population Health & Inequalities Plan – Strategic Alignment

- Joint HWB Strategy as a partner of the HWB
- ICS Health Inequalities Strategy
- Resilient Communities Offer
- Walsall Healthcare

How do we decide on the areas of focus for WHT?

Phase 1: Plausibility & Pragmatism

- Build on existing programme of work
- Go for additional areas that 'make sense' [ease; opportunity; interest; requirement; funds; literature]
- Prepare the infrastructure for a more systematic approach

Phase 2: Certainty & Analysis

- Based on activity / outcomes data relating to people we see at WHT & (un)met need in the community
- Evidence-based approach
- Clear criteria to identify areas for intervention; projected / actual impact of initiatives

Focus on:

[a] reducing inequity of outcome for those we treat

[b] reducing inequity for those that we don't treat [access; assessment; attrition; clinical thresholds; acceptability]

Key elements of the approach need to include:

Dimension	Focus
Restoring NHS services inclusively	Maternity 0-19 years service Elective Recovery: Planned Care Urgent & Emergency Care Cancer Services
Digital Exclusion	Implementation of use of digital to improve access to health care (at home) Monitoring impact & ensuring face to face options available
Data Quality	Improving the quality of ethnicity coding Monitoring systems for impact of health inequality work
Accelerating Prevention	Primary Care / Community: screening programmes; refugees Secondary Care: smoking cessation
Leadership & Accountability	Education & Training for medical staff & senior leaders Use of Health Equity Assessment Tool (HEAT)

Phase 1: Build on existing programme of work

Dimension	Focus	What next?
Accelerating Prevention	**Smoking Cessation:** • ***General:*** Team in place and steering group established with Salman Mirza and Roseanne Crossey • ***Maternity:*** Team established	Monitoring of activity & outcomes by protected characteristics
	Refugee Health • Health Visitor with responsibility for refugees • Midwifery service for Afghan refugees	Monitoring of activity & outcomes by protected characteristics Review of key themes from practitioners & action to address

Phase 1: Build on existing programme of work

Dimension	Focus	What next?
Accelerating Prevention	Outreach Support Team: Cancer, Palliative & End of Life Care	• Increase community service-led activities (significantly reduced during pandemic). • Provide 'prevent cancer' education with exercise programmes. • Continue working with low performing GP's to improve the uptake of screening. • Provide easy-to-read information on screening to limited education / language population (not limited to Learning Difficulties/Disabled). • Host live demonstrations of using screening kits.

Phase 1: Build on existing programme of work

Dimension	Focus	What next?
Restoring NHS services inclusively	**Maternity:** • Carol King-Stephens has extensive programme mapped out	**Walsall Together** is to provide support for this around patient education materials; premises; access to funds Project group with Comms to support this work?
	Gynae pre-operative optimisation • ***Community Review:*** structured review of all people on Gynae waiting lists considered 'not fit for surgery' and offering targeted interventions to enable them to have surgery	***Dartmouth Project:*** structured support being agreed with external agency - opportunity to formalise the pre-op approach by tying into GP MDTs and then expand the model into other specialties **Pre-operative optimisation** • ***'Not fit for surgery':*** Extend review of patients deemed 'not fit for surgery' to other specialities

Phase 1: Build on existing programme of work

Dimension	Focus	What next?
Restoring NHS services inclusively	**National focus on Excess deaths post-Covid** Priorities: Cardiovascular & Diabetes ***Cardiology:*** • Heart Failure Pathway in Community Services for acute and long term condition management	***Diabetes:*** • Work with Community Diabetes Service to remodel care delivery [in conjunction with Dr Anand Rischie]
Data Quality	**Elective Care: review of waiting lists** • ***PTL analysis:*** PTLs are being reviewed by deprivation / ethnicity	**Next steps:** [1] improve the coding of ethnicity on MDS [2] Interpretation of findings & focus of each service

Phase 1: Additional areas that 'make sense'

Dimension	Focus
Accelerating Prevention	**Physical inactivity and unhealthy diet** ***Guidance:*** • Screening of hospital inpatients for unhealthy diet / physical inactivity • Brief intervention & offer of Interventions [e.g. Moving medicine resources; Social Prescribing] ***Proposal:*** In-reach service using Vol sector / long term unemployed [as paid post] to go onto the wards / into OPD and offer an intervention to people by case finding • Focus on: pre-op assessment clinics; diabetes clinics; Fracture clinic; Discharge Lounge
	Alcohol Service • Service response for patients with alcohol dependency seen as acute attendance at WMH

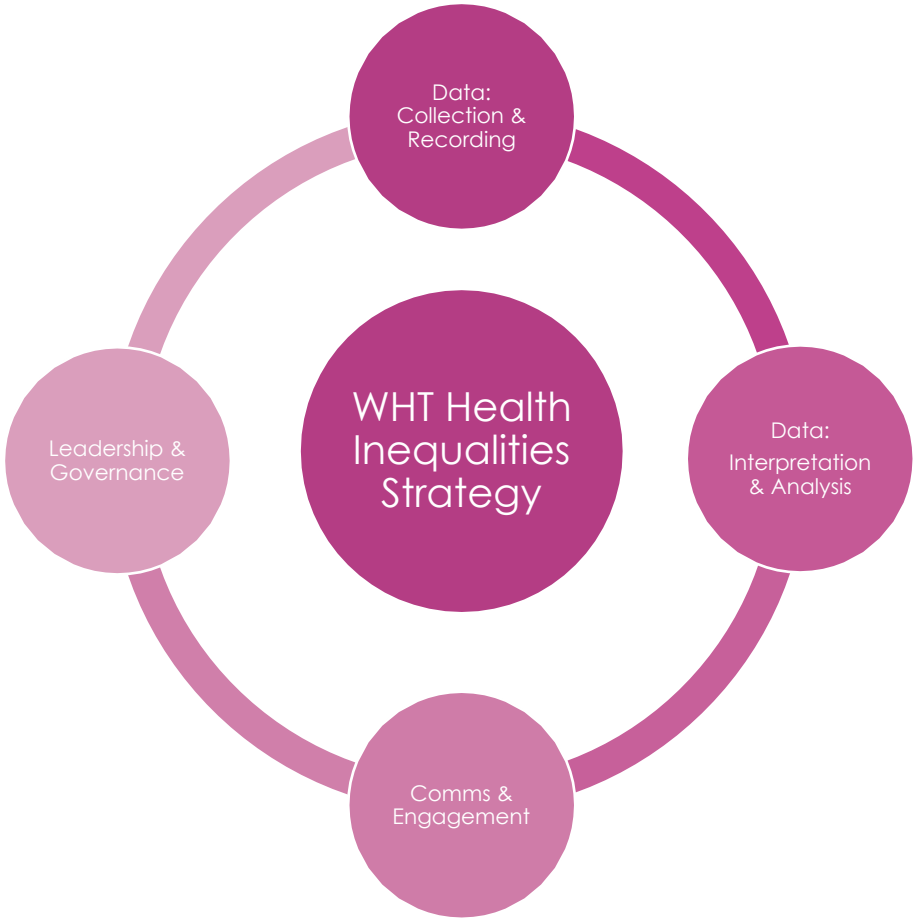
Phase 1: Additional areas that 'make sense'

Dimension	Focus
Restoring NHS services inclusively	**Ethnic disparity in prostate cancer:** • Affects more black males & at a younger age / higher acuity than white males **Considerations:** ***Screening programmes:*** • What can WHT do to support these? Joint work with urology and Public Health / Primary Care? Focus on particular areas of Walsall? Do we incorporate this into the access work being undertaken by maternity / mental health Barbershops work ***Recruitment into Medical trials:*** • What is the route to these and how do we promote it through the Trust research team?

Phase 1: Additional areas that 'make sense'

Dimension	Focus
Restoring NHS services inclusively [2]	**Waiting List: management of Neuro Rehab waiting list** • Client group has higher prevalence of brain injury and cognitive impairment hence greater barriers to accessing care ***Considerations:*** • What is the DNA rate compared to other specialities? • Review the waiting list management process to ensure that this group of patients is not disadvantaged - text reminder service / telephone reminders as more appropriate
	Waiting List validation • Potential to 'validate out' people with higher need ***Considerations:*** • Review literature on processes for waiting list validation and seek to implement / benchmark against national best practice

Phase 1: Prepare the infrastructure for a more systematic approach



Phase 1: Data

Collection & Recording: Are we collecting the data we need?

- Are we recording Protected Characteristics? [Configuration of data recording; training for staff & system processes]
- What information are we using / do we need from other sources? [Data sharing agreements; population profiles]
- Are we cross-referencing against Protected Characteristics? [SUI; near misses; complaints; mortality reviews; vaccination / screening uptake; coroner's inquests; readmissions; clinical outcomes; DNA rates; patient removals from PTL; 'not fit for surgery'; HEAT assessments]

Interpretation & Analysis: Do we know how to interpret this data?

- What are the key themes emerging from the data sources?
- What data are we not seeing / able to access and what does this tell us in itself?
- How do we translate this into a set of priorities and a plan to address them?
- What is the evidence-base for interventions?
- What are we seeking to achieve?
- How do we know we are having the intended impact?

Phase 1: Comms & Engagement

Communications

- How accessible is the Trust web-site for all sections of the population?
- Digital exclusion: how do people get access to our information if they do not have access to digital comms? Is our digital offer acceptable / relevant to parts of the population?
- How do staff get easy access to health information material that is relevant to target groups?

Engagement

- Are our engagement strategies appropriate for 'marginalised' groups in the population that we serve?
- How do we demonstrate that we are prepared to listen and act on user / community views?
- How do we engage our staff to change individual practice & shape Trust priorities?

Phase 1: Leadership & Governance

Leadership

- What money is available to support this work? Internal & external funds
- How do we influence spending decisions from a HI perspective?
- What behaviours do we expect from leaders within the organisation?
- What training do we consider to be core for all staff / clinical staff? [e.g. Mind the Gap] How do we implement this within WHT?

Governance

How do the following take account of health inequalities?:

- Business cases
- Trust policies
- Service reviews
- Performance monitoring
- Quality improvements

What next?

- Circulate outline strategy proposal for comment / review
- Configure Health Inequalities group around the key themes / approaches agreed
- Identify leads & project support for the 4 groups in Phase 1 (Data collection; Data Analysis; Comms & Engagement; Leadership & Governance)
- Develop programme structure to oversee the operational implementation of agreed schemes

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – 7th December 2022			
Walsall Together Partnership Board Highlight Report			**AGENDA ITEM:**
Report Author and Job Title:	Rachael Gallagher, Personal assistant, Walsall Together	**Responsible Director:**	Patrick Vernon, Chair, Walsall Together
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☐		
Assure	• Pressures experienced across discharge pathways, as a result of increased numbers of out of area patients, are being addressed through partnership working with neighbouring places in the Black Country and Staffordshire		
Advise	• The Walsall Together Partnership Board met on Wednesday 19th October, chaired by Professor Patrick Vernon • There was a GP engagement event led by Walsall Together on 17th November 2022		
Alert	• WT Partnership Board is holding an awayday on 9th December to review place-based arrangements and to confirm priorities for 2023/24		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk - Failure to deliver care closer to home and reduce health inequalities		
Resource implications	None		
Legal and/or Equality and Diversity implications	The issue of health inequalities continues to receive growing prominence locally and nationally. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare.		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Walsall Together Partnership Board
Highlight Report
November 2022

1. PURPOSE OF REPORT

This report provides an overview of the key items discussed at the Walsall Together Partnership Board at its meeting on Wednesday 19th October 2022.

The Chair of the meeting was Professor Patrick Vernon.

There was no partnership board meeting in November and instead the time was allocated to supporting a GP Engagement Event on 17th November 2022.

2. BACKGROUND

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

3. BOARD HIGHLIGHTS (October 2022)

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

3.1. Operational Update:

September had seen an increased delay in discharges for out of area patients. The issue is being addressed and connections have been made with neighbouring Trusts to address the issue.

3.2. User Story:

The Board were presented with an update from Community Associations within Walsall. This outlined the voluntary work that happens in the community and the benefit that this has on the health and well-being of people and communities. There was discussion about how the Partnership could better connect statutory services to the work being undertaken by these groups

3.3. Transformation Report:

The board received assurance that the transformation programme continues to make progress with no significant risks to report.

3.4. Place Development:

Board was assured that work to implement the objectives of the place development programme continued in line with the agreed plan. Following approval of the high-level governance model for Walsall place, discussions remained in progress to seek formal approval from the Integrated Care Board and Cabinet.

It was agreed that there would be a Board away day on 9th December to review place-based arrangements and confirm priorities for 2023/24.

4. GP ENGAGEMENT EVENT (NOVEMBER 2022)

An event was held for GPs and practice staff to brief them on the role of Walsall Together and provide them with examples of current and future partnership working. The event was jointly chaired by Dr Anand Richie and Patrick Vernon and was attended by over 100 people.

The session provided an opportunity to consider the collaboration agreement between primary care and Walsall Together. Practices had the opportunity to articulate what they sought from working with the partnership and how their needs could best be addressed. The Walsall Together Partnership Board will consider the outputs from this session at the away day in December.

5. RECOMMENDATIONS

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

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – Wednesday 7th December 2022			
Care at Home Report		**AGENDA ITEM:**	
Report Author and Job Title:	Michelle McManus, Director of Transformation & Place Development	**Responsible Director:**	Matthew Dodd, Director of Integration
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve ☐ Discuss ☐ Inform ☒ Assure ☒**		
Assure	• ***Service pressures:*** continue to impact on Community Services with mitigating actions having been implemented. Demand on locality teams increased in month but they were able to meet 85% of demand. • ***Avoiding Hospital Admissions:*** Services such as the Integrated Assessment Hub, Care Navigation Centre and Rapid Response continued to have a positive impact in reducing numbers of admissions to Walsall Manor Hospital.		
Advise	• ***No Criteria to Reside (Medically Stable for Discharge):*** The number of patients in Walsall Manor Hospital who live outside Walsall and who require complex discharge support has increased. The Trust has led a group on behalf of the ICB to develop a set of key contacts for all hospitals across the Black Country and a monitoring & escalation process. This will now be implemented by the ICB on behalf of the system. • ***Health Visiting:*** Recruitment continues within the Health Visiting Service. A trajectory for restoration of services is now being developed with Public Health, however this will be a phased approach over several months • ***Walsall Intermediate Care Service:*** The Service was notified in November that it has been successful in becoming a national pilot site for the Intermediate Care Recovery Service. • ***Walsall Together:*** The Walsall Together Partnership Board and Walsall Joint Commissioning Committee have agreed a high-level model for place-based governance		
Alert	• ***Walsall Intermediate Care Service:*** Due to the demand trend and the increase in cost of care the ICS budget is under significant pressure as it is exceeding both the operational and financial model commissioned. Discussions with commissioners are taking place regarding the deficit with a risk share approach under discussion.		
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

October 2022

1. PURPOSE OF REPORT

This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain during October 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 also provides a summary of place-based partnership arrangements in Walsall, following on from the Trust Board development session in November.

2. BACKGROUND

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

The Health and Care Act (2022) formalised Integrated Care Systems (ICS) as legal entities with statutory powers and responsibilities. A key plank of ICS policy is that much of the activity to integrate care, improve population health and tackle inequalities will be driven by organisations collaborating over smaller geographies within ICSs referred to as 'places'. The 2022 Act did not create any legal requirements for place-based partnerships, leaving flexibility for local areas to determine their form and functions. However, the following publications provide additional guidance for place-based partnerships and are likely to be utilised within 'readiness to operate' assessments:

- Policy White Paper, February 2022 https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations
- NHSE and LGA Thriving Places, September 2021 https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

Following approval of the Walsall Together business case in early 2019, the following governance arrangements are in place.

Integrated Delivery

- Walsall Healthcare (WHT) is the Host Provider, which is a specific variation on the Lead Provider model, intended to provide the foundations of a governance model that could transition to a Lead Provider model in the future
- WHT provides vehicle for governance by establishing a place-based Board (Walsall Together Partnership Board - WTPB) and management structure within the framework of its existing corporate structure
- WTPB is established as a sub-committee of the WHT Board
- Delegation of decision-making authority is made to the WTPB, with representation from partner organisations

Integrated Commissioning

- A Joint Commissioning Committee sits within the Adult Social Care, Public Health and Hub Directorate for the Council and is the agreed committee for joint commissioning discussions as per current ICB arrangements
- JCC is the formal governance for integrated commissioning, providing strategic commissioning leadership in relation to the health and social care responsibilities
- It ensures the alignment of commissioning for services in scope of Walsall Together

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 September.

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

3.1 Demand: Demand for Community Locality Services increased to 6,827 hours of care (6,419 hours in September), while the Care Navigation Centre saw a sustained high level of demand with 1,142 calls.

3.2 Capacity:

Locality Teams: Against the increased demand, Locality Community Teams met 85% of this demand in October and delivered 5,784 hours of care, compared to 5,536 in September. Work around recruitment and sickness management continues as the response to the variation seen in capacity.

Health Visiting: Recruitment continues within the Health Visiting Service. A trajectory for restoration of services is now being developed with Public Health, however this will be a phased approach over several months

No Criteria to Reside (Medically Stable for Discharge): The number of people at Walsall Manor Hospital who were medically stable for discharge and on discharge pathways 1, 2 & 3, remained stable at 51 during September and October. The average length of stay as medically stable reduced to 4 days in October, indicating growing demand for support with complex discharge. Within this cohort there has been an increase in the numbers of patients in Walsall Manor Hospital who live outside the borough Walsall. A task & finish group led by the Trust on behalf of the ICB has drawn up a set of key contacts for all hospitals across the Black Country and a monitoring & escalation process which is to be implemented by the ICB.

Intermediate Care Service: Due to the increased demand and the increase in cost of care the ICS budget is under significant pressure as it is exceeding both the operational and financial model commissioned. Discussions with commissioners are taking place regarding the deficit with a risk share approach under consideration.

Walsall Intermediate Care Service was notified in November that it has been successful in becoming a national pilot site for the Intermediate Care Recovery Service. This will provide structured support with the local approach to Home First. This model of care

enables therapists to conduct assessments in a patient's home on the day of discharge, with any identified care and equipment being put in on the day itself, thereby removing time spent in hospital waiting for home assessments and sourcing of equipment and care.

Systems Pressure Plan: In October, the Partnership received notification about funding for out of hospital developments from the Service Development Fund, Ageing Well allocation and Community Services investment budget. This will support the expansion of Virtual Wards for respiratory, cardiology and frailty patients across the borough.

4. RISK REGISTER

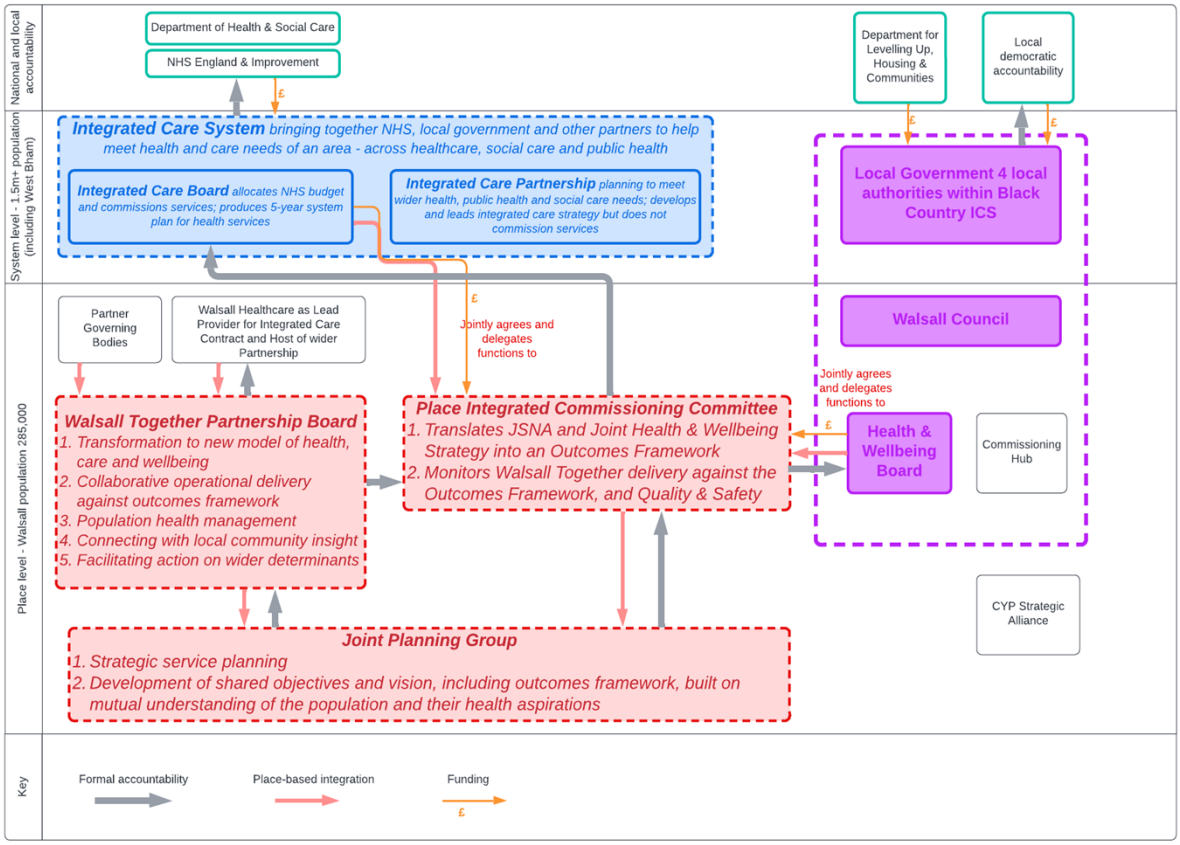
The overall risk score on the Care at Home Board Assurance Framework (BAF) remains at level 12. The BAF remains under review by the partnership and in parallel to the review of the Trust Strategy. Along with the partnership risk register, it has also been reviewed in the context of the risks identified regarding funding to support winter pressures and maintenance of flow, as reported in this paper.

The following risk remains on the Corporate Risk Register but has been reduced from level 20 to level 16, following establishment of partnership and Trust health inequalities steering groups, and development of a Population Health & Inequalities Strategy:

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

5. PLACE-BASED PARTNERSHIP DEVELOPMENT

The Walsall Together Partnership Board and Walsall Joint Commissioning Committee have agreed a high-level model for place-based governance (see below), in alignment with the original direction of travel outlined in the Walsall Together business case; the Health & Care Act 2022; and the policy white paper *Health and social care integration: joining up care for people, places and populations* (February 2022). These proposals build on existing arrangements and seek to increase the level of collaboration on both strategic planning and delivery of integrated health and care.



Building on existing joint commissioning arrangements, we are requesting formal delegation of responsibilities from the Integrated Care Board (ICB) and the Council (Cabinet/HWB) to a newly established Place Integrated Commissioning Committee (PICC), for services agreed to be in scope for 'control' ('control' defined as shaping service models, managing delivery, and redistributing system-allocated resource) at place.

The Health & Wellbeing Board will set the medium to long-term ambition and priorities for health and wellbeing in the Borough, also feeding into the Black Country Integrated Care Partnership strategy. The PICC will translate the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy into an Outcomes Framework.

Statutory commissioning responsibilities will be retained by the PICC, which will be separate to the Walsall Together partnership. Legally, the PICC will need to report into the ICB for NHS expenditure and the Cabinet for the Council elements. However, greater collaboration on several processes traditionally associated with and undertaken solely by commissioning will be formally transferred to the Walsall Together partnership, to increase the level of collaboration across all partners including providers. The Health & Care Act (2022) provides for this.

Inherent in the development programme is the recognition that moving to a more collaborative model brings some risks regarding how to manage conflicts of interest and to ensure transparency. While these risks are not unique to collaborative models, they demand careful management and formal structures to support collaborative service planning. This involves building mutual understanding between local commissioner and provider leaders, a process which takes time but is essential. Developing shared views

and understanding among senior leaders goes alongside a wider process of change for operational staff that focuses on supporting them to work more effectively with colleagues in other local organisations. Within Walsall, 'System Leadership' (focussed on leading across local organisational/sector boundaries) is a workstream in our Place Development Programme. The scope will include Walsall Together partners and wider commissioning teams to ensure we role-model the collaborative values that have delivered benefits to date.

There remains a substantial amount of detail to work through in the coming months to define the operating model for the above governance model. This work will include a review of the governance between Walsall Healthcare Trust Board and the Walsall Together Partnership; key executives from Walsall Healthcare are engaged in this process.

As discussed at the recent WHT development session, the key next steps for the Walsall Together partnership are:

Operating Model

- Ensure governance arrangements are robust enough to hold providers to account, confirm risk sharing, and to give assurance on the level of decision making the Trust Board can take without the other partners under a Lead Provider model

Commissioning Model

- Work with Host Providers and the ICB to agree where there will be differences in the scope of services and pace of implementation across each of the 4 places in the Black Country
- Continue to develop an implementation plan and timeline for Walsall to transition from the current model towards a single ICB contract for services in scope, noting that we are seeking delegation of some services from 1st April 2023
- The current JCC and Local Commissioning Board will be abolished in advance of 1st April 2023, operating the PICC in shadow form at the earliest opportunity following formal approval from the ICB and Cabinet

Resources

- Walsall Together has the largest scope of the 4 Black Country places and is closest to being approved as 'ready to operate'.
- Go-live is subject to appropriate due diligence and resourcing

6. RECOMMENDATIONS

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

APPENDICES

Appendix 1: Operational Performance Report for October 2022: Walsall Together

Walsall Together

Walsall Together Partnership Operational Update: November 2022

Matthew Dodd
Director of Integration

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0

Tier	Activity	Thresholds			Sep-22	Oct
Tier 0: Resilient Communities						
Social Prescribing	whg - No. referrrals received				36	51
	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	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Workforce: Anchor institutions	No. staff employed by whg via scheme				75	79	86	96	96	100	108	98	95	120
	% whg customer's				37%	37%	38%	39%	38%	38%	38%	38%	36%	40%

[Emergent] Score Card for WT Tiers – Tiers 1

Tier	Activity in-month	Thresholds			Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services														
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	6228.5	5210.5	5713.5	5495.3	6452.75	5871.5	5638	5688.3	5536	5784.3
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	860.50	920.00	1172.50	906.00	438.25	787.00	950.00	733.25	883.25	1043.3
	% of hours demand unmet	>23%	20%-23%	<20%	12.1%	15.0%	17.0%	14.2%	6.4%	11.8%	14.4%	11.4%	13.8%	15.28%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	26	23	25	25	26	28	27	27	26	25
	No. referrals received	<100	100-200	>200	25	24	22	19	30	39	25	29	24	24
	No. cases reviewed	<100	100-200	>200	108	89	117	83	102	142	129	107	110	109
Adult Social Care	1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	<100%		100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).				3.3%	3.3%	3.6%	3.8%	4.0%	3.9%	4.0%	4.0%	3.9%	3.9%
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).				84.9%	84.9%	85.1%	85.6%	85.7%	85.7%	85.5%	85.8%	85.5%	85.5%
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000	<3.1		>= 3.1	7.8	3.0	11.9	0.6	0.6	1.8	3.6	5.4	6.0	6.6
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8	479.2	510.9	562.4	47.5	108.9	140.6	172.3	221.8	265.4	326.7
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%	81.8%	80.4%	78.1%	84.6%	86.9%	79.3%	82.2%	77.7%	78.6%	77.2%
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				831	718	930	905	939	989	1063	1012	984	969
	Care and Support Assessments and 3 Conversations Completed - Total				296	429	316	280	327	358	285	355	297	352
	Monthly Adult contacts completed by Team				1,228	1,207	1,314	1,162	1,247	1,207	1,148	1,172	1,120	1,142

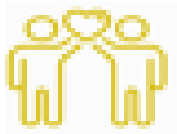
[Emergent] Score Card for WT Tiers – Tier 2 & 3

Walsall Together

Tier	Activity in-month	Thresholds			Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Tier 2: Specialist Community Services														
ASC Safeguarding Concerns	Concerns received				291	336	323	284	381	354	322	388	338	321
	Concerns progressing to s42 eqnuiry				73	91	79	76	61	65	56	45	53	32
	% of concerns progressing to s42 enquiry				25%	27%	24%	27%	16%	18%	17%	12%	16%	10%
	Safeguarding cases in progress				34	86	63	80	84	129	97	120	82	97
Tier	Activity in-month	Thresholds			Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Tier 3: Intermediate Care, Unplanned Care & Crisis Services														
Care Navigation Centre	Calls received	<435	435-512	>512	1225	1170	1338	1278	1270	1307	1323	1207	1171	1142
Rapid Response Team	Referrals received	<160	160-247	>247	260	254	294	281	294	242	277	245	250	285
	% admission avoidance	<73%	73%-87%	>87%	90.4%	91.3%	85.7%	91.9%	89.2%	98.0%	90.0%	90.2%	90.1%	90.2%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50-57.5	<50	48.00	45.88	52.67	50.28	46.40	50.10	54.10	52.10	51.30	50.59
	Average number of days MSFD	>5.75	5.0-5.75	<5.0	3.4	3.5	3.8	4.3	4.0	4.0	4.0	4.6	4.6	4.0
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21-25	21<	32	26	28	28	27	25	27	26	27	27
	Domiciliary Pathways - Average service users				200.2	181.5	180.25	198.25	213.6	222.2	203.5	204.4	177	177
	Bed-based Pathways - Discharged ALOS	>36	24-36	24<	43	38	37	54	48	48	47	48	36	36
	Bed-based Pathways - Average beds in use				74	82.5	90	75	82	81	78	81	93.25	93.25
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	158	168	162	210	193	224	219	157	165	210
	Prevent Readmission	35<	35-50	>50	41	37	27	20	19	10	5	9	23	11
	Early Supported Discharge	40<	40-54	>54	35	44	45	29	31	48	85	49	52	61
	Assisted Discharge	35<	35-50	>50	54	40	35	56	68	76	44	74	86	82

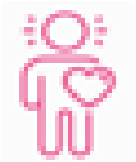
Tier 0 Resilient whg The H Factor Social Prescribing Programme .

332 Clever Conversations



51 sign up to the Social Prescribing programme

17 improving Warwick & Edinburgh Score

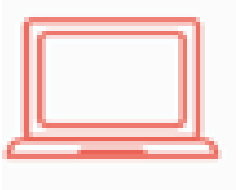


34 increased their confidence / self esteem

20 Referrals made to external support service Referrals

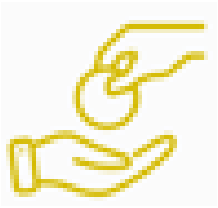
3 Completing training or education

24 Referral to whg Money Advice Service



7 Referrals to Clickstart Digital Support

15 Referrals for a fuel or Food voucher

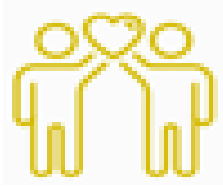


£377 requested from the Household Support Fund

9 Referral to whg Hardship Fund

Tier 0 Resilient Communities Diabetes Matters

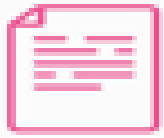
138 Clever Conversations



12 new customers were identified as needing support

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

2 Hospital/GP appointments attended by the team



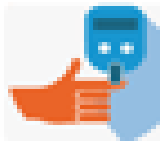
1 Medication review has been arranged by the team

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

3 Referrals to whg Money Advice Service

3 Referrals to Aids and Adaptations

3 External Health Referrals made



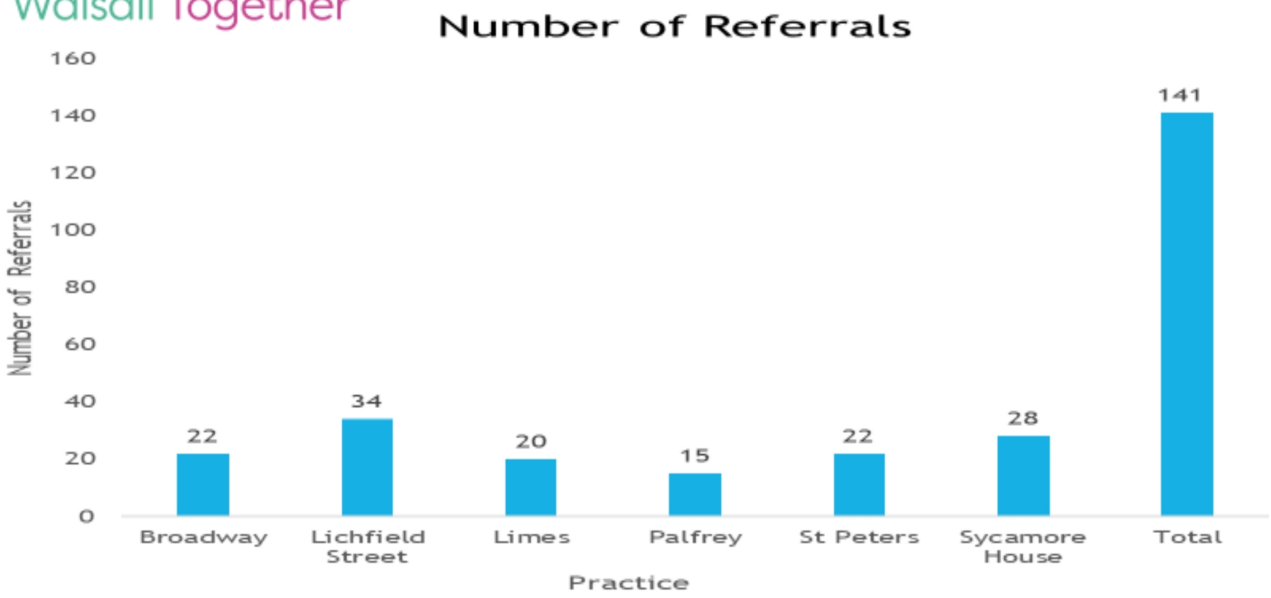
2 Diabetes Pathway referrals made with customers needing specialised support who are not engaging with the diabetes pathway team.

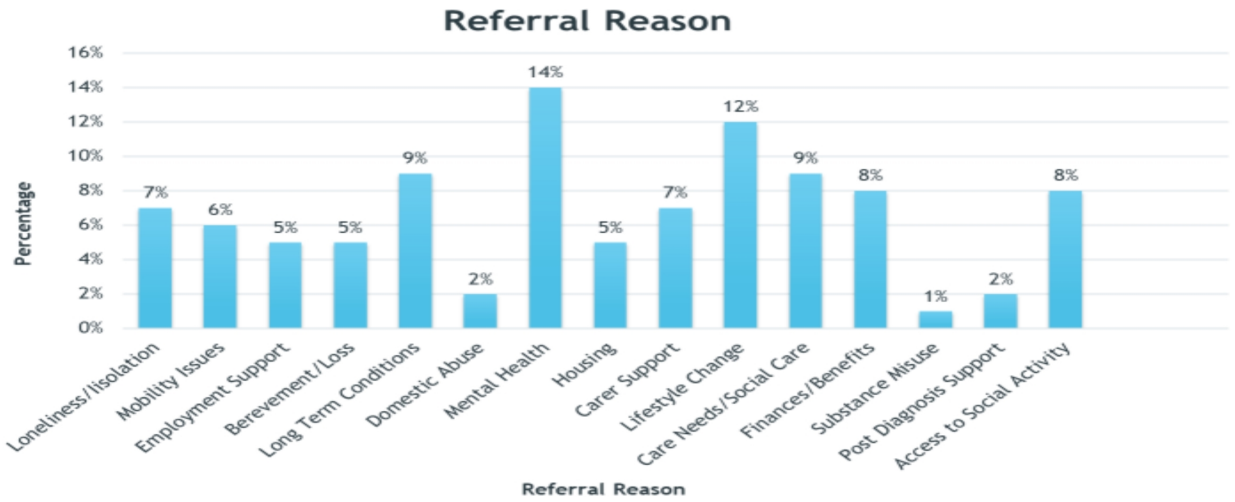
18 Community Events attended

4 Community Organisations worked alongside

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

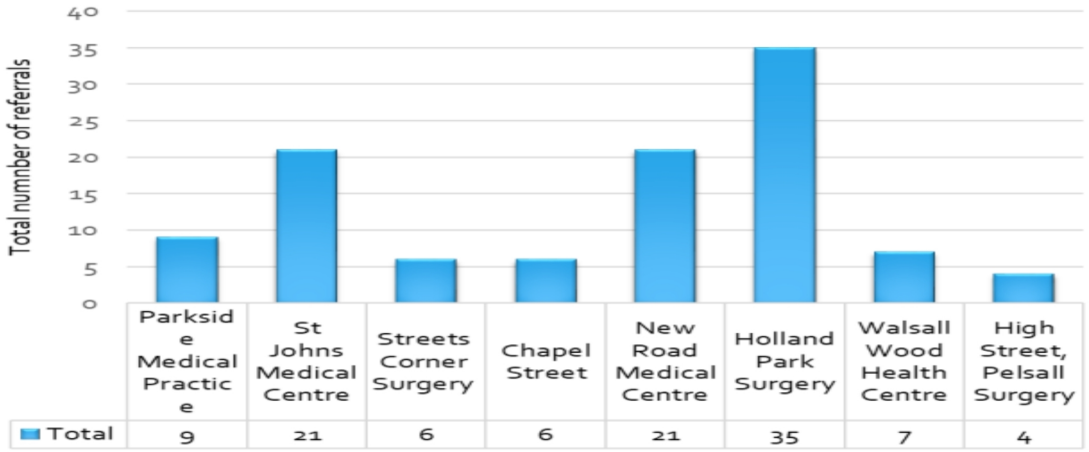


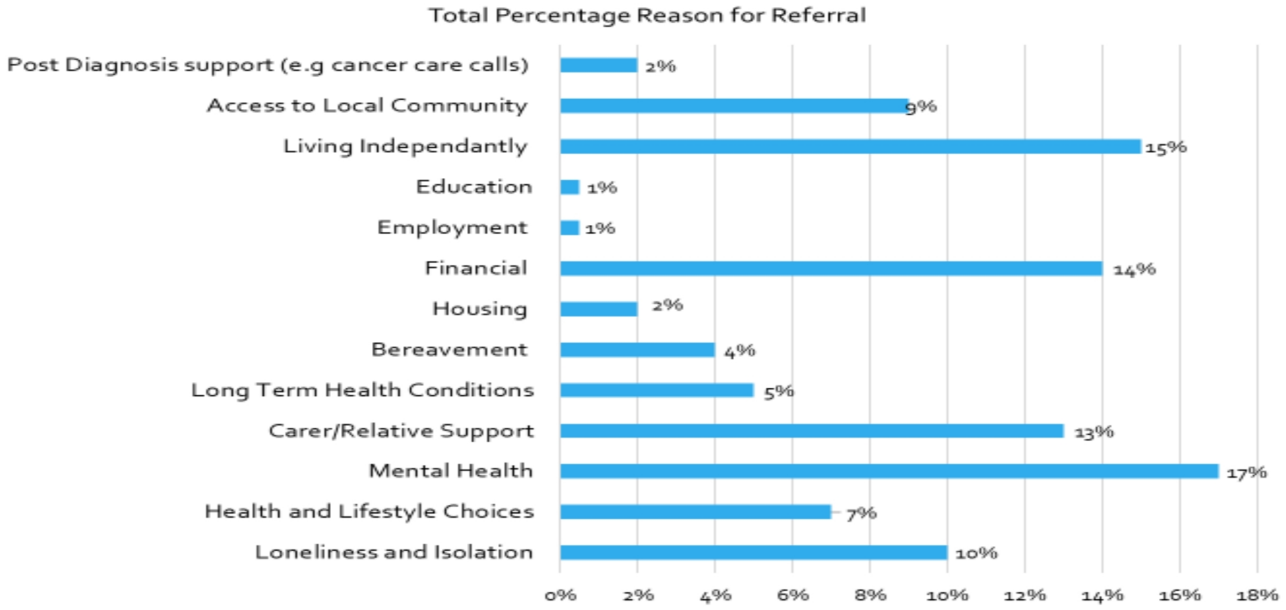


Last updated on July 2022

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

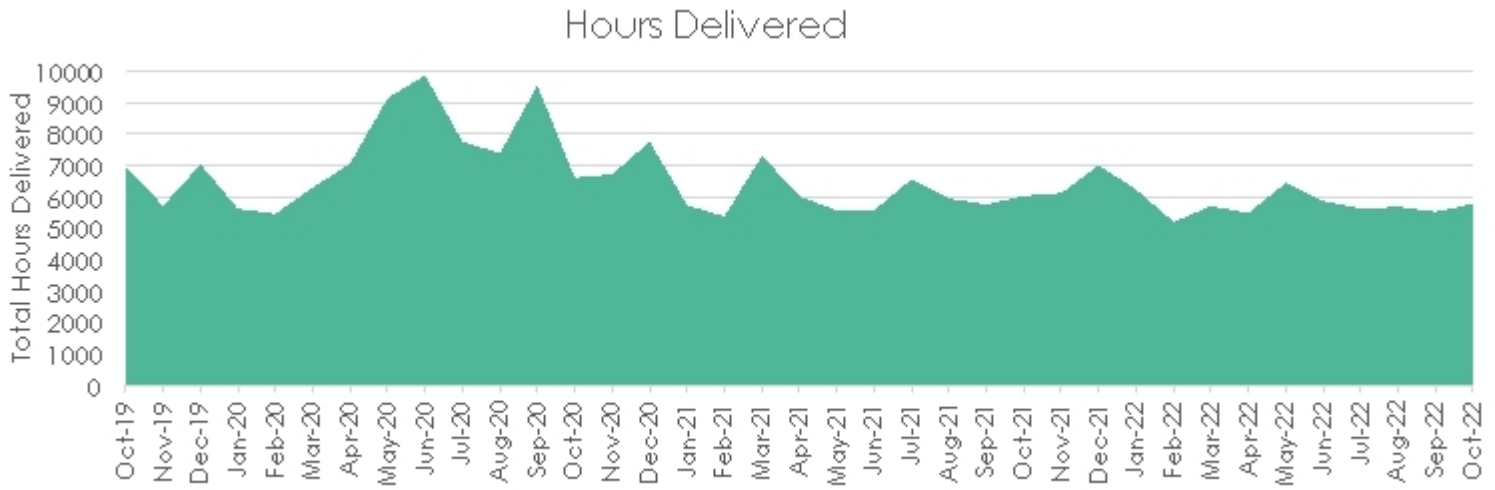




Last updated on July 2022

Tier 1:

Community Nursing Capacity and Demand:



The Locality Teams delivered over 5,500 hours

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

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

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

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

Last updated on September 2022

Tier 1: Primary Care Standard Operating Procedure (SOP)

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

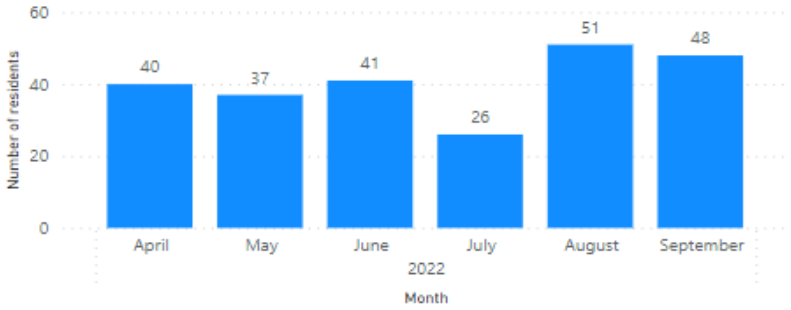
Current Pressures:

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

Last updated on May 20212

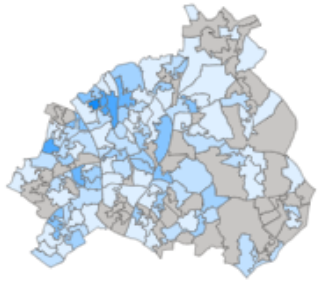
Tier 1: Making Connections Walsall

Total residents



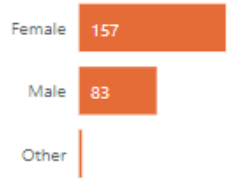
Electoral ward

LSOA (Lower Super Output Area)

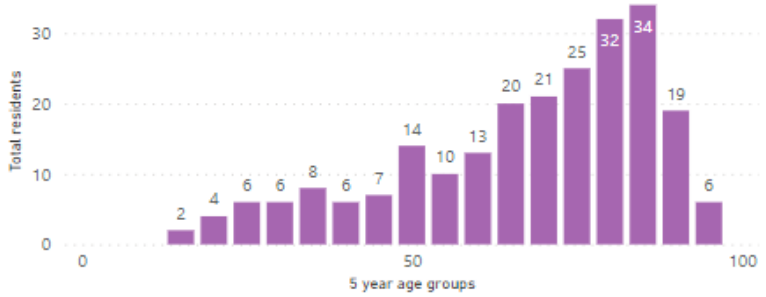


Client type	n	%
COVID_19	36	15%
Making Connections	207	85%
Total	**243**	**100%**

Locality	n	%
West	82	34%
North	74	30%
East	50	21%
South	37	15%
Total	**243**	**100%**



Residents age



Ethnicity_1	n	%
A: White _ British	171	70.4%
Z: Not Stated	27	11.1%
99: Not Known	26	10.7%
H: Asian or Asian British _ Indian	6	2.5%
M: Black / Black British _ Caribbean	6	2.5%
I: Asian or Asian British _ Pakistani	2	0.8%
L: Asian / Asian British _ Other background	2	0.8%
N: Black / Black British _ African	2	0.8%
E: Mixed _ White and Black African	1	0.4%
Total	**243**	**100.0%**

Consider themselves disabled	n	%
Not disabled	102	42%
	82	34%
Disabled	59	24%
Total	**243**	**100%**

Total residents

243

Total contacts

714

Long_Term_Physical_Health_Condition_1	n	%
Yes	149	61.3%
	68	28.0%
No	12	4.9%
Not stated	10	4.1%
Unknown	4	1.6%
Total	**243**	**100.0%**

Last updated - September 2022

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

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

ARRS Workers in Post

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

ARRS workers due to start:

- South 2 -1 WTE

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

- Banding/NMP under review

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

Last updated : September 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
- Number of referrals picking up again and coming through to the service

Last updated on August 2022

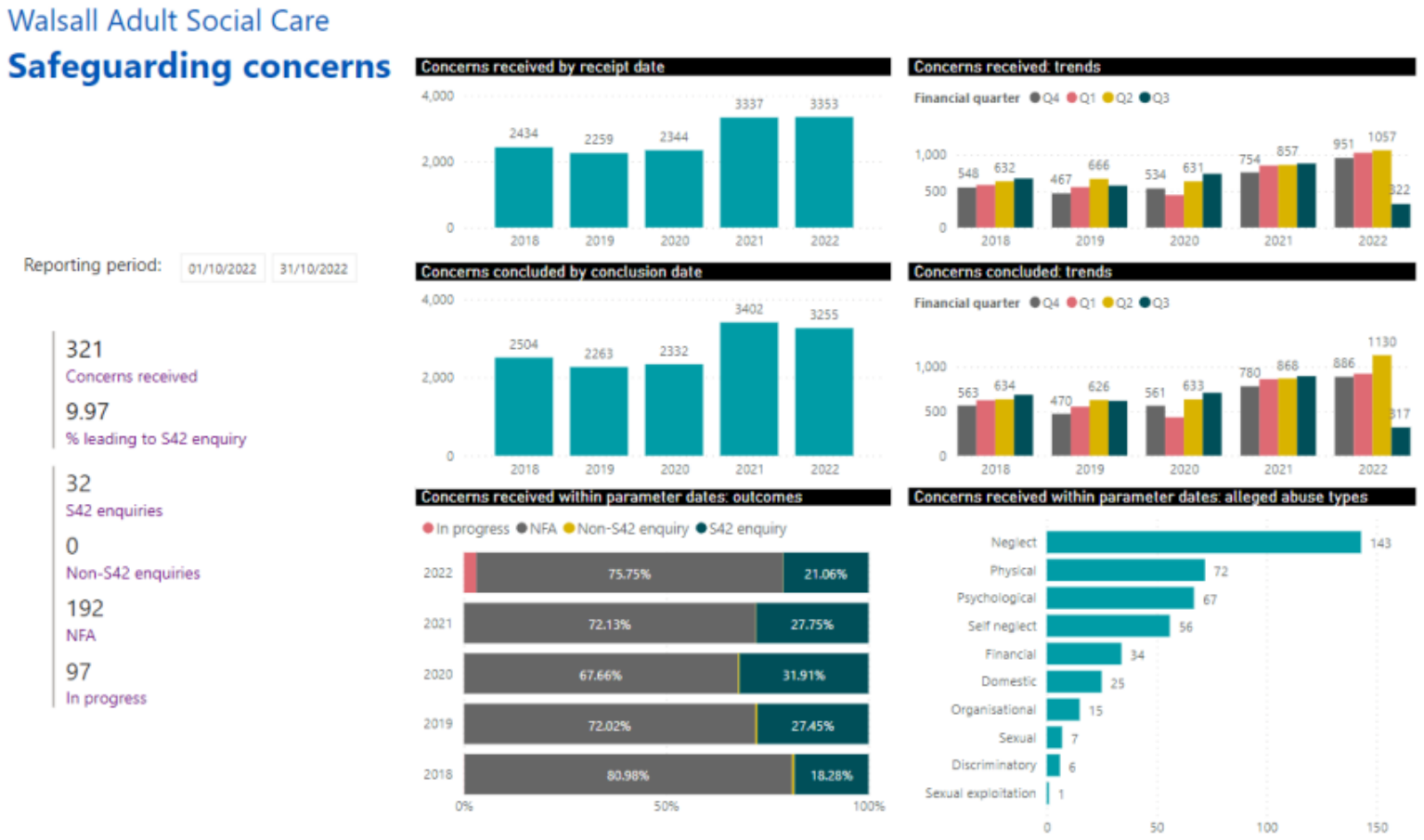
Tier 2:
Adult Social Care

ASC have received 321 concerns which is a small decrease in cases on the previous month.

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

There are currently 32 opens S42 enquiries. This has been raised with managers to ensure the timely completion of enquiries which includes caused enquiries. Emphasis has also been placed on the need to inform people including referrers of outcomes following enquiries. This approach has caused a reduction.

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



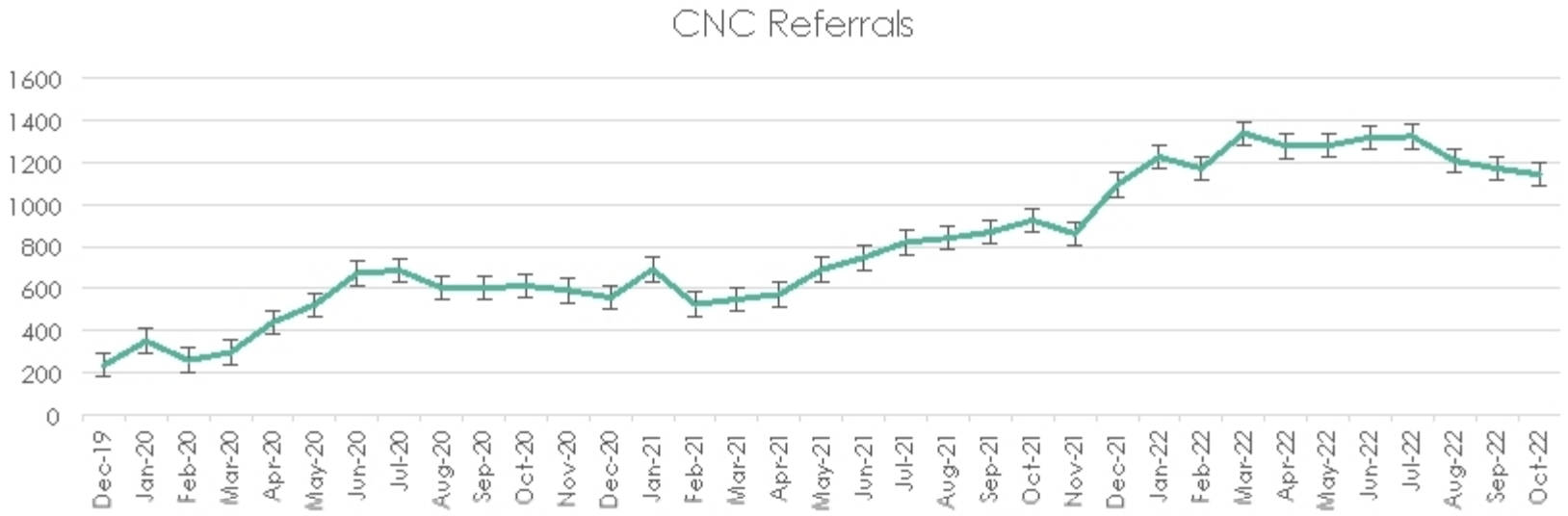
Last updated : October 2022

Walsall Together

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
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2183	2187	2181	2198	2197	2230	2234	2236						
	AACM	1895	1951	1954	2045	2100	2188	2183	2187	2181	2198	2197	2230	2234	2236						
	Jennie Pugh	**91.3%**	**97.3%**	**98.4%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**						**100.0%**
1E: Proportion of adults **(aged 18-64)** with learning disabilities in paid employment (NI 146).	Mosaic, H21 & Provider spreadsheets	6	10	1	7	14	19	21	20	21	21	22	22	22	22						12
	AACM	551	585	587	596	574	573	576	527	531	538	545	549	558	565						
	Jeanette Knapper	**1.1%**	**1.7%**	**0.2%**	**1.2%**	**2.4%**	**3.3%**	**3.6%**	**3.8%**	**4.0%**	**3.9%**	**4.0%**	**4.0%**	**3.9%**	**3.9%**						
1G: Proportion of adults **(aged 18-64)** with Learning Disabilities who live in their own home or with their family. (NI 145).	Mosaic, H21 & provider spreadsheets	473	497	505	502	494	489	490	451	455	461	466	471	477	483						
	AACM	551	585	587	596	574	573	576	527	531	538	545	549	558	565						
	Jeanette Knapper	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**85.1%**	**85.6%**	**85.7%**	**85.7%**	**85.5%**	**85.8%**	**85.5%**	**85.5%**						**80.0%**
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	7	11	22	10	24	18	20	1	1	3	6	9	10	11						15
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500						
	Jennie Pugh	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**11.9**	**0.6**	**0.6**	**1.8**	**3.6**	**5.4**	**6.0**	**6.6**						**9.1**
2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	271	309	311	329	301	311	284	24	55	71	87	112	134	165						300
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500						
	Jennie Pugh	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**562.4**	**47.5**	**108.9**	**140.6**	**172.3**	**221.8**	**265.4**	**326.7**						
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	79	93	106	96	111	115	125	88						
	Provider Services	317	130	266	73	91	125	103	110	122	121	135	148	159	114						
	TBC	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**78.1%**	**84.6%**	**86.9%**	**79.3%**	**82.2%**	**77.7%**	**78.6%**	**77.2%**						**82.0%**

Tier 3:
Care Navigation Centre (CNC):



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

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

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

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

Last updated : October 2022

TIER 2 Workforce Development Work 4 Health

whg/Walsall NHS Trust's Recruitment Programme

whg Work 4 Health programme – Total into employment (July - October 2022)

120 secured employment

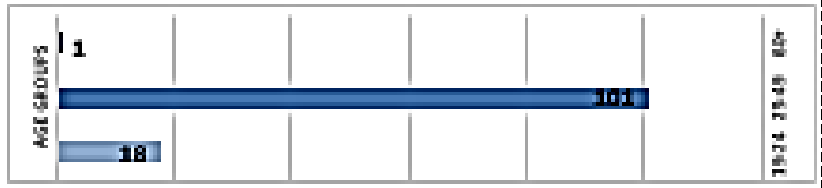
40%

whg Customer's

21% Male

77% Female

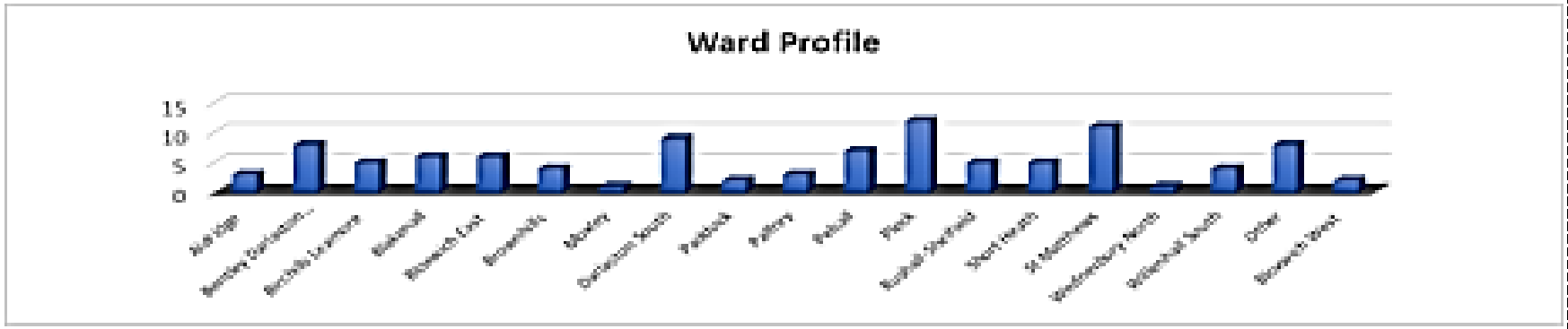
2% prefer not to say



48% BAME

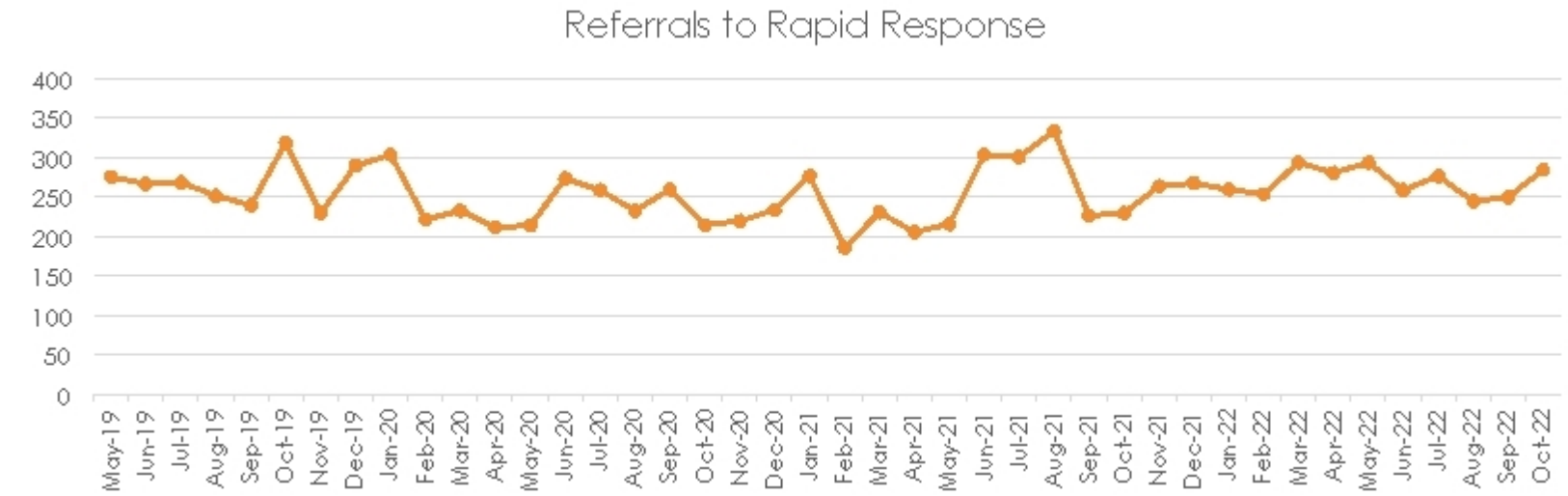
Social Value generated £1,731,960

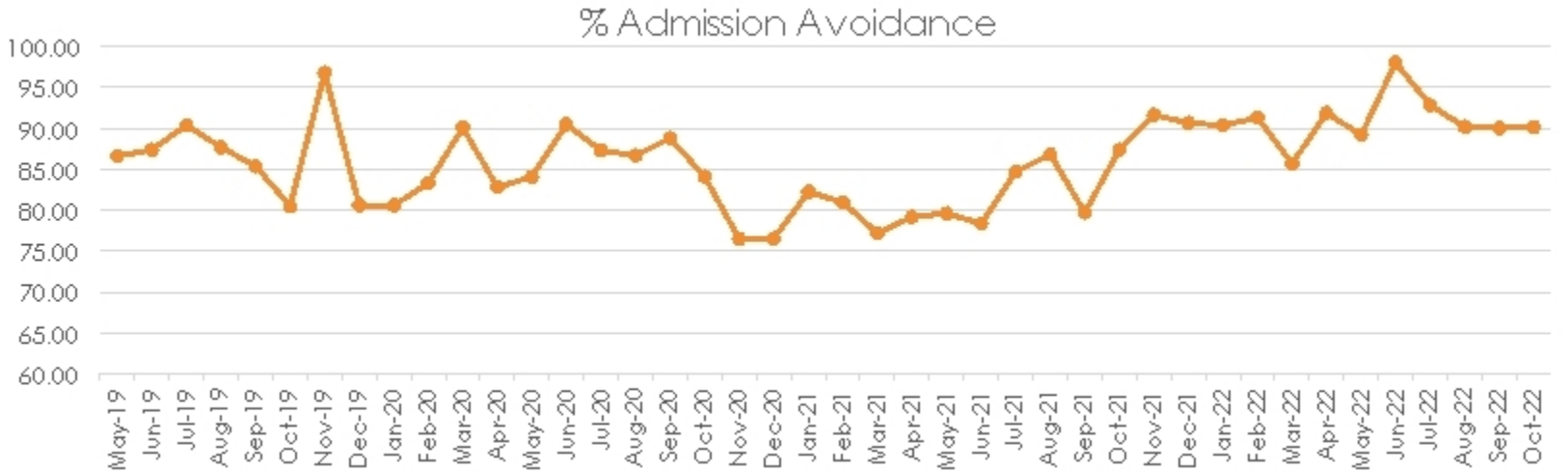
82% Unemployed prior to commencing NHS job role



NHS | Department for Work & Pensions | Walsall College | whg

Tier 3: Rapid Response



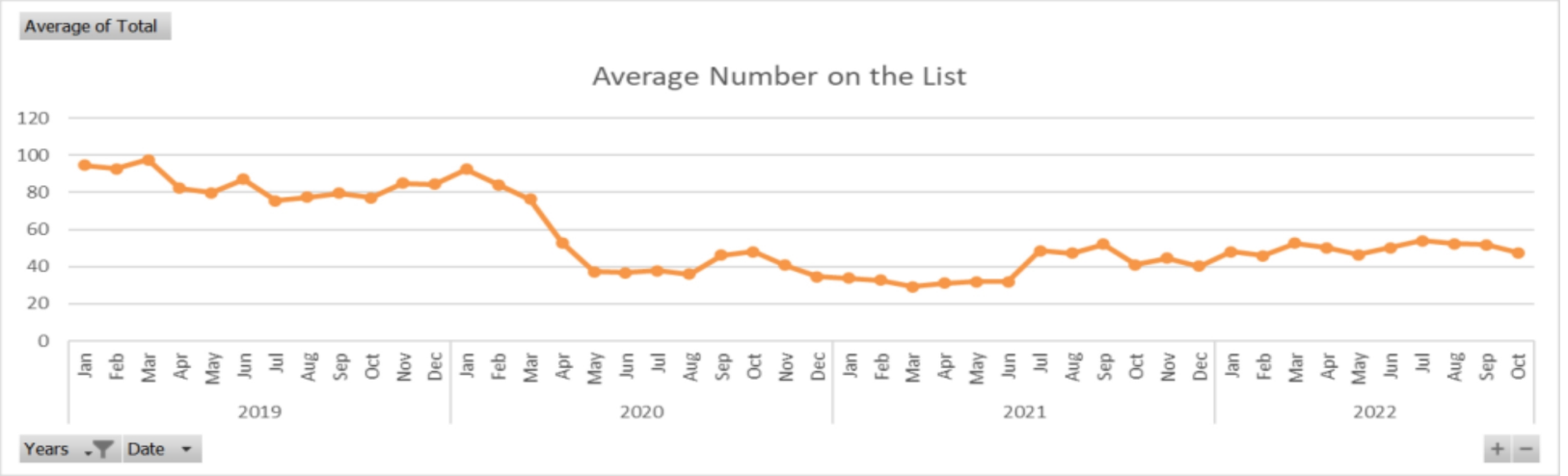


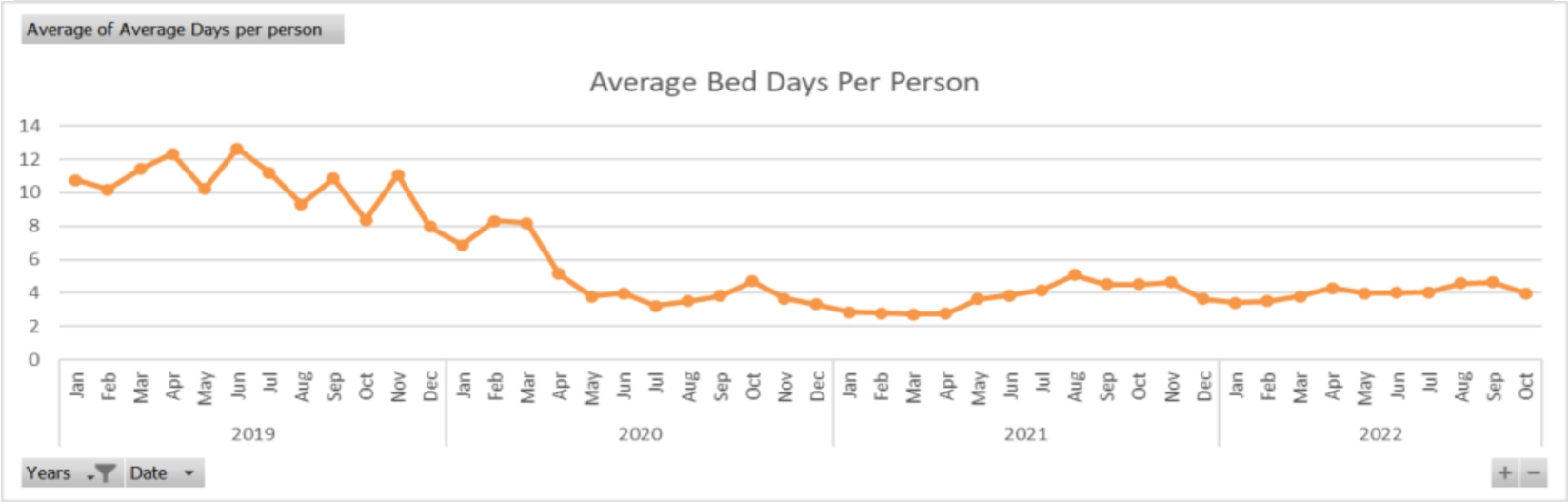
Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals(non –clinical calls as a 3 month pilot with 6 identified conditions). This has not led to a significant level of referrals to date and is being managed within the present capacity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

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

Last updated : October 2022

Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 51 patients during October 2022





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

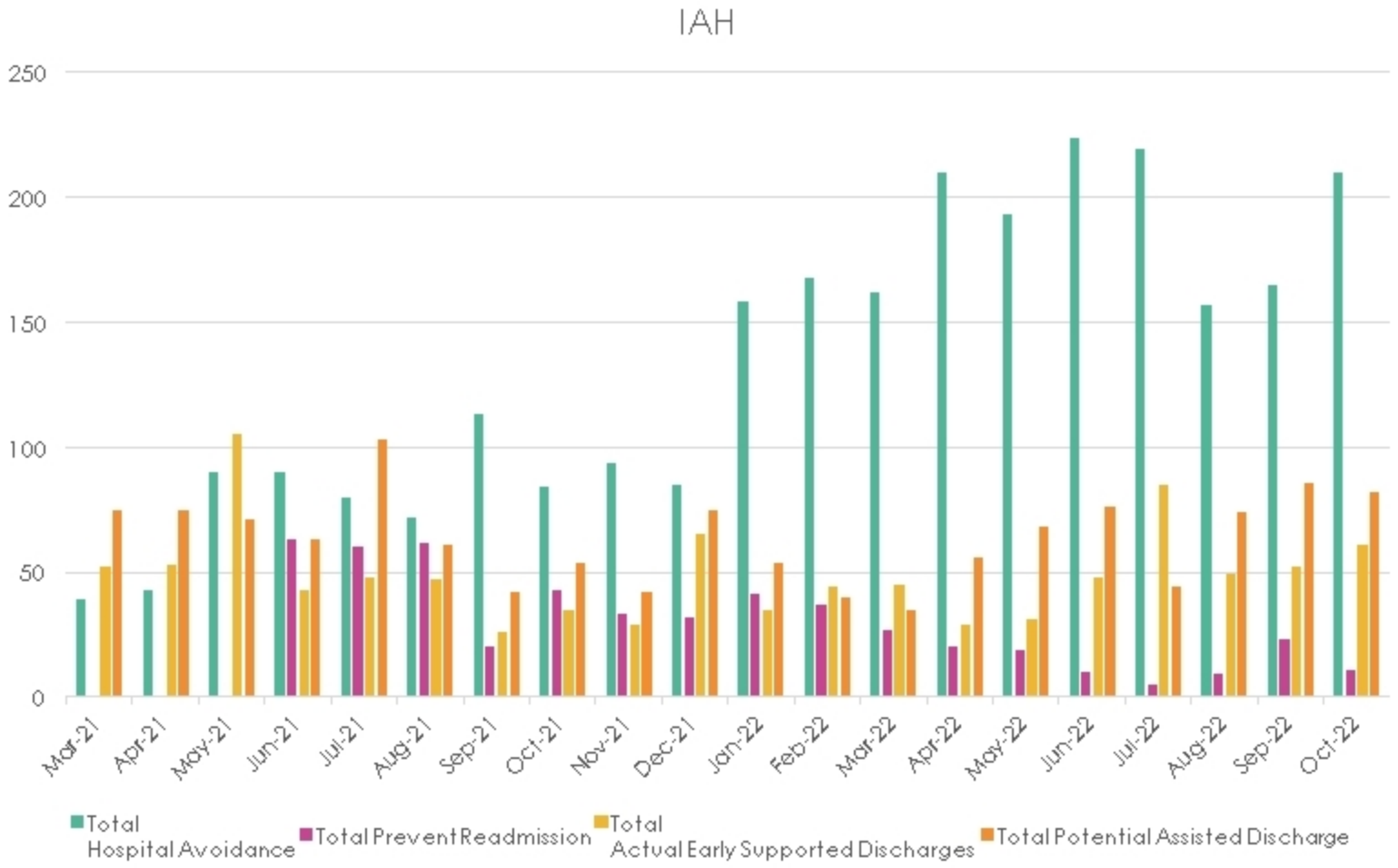
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients.

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

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

Last updated : October 2022

Tier 3/4:
Integrated Assessment Hub:

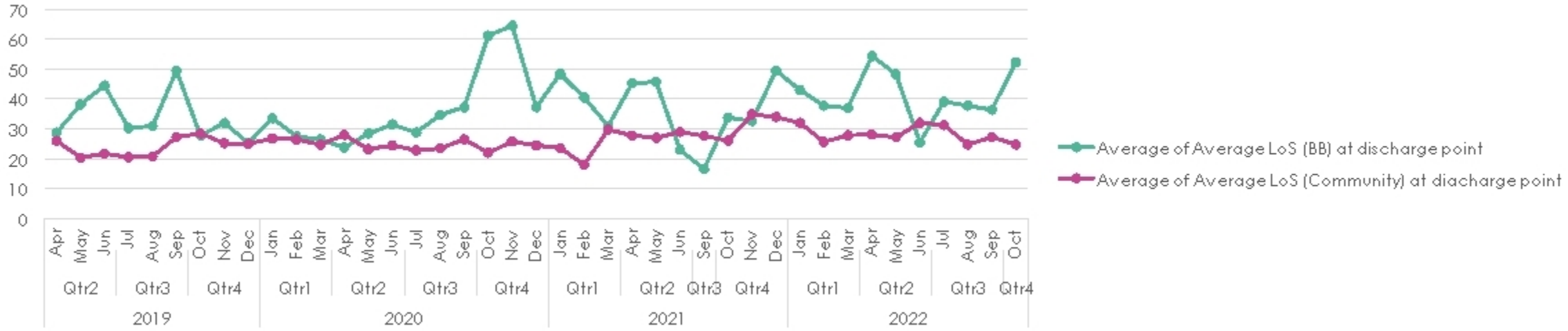


Integrated Assessment Hub

- **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 : October2022

Tier 3: Domiciliary and Bed-Based Pathways



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

Last updated : October 2022

MEETING OF THE TRUST BOARD Wednesday 7 December 2022			
Delegation of Authorisation of Charitable Funds Accounts to Charitable Funds Committee			
Report Author and Job Title:	Dan Mortiboys – Operational Director of Finance	**Responsible Director:**	Russell Caldicott – Chief Finance Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Assure	Members can take assurance from the following. • The Trust's Charitable Funds are undergoing an independent examination by Mazars LLP (the Trust's external auditors). • Once complete the statement of accounts and the report from Mazars on the independent examination will be shared with all Trustees. • If there were any significant findings, a trustee meeting would be arranged.		
Advise	• The Charitable Funds accounts must be shared with the Charity Commission by 31 January 2023. The 7 December 2023 Board meeting is the last full Trust Board meeting before this date. • Therefore, either an extraordinary meeting of trustees has to be arranged to consider the accounts or the responsibility of authorising submission of the statement of accounts delegated to another Committee. • **This paper is requesting that delegated authority be given and approved.**		
Alert	• This report asks for Trust Board to delegate responsibility for authorising the Charitable Funds statement of accounts to the Charitable Funds Committee which meets on 16 December 2022. • All trustees are invited to the December Charitable Funds Committee meeting and therefore have the opportunity to comment on the statement of accounts. • All trustees will receive a copy of the statement of accounts and independent examination report in advance of the 16 December Charitable Funds meeting.		
Does this report mitigate risk included in the BAF TRR?	N/A		
Resource implications	N/A		
Legal, Equality and Diversity implications	The Charitable Funds statement of accounts must be submitted to the Charities Commission 10 months after the close of the accounting period and an independent examination has to have been conducted.		
Strategic Aims	Care ☒	Communities ☒	
	Collaboration ☒	Colleagues ☒	

MEETING OF THE TRUST BOARD			
Digital Strategy			
Report Author and Job Title:	Richard Pearson – Chief Information Officer	**Responsible Director:**	Kevin Stringer – IT Director
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Assure	The draft Digital Strategy for Walsall Healthcare Trust is provided for review and approval. This draft strategy has been reviewed by MAC (Medical Advisory Committee), DAG (Design Authority Group) the Digital Transformation Board, Divisional leads within the trust and the Performance and Finance Committee. The strategy aligns with local strategic drivers and mandated national drivers for Digital Maturity that the trust is expected to achieve by the end of 24/25 financial year. The trust is currently on a journey to implement its EPR and there is a natural alignment with this target date. The ambition to achieve this is fully supported by clinical, operational, and digital teams however there are several risks to delivery that will need to be managed carefully due to competing financial and resource pressures over the delivery timeline. Details of these risks and proposed mitigations are documented in Section 5.3. Following completion of the Minimum Digital Foundation digital maturity assessment the trust has been provisionally allocated £7.8 million over the next 3 years to support delivery of the core EPR functionality that underpins this strategy. Local business cases will be completed to support any enablers that require recurrent funding to be provided. An associated business case for Digital Clinical resources has been submitted to the Trusts investment group in November. This investment will provide dedicated Digital Clinical resources - aligned to the Digital Strategy timelines – that will lead and support the delivery of the EPR programme through the establishment of a clinically led EPR MDT function.		
Advise	N/A		
Alert	N/A		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Yes – trust risk 3019 relating to EPR implementation delays		
Resource implications	External funding will be provided to support the delivery of the Digital Strategy with local business cases completed for any recurrent funding that is required.		

Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
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
NHS Trust

Digital Strategy – 2022-2025

Distribution:	Internal Only
Document Owner:	Richard Pearson - CIO

Document Control

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Change History

Date	Version	Author	Role	Comments
01/09/2022	0.1	Richard Pearson	Chief Information Officer	Initial draft created
13/10/2022	0.2	Richard Pearson	Chief Information Officer	Amendments made following review by Chief Clinical Information Officer and Head of Digital Transformation
25/10/2022	0.3	Richard Pearson	Chief Information Officer	Modification to Digital Patient enablers
03/11/2022	0.4	Richard Pearson	Chief Information Officer	Incorporating feedback from Divisional Teams
30/11/2022	0.5	Richard Pearson	Chief Information Officer	Incorporating feedback from Performance and Finance committee

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1 CURRENT POSITION

The Trust's previous 3-year digital roadmap from 2019 to 2022 focussed on replacing the previous PAS system (Lorenzo) with a System C Careflow PAS that delivers Emergency Department, Outpatients, Inpatients and Contacts functionality alongside a fully integrated Theatres system (Bluespier). The System C Careflow EPR platform would then be developed with additional clinical modules and functionality.

Significant delays to the roadmap and challenges to delivery were caused by the Covid pandemic that led to diversion of Operational, Clinical and Digital resources to support the changing priorities of the Trust.

Despite the delays and re-prioritisation, the Trust has successfully delivered a stable foundation upon which to build moving forward.

- Proven GDE (Global Digital Exemplar) EPR platform capable of delivering HIMMS level 7 functionality.
- Fully Digital ED system with electronic noting and care pathways. Including the automatic population and distribution of discharge summaries from ED.
- Deployed EDMS (Electronic Document Management System) to pilot service (Child Health) to remove requirement for paper notes and allow real time access to content captured.
- Deployed Clinical Communication and collaboration platform to pilot service (Paediatrics) to provide electronic handover, task management and secure team communication.
- Deployed electronic ward whiteboards to Medicine wards to improve ward round processes and management of patient flow.
- Replaced storage area network to provide scalable and performant storage for the Trust's hosted systems
- Significant desktop replacement and upgrade programme carried out to reduce the age of end user devices in use within the trust and support virtual consultations with patients and virtual meetings with colleagues through the deployment of integrated web cams into all clinical areas.
- Deployment of both secure BYOD (bring your own device) and collaborative GovWifi wireless networks to enable staff and partners access to secure Wi-Fi on any device
- Deployment of Virtual Desktops to support clinicians and operational staff working from different locations and across sites and provide external clinicians the ability to access Walsall Healthcare clinical systems without requiring a Walsall Healthcare issued device
- Deployment of MyPreOp software to improve and enable remote pre-operative assessments
- Supported an enormous shift in working practices from office based to home and hybrid models. Trust wide deployment of Microsoft Teams to support virtual meetings and new ways of working for staff and the massive expansion in provision of Trust laptops and secure VPN connectivity to enable clinical and non-clinical staff to work remotely.

We have delivered discrete pieces of the jigsaw and in doing so have gained valuable insight and learning that we will now incorporate into the planning for deploying the full EPR functionality that is required.

2 DRIVERS FOR CHANGE

2.1 NHS LONG TERM PLAN

The NHS long term plan was published in 2019 and Chapter 5 is dedicated to Digital requirements to support the priorities for the NHS. Key points to consider in this Strategy are shown below.

- Create straightforward digital access to NHS services and help patients and their carers manage their health.
- Ensure that clinicians can access and interact with patient records and care plans wherever they are.
- Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition.
- Use predictive techniques to support local health systems to plan care for populations.
- Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administrative burden.
- Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education.
- Mandate and rigorously enforce technology standards to ensure data is interoperable and accessible.

The timelines indicated in the Long-Term plan state that by 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored, and transmitted electronically, supported by robust IT infrastructure and cyber security.

2.2 WHAT GOOD LOOKS LIKE

The WGLL (What Good Looks Like) framework consist of 7 success measures grouped under the 3 domains of Digitise, Connect and Transform. The framework describes arrangements across the whole ICS (Integrated Care System) including all constituent organisations. Key outcomes that align with the Trusts Digital Strategy are outlined below.

1. Well led

    - Share an ICS wide Digital Strategy that drives levelling up and is underpinned by a sustainable financial plan
    - Ensure clinical representation and input is key to development of Digital Strategy
    - Ensure review and alignment of all ICS organisations Digital Strategies, Cyber Security plans and procurements

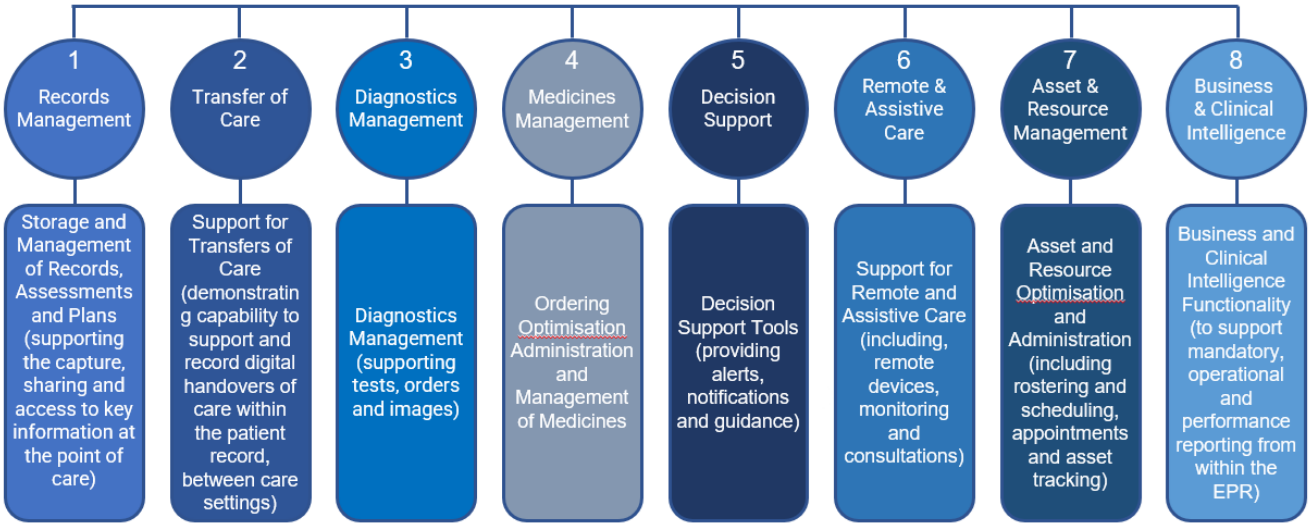
2. Ensure smart foundations
    - Progress towards net zero carbon, sustainability and resilience
    - Foundation infrastructure is reliable, modern, secure and resilient
    - Implementation of hybrid cloud strategy, cloud first approach to new system procurement and moving to Office 365 across the Trust
    - Planning and investment in modern infrastructure to retire unsupported systems
    - Review opportunities for consolidation and simplification of infrastructure to include spending and contracts
    - Ensure levelling up of electronic care record systems, including using greater clinical functionality and links to diagnostic systems and EPMA (Electronic Prescribing and Medicines Administration)
3. Support professionals
    - Promote and use systems and tools to enable frictionless movement of staff across the ICS – allowing staff from different organisations to work flexibly and remotely where appropriate
    - Ensure that front line staff have the information they need to do their job safely and efficiently at the point of care

- Ensure workforce is digitally literate Digital and Data tools and systems are fit for purpose

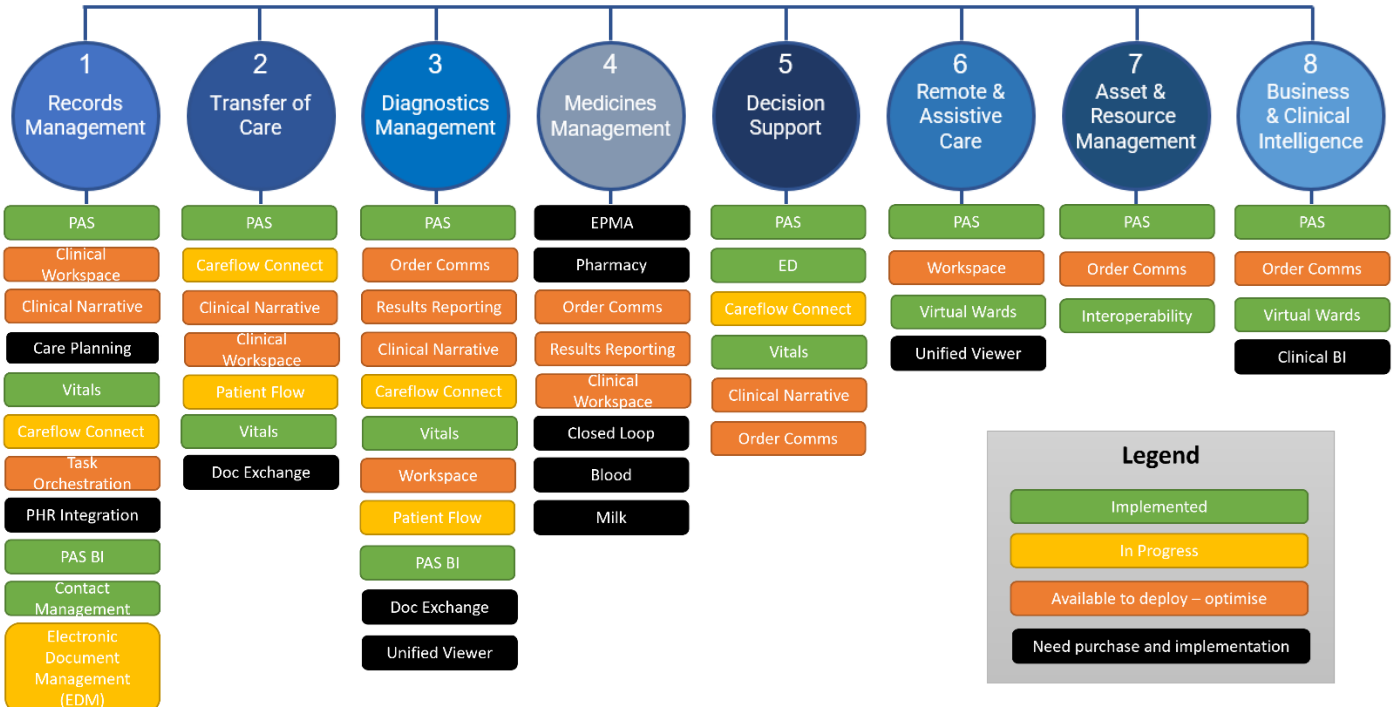
4. Improve care
    - Ensure the organisation makes use of tools and technologies that support safer care such as EPMA and bar coding.
    - Ensure the organisation implements decision support and other tools to help clinicians follow best practice and eliminate quality variation
    - Contribute to ICS wide Population health system and utilise this system to re-design care pathways and provide the right care to patients in the most appropriate setting
5. Safe practice
    - Ensure the Trust fully uses the national cyber services provided by NHS Digital and is a key member of ICS Cyber subgroup.
    - Establish a process for managing Cyber risk with mitigation plans, investment and progress regularly reviewed
    - Ensure the organisation supports and complies with the Data Security and Protection toolkit
6. Empower citizens
    - Implementation of digital communication tools to enable self-service pathways such as self-triage, referral condition management, advice and guidance
    - Provide direct patient access to care plans, test results, medications, correspondence and appointment management
    - Make consistent use of national tools (nhs.uk and NHS app) supplemented by complimentary and integrated local digital services that provide a consistent and coherent user experience
7. Enable Innovation
    - Delivery and development of an ICS-wide intelligence platform with a fully linked, longitudinal dataset (including primary, secondary, mental health, social care and community data) to enable population segmentation, risk stratification and population health management
    - use data and analytics to redesign care pathways and promote wellbeing, prevention and independence (for example, identifying patients for whom remote monitoring is appropriate)
    - make data available to support clinical trials, real-world evidencing and AI tool development

2.3 LEVELLING UP – MINIMUM DIGITAL FOUNDATIONS

The MDF (Minimum Digital Foundations) are nationally defined core capabilities that have been developed in line with existing digital maturity models. The foundation capabilities set the bar for a minimum level of digital maturity that each Trust should meet by the end of the 24/25 financial year. Levelling up funding will be provided centrally, based on local digital maturity assessments carried out against the MDF core capabilities. The core capabilities that we are required to meet are grouped into 8 Business Functions and are defined below.



The Trust has completed a self-assessment of these core capabilities and created a functionality matrix that shows the status for each of the 8 Business Functions mapped to the relevant System C EPR module. Green modules are complete and embedded, yellow modules are in progress, orange modules are available to the trust as part of its EPR contract – delivery resources are required to support implementation and adoption, and black modules require purchase and implementation.



3 DIGITAL FRAMEWORK

To achieve the strategic outcomes that are required we have defined five key themes of focus. These five themes will underpin the delivery of the Digital Strategy. The core enablers that will deliver the required outcomes from these themes are detailed in the Delivery Plan (Section 5)

Robust infrastructure – supports improved reliability and response time. This is the foundation of Digital usability and satisfaction

- IT Fundamentals – we will ensure the fundamentals of IT service provision are reliable, performant, secure and scalable (Local area network, Wi-Fi, storage network, devices, telephony)
- Cyber security – we will continue to develop the Cyber security function to ensure our services are safe and protected. We will expand on collaboration already in place with the regional Cyber team and partners The Royal Wolverhampton Trust.
- Device optimisation –we will reduce the average age of end user devices to ensure staff have effective and modern devices to support the increased dependence on Digital systems
- Automation – we will automate current manual processes using technology. This will improve the accuracy and compliance of our systems and free up engineer resources to support an improved service (e.g., starters, leavers and user change process, automated build and patching of mobile OS devices)
- Role based IT – standardisation of IT equipment in use based on clinical role. Supplying staff with devices that are suitable for the environment they work in; support mobility and hybrid working and allow access to the EPR wherever it is required

Skills and Workforce – ensuring we have the right skills, resources, and training to support the Digital Strategy

- Review of Digital resources – we will review the resources allocated to Digital Services to identify where additional resources are required to support effective delivery. We shall adopt a system where BAU activities are not affected by delivery of new projects. We shall achieve this by separating BAU staffing from project deployment resources.
- Manage the backlog - Manage the digital backlog against continuing need for Digital development and new upgrades. We shall review the existing and projected workload and backlog to achieve a balance with staffing resources, reviewing current staffing levels and seeking investment it areas that require development.
- Application management is currently a split responsibility and not co-ordinated. This means the applications and information assets within the Trust are not managed consistently. We will review this and propose a new structure to support all applications effectively.
- Review and relaunch a modern Service Desk platform – focussing on guided self-serve, first time fix and incorporating ‘shift left’ best practices to ensure the solution to issues is closer to the customer, resulting in faster and more efficient resolutions.

- Digital clinical resources – we will seek investment to expand the capacity of the current Digital clinical workforce. Creating a digital leadership network of clinicians within the organisation. We will formalise the role of the Digital Nurse and work in partnership with the CNIO and CCIO to ensure we have appropriate clinical resources working on clinical system deployments.
- Workforce skills – the Trust has a wide variation in levels of digital sills across staff and service users. Supporting our staff in their digital and data skills should be a priority for the Trust. We will review our current roles and benchmark against national standards such as SFIA (Skills for an Information Age) and DDaT (Digital Data and Technology)
- Learning Management System – we will implement and develop a learning platform that provides role-based pathway learning.

Digital Clinician – provide clinicians with tools that add value, not burden and provide efficient and real-time access to the data that is required at the point of care.

- Simplify logons – we will remove the high level of friction that is experienced by our teams when accessing patient information. Removing multiple logons and simplifying access to the disparate systems that are in use.
- Implement enabling technologies – we will implement and augment Digital systems that support patient care rather than being viewed as an administrative barrier, improving productivity and effectiveness for our clinical workforce.
- Data at the point of care – we will ensure data that is required is captured digitally so it is available to share and access in real-time within the EPR platform.
- Optimise and extend the use of our EPR – we will complete the deployment of the existing EPR modules whilst working closely with end users, and develop plans and secure funding for the implementation of additional modules to achieve both the Minimum Digital Foundation core capabilities and HIMMS level 5 by March 2025.

Digital Patient – providing access to their records and increasing engagement in their own care

- Accessible records – we will work on enabling patients to access to their own healthcare data through implementation of personal health record, aligning with ICS strategy for a single point of access, integrated within the NHS app.
- Self-service – we will provide patients self service capabilities for cancelling and amending their own appointments
- Remote monitoring – support patients to be cared for within their own homes through implementation of remote monitoring and virtual wards.
- Empower patients - provide patients with the tools and technologies to support participation and management of their own care. Including collaborative care plans, implementation of patient choice for digital correspondence, expansion of virtual

consultations and ability for patients to complete clinical assessments and triage questionnaires remotely.

Integration, Sharing and Population Health – sharing data with health and social care partners to improve patient care and unlocking the value in Population health data to improve health outcomes for patients.

- Supporting regional interoperability and contributing to the Shared Care Record system to enable pathway re-design across organisational boundaries and timely access to key clinical data that has been captured at partner organisations within the ICS.
- Integration within the ICS – deploy and develop the Shared Care Record to provide a unified view of patient records and ability to define patient pathways, share tasks and electronic forms across organisational boundaries.
- Population Health – we will work with the ICS on implementing Population Health analytics as part of the Graphnet Shared Care Record
- Transfer of Care – structured and coded data captured electronically for onward sharing to Primary Care and the shared care record
- Development of API architecture as part of our EPR platform to enable bi-directional interfacing of data

4 PRINCIPLES

4.1 CLINICALLY LED – DIGITALLY DRIVEN

Improving shared ownership is essential to improving overall satisfaction and outcomes – end users need to feel a sense of partnership with Digital teams with a voice on prioritisation and planning. We have a strong Design Authority Group that is used to provide a clinical steer on key decisions, this is supported by our CCIO. We will look to expand both the number of roles and time allocation for the clinical roles that work with Digital Services. This will include the creation of an EPR MDT function with dedicated Digital clinician roles to drive the adoption and implementation of the clinical EPR modules.

4.2 DEVICE AGNOSTIC

We will ensure all new systems that are implemented are device agnostic. Breaking supplier lock-ins to specific ecosystems, allowing the trust to choose the most suitable device and enabling all systems to be accessible from any device.

4.3 CLOUD FIRST

Adopting a cloud first approach to new systems that are implemented and reviewing our current systems to define a costed strategy for moving to cloud over time. A cloud first approach will allow the trust to be more flexible and responsive and will remove barriers to collaboration with partners.

4.4 SINGLE SIGN ON

Ensuring any new systems that are implemented can utilise single sign on whilst working on retrofitting single sign on for all key clinical systems to reduce the overhead and burden on clinicians and enable them to focus on caring for patients.

4.5 COLLABORATIVE PROCUREMENT

We will work with ICB colleagues and partners to ensure when we look to procure new systems we will review all options for collaborative procurement. Standardising and converging systems over time to reduce barriers to access, deliver efficiencies and enable greater collaboration opportunities.

4.6 PARTNERSHIP WORKING

We will explore opportunities for partnership working and convergence with Royal Wolverhampton Trust to deliver improved services, shared access to systems to support new care pathways and support for the Digital Systems that are provided. Sharing best practice and knowledge from both organisations.

We will also work closely with our partners within the broader ICS to identify opportunities for future convergence to simplify and reduce the number of competing systems in use and enabling greater staff mobility across organisational boundaries within the ICS.

4.7 MEASURED AND EVIDENCED

We will independently review our Digital Maturity in line with the HIMMS standard at the end of this strategy to independently assess and assure our progress.

5 DELIVERY PLAN

5.1 ENABLER'S

This table details the local enablers mapped back to the key drivers for change for both **What Good Looks Like** and **Levelling Up – Minimum Digital Foundations** as well as alignment to the Trust's 4 strategic aims – **Care**, **Colleagues**, **Collaboration** and **Communities**

Pillar	Enabler	Narrative	Success measure	Alignment to key drivers	Alignment to Trust strategy
Robust infrastructure	**Server upgrade**	Upgrading all hosted servers to latest versions of operating system and databases	Supported, secure and robust infrastructure with all hosted servers on latest supported versions of operating systems	Digitise - Ensure smart foundations	Colleagues
Robust infrastructure	**Acute Network Upgrade**	Upgrading and replacing all legacy network equipment (LAN and Wi-Fi)	Faster, more reliable network access	Digitise - Ensure smart foundations	Colleagues
Robust infrastructure	**Role based IT**	Review of IT equipment used based on clinical role and working environment.	Clinical staff able to access EPR system wherever and whenever needed	Digitise - Ensure smart foundations	Care Colleagues
Robust infrastructure	**Community network upgrade**	Upgrade and replacing legacy Community network hardware	Faster, more reliable network access	Digitise - Ensure smart foundations	Colleagues
Robust infrastructure	**NHS.net and O365**	Moving to NHS.net and O365 shared tenant to provide alignment with partners and greater collaboration	All staff migrated to NHS.net and Office 365 shared tenant. Improved collaboration	Digitise - Ensure smart foundations	Care Colleagues
Robust infrastructure	**Cyber security**	Review of Cyber Security roles and resources to deliver excellent organisational Cyber health and collaboration with RWT	Collaborative Cyber security function across WHT and RWT providing improved protection to both Trusts	Connect - Safe Practice	Colleagues
Robust infrastructure	**Automation of mobile device upgrade and patching**	Improvements to mobile device management and patching process	Implementation of fully automated mobile device build and patching process	Digitise - Ensure smart foundations	Colleagues

Skills and Workforce	**Digital resource review**	Increase Digital project resources to ensure clinically led EPR deployment and adequate resources to support Digital transformation. Provide opportunities for progression and internal development within Digital Services structures to support internal staff development.	Establishment of clinically led EPR MDT function to deliver the clinical modules within the EPR programme	Digitise - Support professionals	Colleagues
Skills and Workforce	**Application Management**	Increase Application management resources to ensure BAU systems are managed consistently and effectively	Improved management of live systems - leveraging more value from the functionality and optimising support	Digitise - Support professionals	Colleagues
Skills and Workforce	**Service Desk platform**	Review and optimise current system or replace with new Service Desk platform	Simpler and more efficient process for staff to request support from Digital Services	Digitise - Ensure smart foundations	Colleagues
Skills and Workforce	**Shift Left**	Training, education, and new operating models to ensure solution to issues is closer to the customer	Improved response to incidents, quicker resolution, and improved customer experience.	Digitise - Support professionals	Colleagues
Skills and Workforce	**SFIA review**	Review and align IT skills against SFIA (Skills for an Information Age) framework, identify gaps and required skills development plans	All Digital job roles reviewed against SFIA with gaps identified and plans to address	Digitise - Well led	Colleagues
Skills and Workforce	**Learning Management**	Implement role-based learning pathway platform for Digital Services	All Digital staff onboarded to and using role-based IT training pathways.	Digitise - Support professionals	Colleagues
Digital Clinician	**Community EPR**	Review of current Community systems against requirements to consolidate onto a single system optimised for Community use.	Single system in use across Community services that provides all the required functionality and improves clinical outcomes	Digitise - Support professionals 1 – Records Management	Care Collaboration Communities

Digital Clinician	**EDM (Electronic Document Management)**	Removing the requirement for paper health records by implementing an electronic document management system to store scanned / uploaded unstructured patient documentation	No requirement for paper health records to be delivered to clinicians, newly created paper content ingested and available electronically	Digitise - Support professionals 1 – Records Management	Care Collaboration
Digital Clinician	**Single Sign On**	Implement Single Sign on solution for Clinicians to manage access to multiple systems required to carry out clinical duties	Successful deployment and adoption of Single Sign on system across the trust.	Digitise - Support professionals 7 - Asset and Resource Management	Care Colleagues
Digital Clinician	**Patient Flow**	Implementation of cloud based real time view of ward capacity, clinical status, and operational needs. To improve management of patient throughput from pre-admission to discharge	All wards live and using Patient Flow to improve patient throughput on wards	Digitise - Support professionals 1 – Records Management	Care Collaboration
Digital Clinician	**Care Flow Connect**	Communication and collaboration for team-based care co-ordination. Patient messaging, clinical photography, handover, alerting, task management and replacement of non-urgent bleeps	Entire Trust using Care Flow Connect for improved handover, internal referrals, and care co-ordination	Digitise - Support professionals 2 - Transfers of Care	Care Collaboration Colleagues
Digital Clinician	**Clinical Workspace**	Clinically optimised and consolidated view of the entire Careflow EPR clinical product suite, as well as single sign-on integration with 3rd party applications such as PACS and ICE.	Successful deployment and adoption of Clinical Workspace across the trust supporting the decommissioning of Fusion + platform.	Digitise - Support professionals 1 – Records Management	Care Collaboration
Digital Clinician	**Clinical Narrative**	Recording of structured and un-structured electronic notes in both Careflow desktop and on mobile device. Replacing paper forms through the Trust	Reduction in paper based clinical processes within the trust	Digitise - Support professionals 5 - Decision Support	Care Collaboration

Digital Clinician	**OCRR (Order Comms and Results Reporting)**	Consolidating order and results information within the Careflow EPR platform. Enabling results data to be integrated into Clinical Narrative and decision support processes.	Results available directly in Careflow EPR system supporting the decommissioning of Fusion + platform.	Digitise - Support professionals 3 - Diagnostics Management	Care
Digital Clinician	**Care planning**	Electronic care plans tailored to meet patient needs in a collaborative manner using agreed local and national guidelines	Care planning in use to optimise and standardise patient care and further reducing the need for paper	Digitise - Support professionals 1 – Records Management	Care Collaboration Communities
Digital Clinician	**EPMA (Electronic Prescribing and Medicines Administration)**	Accurate and safer prescribing through pre-defined prescription templates, drug decision support alerts and pharmacy prescription validation	EPMA solution deployed as part of Careflow EPR with medicines decision support	Connect - Improve Care 4 - Medicines Management	Care
Digital Clinician	**Digital Maturity Assessment**	Undertake a full HIMMS assessment to measure the Trust digital maturity.	An evidence-based report showing the Trusts accurate level at the end of the Digital Strategy	Digitise - Well led	Colleagues
Digital Patient	**Remote monitoring**	Support patients to self-monitor in their own homes enabling higher acuity supported discharge	Increased use of virtual wards and supported discharge to reduce demand on acute beds and provide better care to patients	Transform - Empower Citizens 6 - Remote and Assistive Care	Care Communities
Digital Patient	**Patient Engagement Portal**	Provide patients more control to manage hospital appointments, receive digital correspondence and access guidance and questionnaires digitally	Patient portal deployed and adopted by patients with increasing delivery of digital correspondence over paper	Transform - Empower Citizens 6 - Remote and Assistive Care	Care Communities

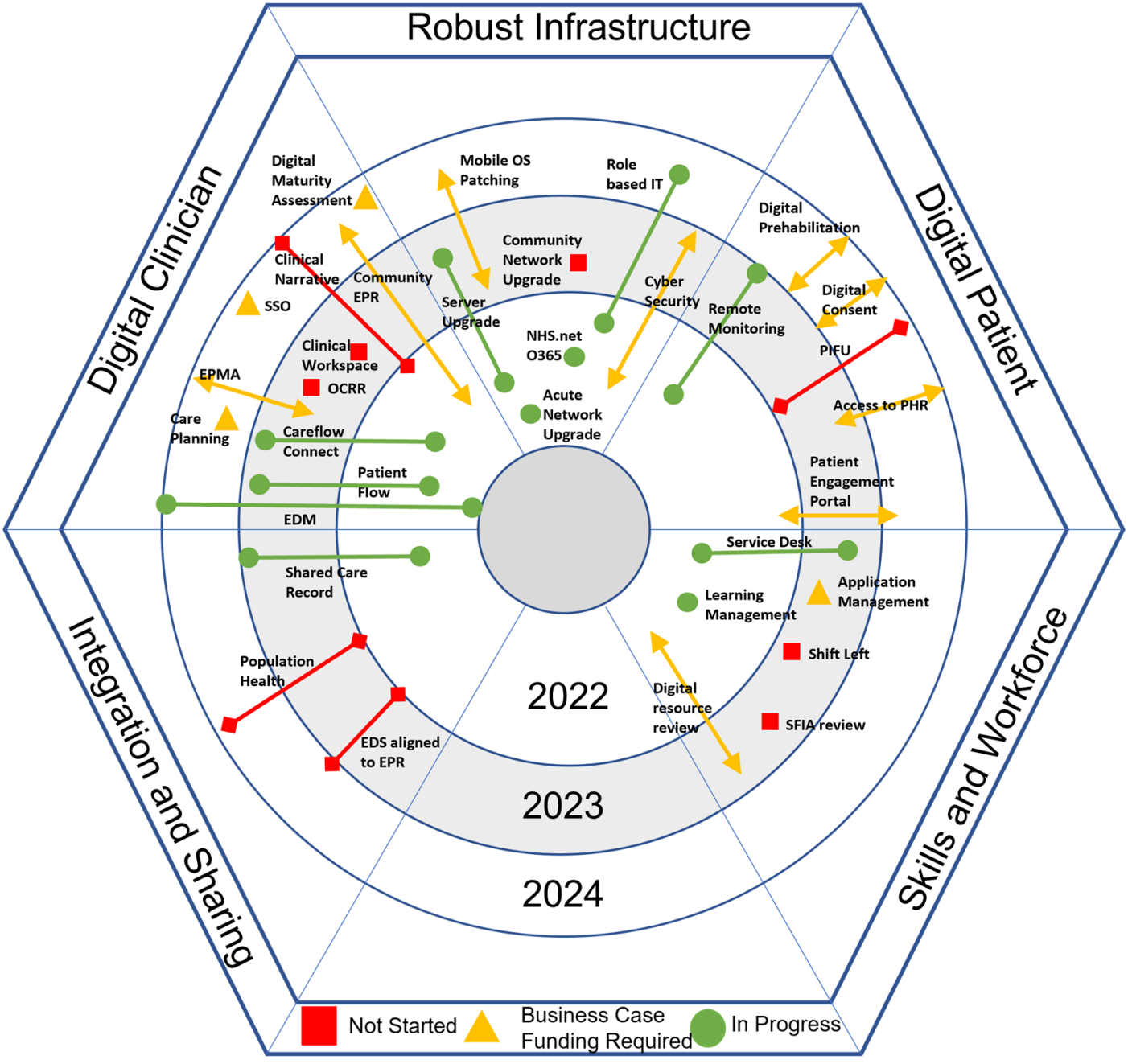
Digital Patient	**Personal Health Record (PHR)**	Provide patients access to their Health record and the ability to contribute to their care plans	Patients able to access their health record and have access to the tools to enable them to participate and manage their own care	Transform - Empower Citizens 6 - Remote and Assistive Care	Care Collaboration Communities
Digital Patient	**(PIFU) Patient Initiated Follow Up**	Provide more flexibility for patients to be enrolled on Patient Initiated follow up pathways	Patients have the flexibility to arrange their follow-up appointments as and when they need them.	Transform - Empower Citizens 6 - Remote and Assistive Care	Care Communities
Digital Patient	**Digital Prehabilitation tools**	Providing patients with remote health coaching for pre- and post-surgery. To include coaching, personalised lifestyle programs and exercise videos to reduce the risk of complications and improve health and wellbeing	Patients have access to remote health coaching to support them on prehabilitation pathways	Transform - Empower Citizens 6 - Remote and Assistive Care	Care Communities
Digital Patient	**Digital Consent**	Provide patients with the ability to consent to surgery remotely, taking and recording informed patient consent. To enhance the patient experience, improve clinical workflows and protect organisational and clinical reputations.	Patients have access to provide informed consent for surgery remotely.	Transform - Empower Citizens 6 - Remote and Assistive Care	Care Communities
Integration and Sharing	**Shared Care Record**	Implementation of ICS wide Shared Care Record system to provide visibility of patient encounters and results from partner care organisations	Shared care record system integrated within Careflow EPR and being used by clinical staff to improve decision making and care	Transform - Enable Innovation 2 - Transfers of Care	Care Collaboration Colleagues
Integration and Sharing	**Population Health**	Implementation of ICS wide Population Health platform to allow predictive techniques to be used to improve the health outcomes of patient groups	Improved health outcomes and pro-active targeted interventions within patient groups	Transform - Enable Innovation 8 - Business and Clinical Intelligence	Care Communities

Integration and Sharing	**Electronic Discharge Summaries (EDS) aligned to EPR**	EDS rewrite to align to Careflow EPR and re-use of data captured as part of patient pathway	New EDS process in use, full alignment to PRSB standards and ability to send structured, coded data items	Transform - Enable Innovation 2 - Transfers of Care	Care Collaboration

5.2 DELIVERY TIMELINE

The visual below shows the key activities and timelines within the Digital Strategy.

- Items in green are already in progress
- Items shown in yellow require investment and procurement of new systems to progress. This investment will be sought from Frontline Digitisation and levelling up funds along with internal business cases.
- Items shown in red do not require system procurement but are not yet started. As part of full project definition, we will identify resource requirements and if additional resource is required investment will be sought from Frontline Digitisation and levelling up funds along with internal business cases



5.3 PRIORITISATION, GOVERNANCE AND DELIVERY RISK

There is a significant amount of work to deliver over this Digital Strategy timeline. Challenges that arise due to funding, workforce and prioritisation will be raised at the monthly Digital Transformation Board for resolution. Quarterly updates on the delivery enablers will be provided from the Digital Transformation Board through to the Performance and Finance Committee to ensure visibility of progress and effective management of issues.

This Digital Strategy highlights what the Trust needs to deliver to meet both national requirements and local objectives, whilst this ambition is fully supported by clinical, operational, and digital teams we have identified several risks to delivery that will need to be carefully managed. These risks will be managed through the Trust's Digital Transformation Board and joint Digital Strategy Forum. A summary of the key priority risks identified for delivery of the Digital Strategy and proposed mitigating actions are shown below.

Risk (there is a risk that the…)	Proposed Mitigation
Levels of investment funding, both Trust and Frontline Digitisation are constrained resulting in a delay to timelines– large deficits to be managed and service delivery prioritised over Digital investment.	Performance and Finance committee will review the alignment of the Digital Strategy with the competing investment decisions at the Trust. Close engagement with the ICB and Regional Teams to ensure alignment on Frontline Digitisation funding allocations.
Trust operational and clinical resources are not able to support the amount of change management that is required due to backlog management and competing priorities.	Utilising the Digital Strategy forum to ensure Digital Strategy enablers are aligned to operational delivery plans. Escalation of resource constraints to Digital Transformation board and quarterly progress report to Performance and Finance committee. Dedicated Digital Clinical resources being sought through separate investment case to create EPR clinical MDT for clinical delivery of the enablers.
National funding will not be released in line with agreed programme plan causing delays in the delivery of the programme	Engagement with Frontline Digitisation leads and ICS and Regional colleagues. Escalation of delays through Trust governance to enable re-planning and mitigation.
Additional deployment resources will be harder to source due to all Trusts working to the same Digital maturity timelines.	Early market engagement to secure resources, partnership working with incumbent EPR supplier, provision of pooled / shared resources within the ICS, partnership working and sharing with other System C Trusts.

Walsall Healthcare NHS
NHS Trust

Trust Board Report	
Meeting Date:	Wednesday 6th December 2022
Title:	Black Country ICS Update
Action Requested:	Approve the report and next steps, noting the recommendation that proposals will come back through to the Trust Board for approval
For the attention of the Board	
Assure	• Discussions around the next steps for the ICB operating model are taking place system wide. Executive leads from the Trust are sitting on a number of the work streams
Advise	• Further discussions around the scope of services and the possible delegation of responsibility will be linked to the work taking place with the Provider Collaboration and OneWolverhampton.
Alert	• It is unlikely that any changes to the delegation of responsibility will be in place before 2023/24. • Decisions in relation to delegation of responsibility will need to be approved by the Trust Board .
Author + Contact Details:	Tel 01902 694290 Email simon.evans8@nhs.net Group Chief Strategy Officer
Links to Trust Strategic Aims	• Excel in the delivery of care • Support our Colleagues • Improve the health of our Communities • Effectively Collaborate
Resource Implications:	None as a result of this report
CQC Domains	Safe: patients, staff and the public are protected from abuse and avoidable harm. Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. Caring: staff involve and treat everyone with compassion, kindness, dignity and respect. Responsive: services are organised so that they meet people's needs. Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	Health Equalities are considered are considered within the draft proposals.
Public or Private:	Public
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

1. Background

The Black Country ICS is led by both an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB). Together, they must develop a plan to deliver the four national aims:

1. improve quality of services and outcomes in population health and healthcare
2. tackle inequalities in outcomes, experience, and access
3. enhance productivity and value for money
4. help the NHS support broader social and economic development.

Working with system partners, the following three strategic ambitions have been agreed for the system:

1. Healthier people
2. Making Black Country the best place to work
3. A system fit for the future

The Black Country ICS is currently developing the new operating infrastructure to enable effective delivery of services across the system from 2023/24. This two Boards have different roles in supporting this.

2. Proposed Operating Model

The ICB is currently working with all stakeholders to develop an operating model for 2023/24. This will support the delivery of the 4 aims of the ICS and strategic priorities of our System. It will also show the interdependencies of Places, Collaboratives and individual organisations.

The proposed model will see a definitive shift to greater autonomy within the Black Country for Provider Collaboratives and Place-based Partnerships. To achieve this, a revised governance and accountability framework is being developed. The proposed model can be found in appendix A.

The date of its full implementation will be guided by several factors, including the agreement of all system partners on the model (recognising the impact on individual provider Boards), supporting enablers (such as financial framework and system protocols) and the agreement of constituent members to a set of mutually agreed principles. The elements of the model are described below:

Integrated Care Partnership (ICP) – The ICP will set the Integrated Care Strategy for the Black Country System.

Integrated Care Board (ICB) - The ICB will, in conjunction with providers, set the health strategy for the System (Joint Forward Plan) aligning to the Integrated Care Strategy set by the ICP; allocate resource; set outcome measures and minimum quality standards and oversee System transformation. ICB Committees will undertake duties in line with the ICB Constitution including System-wide assurance through Strategic Commissioning, Finance, Performance & Digital Committee and Quality & Safety Committee. Such Committee's will be supported by sub-forums such as the ICS Quality Oversight Group and system-wide Strategic Programmes Groups.

Provider Collaboratives / Partnerships – There are seven provider collaboratives/partnerships within our System. Three are system-wide collaboratives that will provide and/or coordinate services across the Black Country with the aim of improving quality, productivity, sustainability and effectiveness of services - Provider Collaborative (Acute); Lead Provider for Mental Health, Learning Disabilities and Autism; Primary Care Collaborative. There are four Place Based Partnerships with the aim of managing all 'out-of-hospital' services, addressing demand and inequalities at Place and acting as true partnerships of NHS, Local Authorities, Voluntary Sector and other partner organisations - Dudley Health and Care Partnership; Sandwell Health & Care Partnership; Walsall Together and OneWolverhampton.

Joint Committees – A Joint Committee will be established to undertake joint planning between the ICB, Local Authority and where appropriate NHSE and respective collaborative/partnership. It will act as the vehicle to hold resource and decisions devolved or delegated by the ICB (and partners) and take joint responsibility for implementation of plans. They will be constituted by the ICB and members of a Collaborative or Partnership

and will ensure conflicts of interest are appropriately managed. Escalation will be through respective ICB Committees.

Strategic Programme Boards – The strategic/enabling boards currently in existence will be re-purposed to act as pan-system forums coordinating work of respective collaboratives and partnerships for the portfolio as required. Their role will be supportive and all services either commissioned or provided by the ICB will flow through one of the above Boards so there is a clear 'line of sight' and accountability via Strategic Commissioning Committee.

The Operating Framework (contained within the appendix) depicts how the layers of the ICB Operating Model will work. This reflects the oversight committees, planning arrangements, delivery models and the support provided through the coordination groups.

3. Next Steps

There are a number of key enabling work streams that are being developed to support the development of the operating model, these are:

Financial framework – A framework that underpins system working will be implemented. It will support the aims of the Operating Model and include clear decision-protocols and collaborative, place and system level. This will cover 4 key areas:

- System Governance and Principles of Joint Working
- Planning and Resource Allocation
- Risk Sharing
- Financial Reporting

Scheme of delegation - The ICB and organisational schemes of reservation and delegation will be reviewed alongside the implementation of the new model. This could enable responsibilities, accountabilities, resources and decisions to be delegated or devolved to forums within defined limits of authority.

Staff and stakeholder engagement - An engagement process on the model with partners commences in January 2023.

Readiness to operate assessment - Each element of the model will be tested for its maturity to take on revised or new responsibility. A readiness to operate framework is in development, in conjunction with NHSE, to aid this process.

Delegation phasing - The new model will not take on full delegated responsibility from April 2023. We are in dialogue with the ICS and do not expect to see any devolution until the Board has agreed the recommendations, this will likely be within 2023/24. The scale will be dependent on collaborative/partnership maturity. The ICB will also not fully transition to the new model until all aspects of the model are agreed. This is likely to be during 2023.

Resourcing - Staffing resources will be realigned from the ICB, Providers and Partners to support the new model at reduced (or no additional) cost.

Oversight and assurance - Formal oversight arrangements with PBPs/PCs will be constructed. This will 'double-run' with individual organisational oversight mechanisms while the ICB transitions to new arrangements. This will also incorporate a Memorandum of Understanding with participating partners and organisations.

4. Recommendations

The Board are asked to:

- Note the proposals around the development of the operating model for the ICB
- Take assurance that all proposals will be presented to the Board for discussion prior to approval

Black Country ICB

Operating Model - DRAFT

QSRM 2 December 2022

MGH Nov 22

Black Country Integrated Care Board

What are we trying to achieve?

An Operating Model for the System that:

- Supports the delivery of the 4 aims of the ICS and strategic priorities of our System, Places, Collaboratives and Organisations
- Allows clinical and service decisions to be made at the most appropriate level in the System,
- Ensures scope of services are effectively aligned to Strategic Programme Boards and Provider Collaboratives/Partnerships
- Has clear, effective decision making and accountability protocols
- Will be clear on responsibilities and accountabilities for achieving ICB statutory duties
- Ensures resource (human and financial) is distributed to meet needs of the model. This will be drawn from the ICB, partners and current providers.
- Has appropriate membership of Provider Collaboratives/Partnerships that is relevant for the responsible scope of services
- Incorporates all NHS providers into a Provider collaborative, as per NHSE requirement
- Recognises that we are one ICS, and a ‘no-detriment’ approach is adopted throughout
- Has been co-produced, and supported by all constituents of the System

Black Country ICB – Operating Framework

BLACK COUNTRY INTEGRATED CARE PARTNERSHIP

STRATEGY

BLACK COUNTRY INTEGRATED CARE BOARD

OVERSIGHT ASSURANCE

- Finance & Performance Committee
- Strategic Commissioning Committee
- Quality & Safety Committee

JOINT PLANNING

- Dudley Joint Committee
- Sandwell Joint Committee
- W'ton Joint Committee
- Walsall Joint Committee
- Provider Collaborative Joint Committee
- MHLDA Joint Oversight Committee
- Primary Care Joint Committee

DELIVERY

Dudley Health & Care Partnership

Dudley Council
BC ICB
Black Country Healthcare
Dudley Integrated Health and Care
Dudley Group NHS Trust
Primary Care Networks
WMAS
Voluntary Sector Council
Healthwatch

Sandwell Health & Care Partnership

Sandwell Council
BC ICB
Black Country Healthcare
Sandwell & West Birmingham NHS Trust
Public Health
Primary Care Networks
Voluntary Sector Council
Citizen Forum Chair
Health Watch

One Wolverhampton

Wolverhampton Council
BC ICB
Black Country Healthcare
Royal Wolverhamptonn NHST
Primary Care Networks
LMC
Compton Care
Voluntary Sector Council
Healthwatch

Walsall Together

Walsall Council
BC ICB
Black Country Healthcare
Walsall Healthcare
Primary Care Networks
One Walsall Community Assoc
WHA
Healthwatch

Provider Collaborative (Acute)

Dudley Group NHSFT
Royal Wolverhampton NHST
Walsall HHealthcare NHST
Sandwell & West B'ham NHST

Mental Health / LDA Lead Provider

Black Country Healthcare NHSFT

Primary Care Collaborative

PCNs
Dudley Integrated Health & Care

COORDINATION

- Elective & Diagnostic Programme
- Urgent & Emergency Care Programme
- Out of Hospital Programme
- Cancer Programme
- Inequalities & Prevention Programme
- LMNS Programme
- CYP Programme
- Digital Programme
- People Programme

Scope of Services

BLACK COUNTRY INTEGRATED CARE BOARD

Provider Collaborative (Acute)

- Electives and diagnostics
- Cancer
- Emergency Department, Same Day Emergency Care (excl. Integrated Assessment Hub or Front Door), Acute Outpatients, Acute Diagnostics
- Non-elective for ambulatory care sensitive conditions
- NHS 111 & 999

Metrics

- ***Oversight Framework –*** all framework measures relating to the above areas including recovery trajectories e.g. 52, 78, 104 Week waits, 62 Day Cancer, ambulance handovers, mortality and infections.
- ***Outcomes –*** e.g. Falls, alcohol related admissions, smoking at delivery, low birth weight.
- **Core20plus6, Clinical Review Standards and Winter Assurance Metrics**

Mental Health & LDA

- All Mental Health excluding below line incl. IAPT
- Learning Disabilities and Autism
- Primary Care Mental Health,
- Dementia diagnosis,
- LD physical health checks,
- SMI physical health checks

Metrics

- ***Planning and recovery metrics*** – e.g. routine and urgent CYP Eating disorders, IAPT waiting times and recovery, access to core mental health services
- ***Oversight Framework –*** e.g. Achievement of MH Standard, Reliance on specialist inpatient care for LD/A – Adults / under 18s, People aged 14+ with LD on GP register receiving an AHC

Place Based Partnerships

- Community and out of hospital services including community outpatients, palliative care, CHC and paediatrics and maternity
- Urgent Care Centres
- Primary Care including Enhanced Services (excl DESs), out of hours and GP Prescribing
- Independent Sector AQP and Non-emergency Patient Transport
- Better Care Fund
- Public Health: Health visiting; family nurse; sexual health; and SMS
- VCSE funding and health inequalities

Metrics

- ***Planning and recovery metrics*** related to out of hospital services e.g. virtual wards and community waiting lists
- ***Oversight Framework –*** *e.g.* prevention and screening, vaccination, post COVID and community response
- ***Outcomes –*** majority of public health outcomes e.g. housing, crime, screening and school readiness
- ***Core 20plus6 and Winter Assurance Metrics***

Primary Care Collaborative

- GP contracts PMS and GMS

Metrics

- ***Planning and recovery metric –*** e.g Primary Care Appointments, % vaccinated, Primary care appointments, Primary care clinician seen
- ***Oversight Framework –*** *e.g.* % hypertension patients treated to target as per NICE Guidance, % patients identified as having 20% plus 10 year risk of developing CVD are treated with statins, People receiving mechanical thrombectomy as % stroke patients, GP referrals to NHS Digital Weight Management Programme
- ***Outcomes –*** e.g. % eligible population (40-74) offered NHS health check / and received NHS health check, estimated dementia diagnosis rate (aged 65+)

- ***Core 20plus6*** - AHCs for 60% of those living with SMI

Timeframes

The following milestones are to be noted:

Mid December	Engagement session with CEOs
Mid December	ICB Board Development Session
January 2023	Commence partner & staff engagement
January – February	Agreement of : • Financial/Risk framework (subject to planning guidance) • Scheme of reservation and delegation, and other governance requirements • Initial delegations/devolution for phase 1 • Memorandum of understanding with partner organisations
February	Consultation on Operating Model (as part of Joint Forward Plan)
March	Approval of Model by Trust Boards, HWWBs, partners
March	Agreement of contractual and other enabler mechanisms
April 2023	Launch of new model – phase 1 (with transition arrangements)
May – March	Quarterly review of Phase 1, with potential for further delegation/devolution
April 2024	Launch of full model

Walsall Healthcare NHS
NHS Trust

Trust Board Report	
Meeting Date:	Wednesday 7th December 2022
Title:	Update from the Black Country Provider Collaboration Programme Executive meetings
Action Requested:	Following discussions held at the Provider Collaboration Executive over recent months, the Board is asked to: • Approve the report including next steps regarding proposals for developing a scheme of delegation
For the attention of the Board	
Assure	• The proposals contained within the reports have been presented to the Trust Management Committee for consideration. A new governance work stream is being developed by the Provider Collaboration which will be chaired by the Group Chief Strategy Officer for RWT & WHT
Advise	• The Provider Collaboration programme is working with colleagues across the ICB to agree the revised 'Target Operating Model' for all groups across the ICS
Alert	• Further discussions regarding potential delegation of decision making are being worked through, recommendations regarding what this looks like will be presented back to the Board for consideration.
Author + Contact Details:	Tel 01902 694290 Email simon.evans8@nhs.net Group Chief Strategy Officer
Links to Trust Strategic Aims	• Excel in the delivery of care • Support our Colleagues • Improve the health of our Communities • Effectively Collaborate
Resource Implications:	There is a commitment from all organisations to commit resources in terms of time for key roles. As a minimum this includes the roles identified so far: CEO, Chair, CMO, CPO, GDoC and GCSO.
CQC Domains	Safe: patients, staff and the public are protected from abuse and avoidable harm. Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. Caring: staff involve and treat everyone with compassion, kindness, dignity and respect. Responsive: services are organised so that they meet people's needs. Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	Health Equalities are considered are considered within the draft proposals.
Public or Private:	Public
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Update from Provider Collaborative Executive Meetings – October and November

Background

During October and November, a Provider Collaborate Executive Meeting and governance work stream meeting took place, the key outputs from these meetings are captured below:

1. Key Updates
   - **ICB delegations** – recent dialogue with ICB colleagues has confirmed that there are unlikely to be any significant delegations within 2022/23
   - **Strengthening Collaboration** – All Trusts have now taken a paper to their Public Boards regarding the intended direction of travel.
   - **Development of delegations from Trust Boards** – The Provider Collaborative Board has encouraged a 'principles-based approach' to the development of a small subset of delegations from Trust Boards which enables the continuation of delivery. A governance work stream to oversee the development of this approach has been developed. The Group Chief Strategy Officer RWT & WHT will chair this.

2. Update on the Case for Change
   A brief paper was presented outlining the background to the discussion at the Collaborative Board, and the guidance provided. In light of work being progressed by the ICB in the development of a Clinical Strategy (which is a key foundational element of the forthcoming Joint Forward Plan) it was agreed to 'pause' any work on a 'Case for Change' and wait for the output of the ICB Clinical Strategy.

3. Feedback from Clinical Leads Group
   The development of a joint Primary and Secondary care educational programme was discussed, it was agreed to progress and ensure details of the interface work that is being undertaken in the Provider Collaborative are shared more widely with Primary care

4. Monthly Performance Report
   The Monthly Clinical Improvement Performance Report outlined the work of the Clinical Networks, highlighting progress and supporting delivery of the three goals identified (Improving Access, Quality & Standards, System resilience & Transformation). Key highlights to note were:
   - 57 projects/priorities been progressed across nine networks
   - All in various stages of being progressed, with many in the planning phase
   - No project/priority has been delivered as yet
   - Some consistent underlying challenges e.g., workforce and IT have been identified
   - There is an urgent need to undertake 'Deep dives' with each Clinical Lead and understand the potential for delivery and impact.
   - Almost a third of all projects/priorities fall in the 'system resilience/transformation' bucket. Consideration needs to be given as to whether this is likely to 'trigger' the NHSE Service Change assurance process with the ICB.
   - Urgent need to triangulate the Clinical Network priorities/projects with the HVLC and GIRFT work to ensure there is a coordinated value and impact of work being undertaken.

5. Workforce HR & OD
   The update report highlighted the positive progress being made in key areas such as International AHP recruitment, Theatres staff marketing, and the pursuit of an ESR Lead to drive forward the ESR alignment programme of work, in addition to a variety of staff workshops planned to progress strategic discussions.

   Key barriers to staff movement remain around IT (e.g., Shared IT Helpdesk), Estates (e.g., ID Cards, Car Parking) and Mandatory Training for which solutions are being actively explored.

6. Digital as an enabler of the BCPC Programme
   It was noted that for safety reasons there was a need to proceed in procuring an EPR rapidly at RWT which would align with that of WHT. Consequently, and for foreseeable future, it was agreed that there would be a 'North-South' approach to the alignment of EPR systems, with the hope that this would converge at some point in the future.

   The development and establishment of a PTL was also generally supported, however the issue of capacity to progress this was raised as a concern.

   Agreement was reached on the options for shared network and access and it was agreed that the COO's and CIOs would get together to review all existing IT/Digital projects at each Trust to determine the prioritisation of work. At would seek to progress this and an independent Chair would be sourced for this short-term task.

7. Communications & Engagement
   Following consultation, agreement was reached on the vision statement for the Provider Collaborative. It was also agreed to establish a standalone website as a key channel through which to showcase and engage upon the work of the collaborative, along with communications resource to support the work.

8. Strategic Developments
   Surgical Robotics – A group has been established to oversee the business case and process for surgical robots. This will include the development of an implementation programme, embracing mobilisation, estates, and training workstreams.

   External opportunities to secure TIF2 Capital resource are also being pursued which has enabled the option of including an additional Orthopaedic Robot (approved within WHT internal processes). Final details of the bid are yet to be confirmed.

   Update from the ICB – The ICB COO attended the executive meeting and provided some key messages around the progress and next steps for the ICB, this included:
   - the development of system wide governance arrangements ('target operating model),
   - the process for developing and establishing the Joint Forward Plan (and its subcomponents),
   - process for establishing strategic commissioning arrangements through the new ICB Committees.

9. Recommendations
   The Board are asked to note the progress made within the provider collaborative, including next steps regarding proposals for developing a scheme of delegation.

MEETING OF THE Trust Board – 7th December 2022			
Sustainability Report			
Report Author and Job Title:	Janet Smith Head of Sustainability	**Responsible Director:**	Simon Evans Group 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 and to seek approval of the Trust Climate Change Adaptation Plan.

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 progress of Green Plan implementation, Net Zero Estates Delivery Plan – Actions and Targets, Trust Climate Change Adaptation Plan, funding opportunities as well as the action priorities in the next 6 months.

Green Plan implementation

a) ***Reduction of the proportion of desflurane used in surgery to less than 5% of overall volatile anaesthetic gases by volume by 31 March 2023***. As of October 2022, the proportion of desflurane used in surgery is at 9.3% which is higher than the 5% national target. The increase was due to supply issues with Sevoflurane which is the product recommended to replace desflurane. The Anaesthetic Department will continue implement the reduction measures to ensure that the level of use remains within the national target.

b) ***Greening Services Scheme.*** The Gloves rationalisation scheme spearheaded by the Infection Prevention and Control Team is launching on 21st November. PPE are currently funded at the national level. By 1st April 2023 national funding will cease and the Trust will have to fund the projected spend of £820,364.69 (see attachment 1). The biggest contributor to PPE usage is examination gloves. In 2021/22 5,445,645 gloves were used in the Trust which contributed to 141,587kgCO2e to the Trust carbon emissions. At its current usage rate, the Trust would need allocate £421,438 to fund the purchase of gloves. Reducing use by 20% through the scheme will result in 28,317kgCO2e reduction in carbon emissions and £84,288 financial savings.

c) **2022-23 Greener NHS regional and national deliverables** The Trust has delivered majority of the deliverables except for the implementation of Walking Aids Reuse Scheme and reducing the use of Nitrous Oxide and Entonox. Reducing Nitrous Oxide and particularly Entonox which is used by Maternity Services will require substantial

capital input. RWT is piloting the implementation of the walking aids reuse scheme. The scheme will be extended to WHT by March 2023.

Net Zero Estates Delivery Plan – Actions and Targets

NHS England and NHS Improvement published the Technical Annex to the Estates Net Zero Plan 26 October 2022. The Technical Annex details the interventions, activities and target dates required to achieve the eleven strategic actions within the Estates Delivery Plan. Attachment 2 shows the summary of actions and targets that the Trust are expected to deliver. An update on the Trust position vis-à-vis targets will be provided in the next report.

Planning for Climate Change: A Climate Change Adaptation Plan.

The Trust Green Plan help the Trust contribute to tackling Climate Change by reducing our own carbon emissions thereby achieving net zero emissions by 2040. This complementary plan seeks to assess and set out action to address the effects of climate change that are already being experienced, observed, or anticipated, even if globally nations do meet their carbon emissions targets. Annex 1 and 3 of the plan (Included in the reading room pack) provides a detailed climate change risk and impact assessment as well as a detailed action plan.

Funding opportunities

1. SBRI Healthcare Competition 22: Delivering Net Zero NHS: Clinical Innovation Competition
2. Innovate UK KTN - Net Zero Heat Programme
3. Public Sector Decarbonisation Scheme (PSDS) future funding rounds.

Action priorities of the next 6 months are the following:

1. Update Green Plan carbon reduction targets and action plan based on the result of the carbon footprinting exercise.
2. Recruit clinical and non-clinical services in “Greening Services Scheme”.
3. Implement a Walking Aids Reuse Scheme
4. Mid-year review of the Green Plan.
5. Sign off an adaption plan as required in the newly released Green Plan guidance.

Carbon reduction initiatives that require capital funding are:

1. Implementation of mixed recycling scheme in all Trust sites. This includes the funding required to implement the walking aids reuse scheme.
2. 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.
3. Decarbonising Trust estates with heat decarbonisation as priority

4. RECOMMENDATIONS

To discuss the progress, approve the Trust Adaptation Plan, the priorities for the next 6 months, the funding opportunities, and the resource implication for planned initiatives.

Walsall Healthcare NHS
NHS Trust

PPE Usage & Predicted Spend

Based on Data from NHSSC & PPE Foundry

Caring for Walsall together

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

PPE usage over the years

PPE Item	FY 19/20	FY 20/21	FY 21/22	YTD 22/23 (Apr – Nov)
Examination Gloves S (Pairs)	1,288,600	1,499,513	1,546,450	922,000
Examination Gloves M (Pairs)	1,998,050	2,184,914	2,363,000	1,401,200
Examination Gloves L (Pairs)	1,113,500	1,427,240	1,470,400	894,100
Examination Gloves XL (Pairs)	54,470	71,460	65,795	38,684
White Apron	1,528,700	2,628,205	2,458,153	1,281,900
IIR Masks	140,350	2,730,602	2,304,890	1,132,694
FFP3	18,710	185,630	119,220	22,363

Predicted Spend FY 23/24

PPE Item	FY 19/20 Unit Price	FY 22/23 Unit Price	Percentage Variance	Predicted Spend 23/24
Examination Gloves S (Pairs)	£0.04	£0.08	109%	£130,871.31
Examination Gloves M (Pairs)	£0.04	£0.07	85%	£174,029.04
Examination Gloves L (Pairs)	£0.04	£0.07	98%	£111,047.22
Examination Gloves XL (Pairs)	£0.04	£0.08	84%	£5,490.92
White Apron	£0.02	£0.02	0%	£45,489.14
IIR Masks	£0.09	£0.15	53%	£301,458.42
FFP3	£0.93	£1.31	41%	£51,978.64
			Total Predicted Spend including 3.5% Inflation	**£820,364.69**

Attachment 2

Summary of actions, dates, and responsible groups (green) in the Estates Net Zero Delivery Plan Technical Annex

Action	Date	Responsible Groups				RWT Implementation Status	Comments
		Trusts & FT	Primary Care	ICSs/Regional	National		
Strategic Action 1: Make every kWh and m3 count							
NHS trusts, NHS foundation trusts and primary care to review options to install energy metering at building level (both electricity and heat) and establish a programme to install metering where feasible	2022/23	+	+				
NHS trusts, NHS foundation trusts and primary care to review options to install energy metering at floor level (both electricity and heat) and establish a programme to install metering where feasible	2026/28	+	+				
NHS trusts, NHS foundation trusts and to review options to install energy metering at department level (both electricity and heat) and establish a programme to install metering where feasible	2028/30	+					
NHSE to establish a central data collection and storage system for energy data for secondary care, followed by primary care	2022/23 (SC) 2025/26 (PC)						
NHS trusts and NHS foundation trusts to track carbon reduction progress and produce annual reports for their boards (Specified in Green Plan guidance)	2022/23						
NHS trusts and NHS foundation trusts to incorporate NZ capital projects in line with the 4-step plan into organisation budgets and report through ERIC (Existing requirement in ERIC)	From 2023						
NHSE to establish a process for tracking, evidencing, and sharing the carbon benefits of successful technologies	From 2022/23						
NHS trusts, NHS foundation trusts and primary care to review options to install building-level water metering at all sites	By 2023/24	+			+		

NHS trusts and NHS foundation trusts to review options to install leak detection systems	By 2026						
NHS trusts and NHS foundation trusts to carry out sustainable urban drainage system assessments	By 2028						
NHSE to develop standard job descriptions, a competency framework, and accountability for energy managers	2022/23						
NHS trusts and NHS foundation trusts to have access to energy management expertise (at least 0.5 FTE), funded from their own resources (As per existing ERIC reporting field)	2023/24						
NHSE and Regional Estates Delivery Groups to develop local plans for engaging new energy expertise where required	2023/24						
NHSE and each region to set up the internal infrastructure, accountabilities, and governance to run its Regional Delivery Group	2022/23						
NHSE and Regional Estates Delivery Groups to develop a schedule of events and invite external experts to participate	2022/23						
NHSE to develop an engagement plan to share best practice, upcoming events and encourage membership to the Regional Estates Delivery Groups	2022/23						
NHSE to explore opportunities to incorporate responsibility for efficient energy use into all EFM job descriptions	2022/23						
Trusts and Foundation Trusts to incorporate energy use accountability into estates staff inductions	2023/24						
NHSE to develop an educational campaign to raise awareness of individual impacts on energy consumption, taking account of individuals' abilities to act in the context of their role	2023/24						
NHSE to develop NZ content for inclusion in estates inductions	2022/23						
Strategic Action 2: Run on 100% clean, renewable energy							
NHSE to review options for existing energy contracts and develop standard frameworks for procurement strategies	2022/23						
NHSE to develop and run campaign to raise awareness of appropriate strategies for energy procurement	2023/24						
All NHS trusts and NHS foundation trusts to have a heat decarbonisation plan, identifying and prioritising the phasing out of existing systems	2023/24						
NHS trusts and NHS foundation trusts to utilise the Heat Decarbonisation Plans to identify opportunities to increase on-site electricity supply for use in heat pump solutions and EV	2023/24						
NHSE to measure the impact of progress made towards net zero	From 2023						

Remove all coal and oil-led primary heating systems (Long Term Plan commitment)	By 2028						
ICSs to develop local and regional plans to increase the amount of renewable energy produced and stored on-site and/or near-site	By 2023/24						
NHS trusts, NHS foundation trusts and primary care to utilise zero carbon building energy, including renewable on-site or owned sources, to cover at least 80% of their emissions (As set out in the "Delivering a Net Zero NHS" report)	2028-2032						
Strategic Action 3: Increase resource productivity							
NHSE to work with NHS trusts and NHS foundation trusts to improve timeliness and accuracy of waste data	By 2022/23						
Every organisation to have a clear plan to transform waste in line with HTM 07-01, which is being revised and published in 2022/23	By 2023/24						
NHS Trusts and NHS foundation trusts to eliminate waste sent to landfill	2025/26						
Ensure every NHS trust and NHS foundation trust has access to waste management expertise (at least 0.5 FTE), funded from their own resources (As per existing ERIC reporting field)	By 2023						
Strategic Action 4: Reduce volume of residual waste							
NHS trusts, NHS foundation trusts, ICSs and the National NHS Estates and Facilities team to work with procurement and our own supply chain to eliminate waste streams where practical	From 2022/23						
Strategic Action 5: Using ULEV and ZEV							
NHS trusts, NHS foundation trusts and ICSs to review existing vehicle procurement contracts and develop a standard framework for regional procurement strategies (Long Term Plan commitment)	To meet LTP 2028 targets						
Strategic Action 6: Establish EV ready estates							
All organisations to have installed EV charging infrastructure to support transition of their owned and leased fleet to zero emission vehicles (excluding ambulances)	2028						
NHS trusts, NHS foundation trusts and ICSs to plan deployment of EV infrastructure by identifying local/regional grid capacity and work with local network operators and/or local authority to plan for increased capacity where necessary	2025						

Strategic Action 7: Ensuring our suppliers meet the minimum standards expected on net zero and social value Strategic Action 8: Ensure all our construction and capital spend is net zero carbon and all tenders included a minimum of 10% weighting for social value							
NHS trusts, NHS foundation trusts, primary care organisations and ICSs to ensure that construction and capital spend includes 10% social value weighting (As set out in "Applying net zero and social value in the procurement of NHS goods and services" report)	From March 2022						
NHS trusts, NHS foundation trusts, primary care, and ICSs to use the Economic Case guidance within HM Treasury Green Book Guidance to assess the economic impacts of capital spend and consider the wider environmental impacts (Existing government guidance)	2022/23						
National NHS Estates and Facilities team to ensure all applicable new builds and major refurbishments are compliant with the NHS Net Zero Building Standard	2023/24						
Strategic Action 9: Increasing healthier, more sustainable menu choices							
NHSE to deliver national recipe and menu bank to offer healthier, lower carbon options for patients, staff, and visitors	2022/23						
NHS trusts and NHS foundation trusts to review and adapt menus to offer healthier, lower carbon options for patients, staff, and visitors	2023/24						
NHS trusts and NHS foundation trusts to implement approaches to measure and reduce food waste (kitchen spoilage and preparation waste, unserved meal, plate waste)	2023/24						
Estates and Facilities teams to have input into their trusts' Food & Drink Strategy, meeting the guidelines set out in the Hospital Food Standards Panel Review	From 2023/24						
Strategic Action 10: Prepare our estates for severe weather events							
NHS trusts, NHS foundation trusts and ICSs to incorporate predicted climatic changes into estates strategies, PCN estates plans, and Business Continuity Plans	As developed						
NHSE to develop a climate change risk assessment to share with trusts / ICSs	2022/23						
ICSs and National NHS Estates and Facilities team to ensure all NHS trusts, NHS foundation trusts, and primary care have specific plans for flooding and overheating where necessary, and monitor their risks/occurrence(s)	2025						
ICSs to use organisational plans for flooding and overheating to develop and prioritise actions in each ICS long term adaptation plan	2025						
Strategic Action 11: Support and encourage our staff to make lower-carbon travel choices							

NHS trusts and NHS foundation trusts to ensure that existing travel plans include support for walking and cycling specifically as this relates to estates infrastructure	2023/24	+					

Summary of actions, dates, and responsible groups (green) in the Estates Net Zero Delivery Plan Technical Annex. Newly introduced recommended actions for trusts, foundation trusts and primary care are indicated with a +

Delivery status

On Track

Slippage

High Risk Against Delivery

Delivered

TBC

Walsall Healthcare NHS
NHS Trust

Planning for Climate Change: A Climate Change Adaptation Plan

2022

Contents

Version control

Name:	Climate change adaption Plan
Version:	V0.03
Date published:	
Owner:	Simon Evans, Group Chief Strategy Officer
Author:	Janet Smith, Head of Sustainability
Consultation:	WHT Estates and Facilities Management Team WHT Emergency Preparedness, Resilience and Response (EPRR) Team Sustainability Group
Next review date:	TBA

Version history

Version	Date	Reason for change
V0.01	02.02.22	First draft for Chief Strategy Officer and Sustainability Group review and comments
V0.2	13.10.22	Final draft incorporating comments from EPRR Lead and Divisional Director, Estates and Facilities
V0.3	18.11.22	Submitted to TMC and Trust Board for approval
V0.4		
V0.5		
V1.0		

Purpose

To provide a clear outline of what is required to enable the Walsall Healthcare NHS Trust to prepare, mitigate and put in adaptation measures to cope with the impacts of climate change.

Our **Green Plan** will help the Trust contribute to tackling Climate Change by reducing our own carbon emissions thereby achieving net zero emissions by 2040. This complementary plan seeks to assess and set out action to address the effects of climate change that are already being experienced, observed, or anticipated, even if globally nations do meet their carbon emissions targets.

This will help the Trust to continue preparing for climate change, demonstrating action on the **Green Plan** and the NHS Net Zero Carbon goal to ensure that policies, programmes, and investment decisions consider the possible extent of climate change.

Scope

This adaptation plan is a part of a set of Trust sustainability plans and strategies that supports the NHS Net Zero Carbon targets and commitments and can be found in Reports and publications - Walsall Healthcare NHS Trusthttps://www.walsallhealthcare.nhs.uk/about-us/how-we-are-run/reports-and-publications/t It covers all clinical and non-clinical services within the Trust.

It has been written for a wide audience, and will be of interest to all staff, in particular:

- Estates management
- Emergency planning, resilience, and response
- Executive team
- Clinical divisions
- Finance division
- PFI partners/contractors who provide services for and/or on behalf of the Trust
- ICT Services

All individuals working on the estate or on behalf of the Trust, whether staff or contractors, are expected to follow the principles of this plan, and any related guidance.

Drivers

1. National Driver

Even with determined efforts to limit global warming, further climatic changes are inevitable in the future and the UK will need to manage the growing risks from climate change. The latest generation of national climate projections, UK Climate Projections 2018 (UKCP18), provides users with scientific evidence on projected climate changes. This up-to-date and robust source of information is used by the UK government and its departments to inform decision making when responding to climate change. The general climate trend predicted by UKCP18 for UK land is an increased chance of warmer, wetter winters and of hotter, drier summers, along with an increase in the frequency and intensity of extremes. Under UKCP18, Storm Desmond, which occurred in winter 2015/16 and caused £1.3 billion in insurance costs, was deemed more than 40% more likely due to climate change. The Intergovernmental Panel on Climate Change (IPCC) also summarises the increasing impact of climate change, and highlights in its latest report that the projections are following a worsening scenario.

By 2061:

- Summers will likely be drier by 16-42%, and hotter by 3.6ºC-5ºC
- Hot spells of over 30ºC for more than 2 days are likely to occur around 4 times a year
- Winters will likely be wetter by 16-42%
- The intensity of rainfall over the year will likely be increased by 7.5%, significantly increasing the likelihood of flash floods

Figure 1- key predictions from UKCP18

Global temperatures have already increased by 1ºC globally. If the UK reaches the commitments made in the Paris Agreement, by limiting warming to 2ºC by the end of the century, the country is still likely to experience more frequent extreme weather events, higher sea levels, and high risks in some areas of flooding and drought, among others.

Despite a 5.6 per cent drop in fossil fuel CO2 emissions in 2020, due to restrictions related to the COVID-19 pandemic, atmospheric concentrations of the major greenhouse gases, carbon dioxide, methane and nitrous oxide, continued to increase in 2020 and 2021, according to the World Meteorological Organization (WMO) State of the Global Climate 2021 report.

This means that adaptation is necessary, regardless of the UK's effectiveness at eliminating greenhouse gas emissions, due to the emissions already released, and the subsequent effects that are 'locked-in' and the warming that has already taken place. Climate Adaptation is also included in the United Nations' Sustainable Development Goals (UN SDGs), and the UK wishes to demonstrate leadership in the delivery of these goals.

The Greening Government Commitments state that:

> "Climate resilience planning and mitigation shall be incorporated at all business levels. Strategic climate impact risk mitigation shall be embedded in strategic programmes and plans including estate rationalisation and disposal. Similarly, climate mitigation and adaptation measures shall be incorporated into projects to ensure deliverables are climate resilient. Where climate risks are identified, appropriate adaptation actions shall be undertaken"

Advice on a net-zero emissions target for 2050 was published by the Committee on Climate Change (CCC) on 2 May 2019. On 27 June 2019 the Climate Change Act 2008 (2050 Target Amendment) Order 2019 came into force. This amended the Climate Change Act 2008 and introduced a net zero target of at least a 100% reduction of greenhouse gas emissions (compared to 1990 levels) in the UK by 2050.

In line with Government's statutory adaptation duties in the Climate Change Act 2008, Government must produce, on a five-yearly cycle, a UK Climate Change Risk Assessment (CCRA), followed by a National Adaptation Programme (NAP). The NAP is a cross-departmental collaboration, bringing together government's policies on managing climate risks in one place. Defra is the lead department for adaptation, and responsible for co-ordinating adaptation work across government. The NAP is primarily for England but also covers reserved and non-devolved matters. Devolved administrations lead their own adaptation programmes. The second NAP was published in 2018, setting out how the UK will address climate risks between 2018 and 2023. It includes actions in a broad range of areas, including flood and coastal erosion risk management, both in the built and natural environment.

The CCC published its 2019 Progress Report to Parliament (July 2019) warning that:

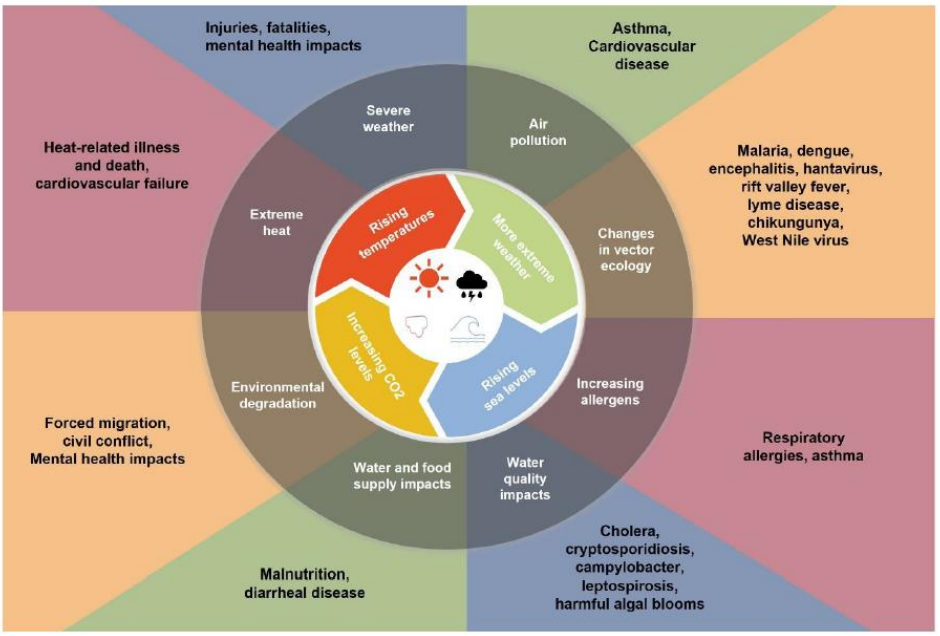
> "Even if net zero is achieved globally, our climate will continue to warm in the short-term, and sea level will continue to rise for centuries. We must plan for this reality. Climate change adaptation is a defining challenge for every government"
>
> "Global average temperatures have already risen by around 1ºC since pre-industrial levels and climate risks are increasingly apparent. Annual average temperature in England has also increased by 1ºC and will keep increasing – by only 0.5ºC by 2100 if the world acts quickly and decisively to cut emissions, but by 4ºC+ if current trends continue. We must therefore plan adaptation strategies for a minimum of 2ºC and up to 4ºC."

Climate Change Impact on Health

Climate change, together with other natural and human-made health stressors, influences human health and disease in numerous ways. Some existing health threats will intensify, and new health threats will emerge. Not everyone is equally at risk. Important considerations in assessing the impact of climate change to individuals include age, economic resources, and location.

In the U.K., public health can be affected by disruptions of physical, biological, and ecological systems, including disturbances originating within the UK and elsewhere. The health effects of these disruptions include increased respiratory and cardiovascular disease, injuries and premature deaths related to extreme weather events, changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health. Figure 1 below shows he impacts of climate change on human health.

Figure 1: Impacts of climate change on human health[iv]



The Department of Health and the NHS has required each Trust in England to prepare and implement a climate change adaptation plan in response to the impact of climate change to the health economy. Adaptation and mitigation actions to build the health sector's climate resilience must be taken so it can effectively respond to climate impacts.

Adaptation plans do not need to explicitly reference temperature thresholds. Climate change certainly has consequences beyond simply increasing temperatures. However, it is a key

principle of resilience preparation to plan for a wide range of possible future changes, and thus adaptation plans should include preparation for reasonable worst-case climate change scenarios. Planning for more extreme change is appropriate where there are high vulnerabilities, low risk tolerance, and a long planning or investment cycle. Adaptation in relation to health and social care are actions or processes that reduce mortality and morbidity associated with climate change, while strengthening the sector's capacity to provide a high standard of care while the climate changes[1]

2. Local Driver

Walsall Council declared a climate change emergency on 16th September 2019 and committed to becoming a net zero carbon authority by 2050. In October 2020, the council published a 5-year Climate Emergency Action Plan 2020-2025. The plan describes the actions the council will take to achieve carbon neutrality and has been categorised in target areas of action:

- Strategy (Taking the Lead)
- Energy
- Waste & Consumption
- Transport
- Nature
- Resilience & Adaptation

It sets out the initial opportunities the council have identified to reduce carbon emissions relating to the council's own estate and operations. It will also continue to engage staff and stakeholders to expand the range of actions that will help meet its target. The plan encompasses Scopes 1-3 emissions using best practice guidance as set by the Greenhouse Gas Protocol.

The Trust has a long-standing partnership with the Council in delivering initiatives to support the city's sustainability agenda such as:

- Reduction of travel and transport carbon footprint by implementing sustainable travel initiatives
- Participating and promoting the Council's walking and cycling strategy
- Supporting the council's targets in improving air quality by reducing "care miles"
- Supporting the scheme that encourages business to eliminate single-use plastics through the implementation of the Trust Green Plan

Strategic Objective

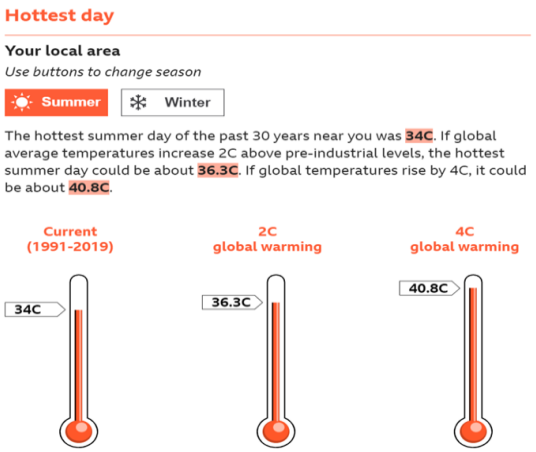
Climate change affects safety, health, infrastructure, and food supplies, and should inform the way the Trust conducts its business going forward.

The Trust must act now to prepare for the likely impacts of climate change. This means the Trust will be considering its estate, its policies, and its people in planning now for the

[1] Third Health and Care Adaptation Report December 2021

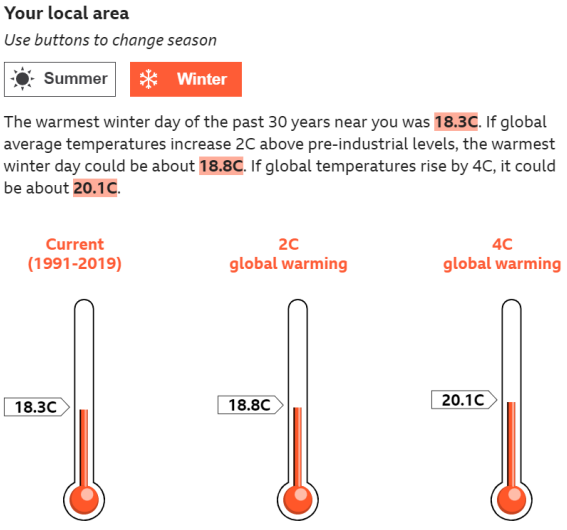
impacts of a 2ºC increase in global and UK temperatures, whilst being aware that a 4ºC increase is a real possibility.

In Walsall, the hottest summer day of the past 30 years was 34C. If global average temperatures increase 2C above pre-industrial levels, the hottest summer day could be about 36.3C. If global temperatures rise by 4C, it could be about 40.8C.



Source: The Met Office climate projections
What will climate change look like in your area? - BBC News

The warmest winter day of the past 30 years in Walsall was 18.3C. If global average temperatures increase 2C above pre-industrial levels, the warmest winter day could be about 18.8C. If global temperatures rise by 4C, it could be about 20.1C.



Source: The Met Office climate projections
What will climate change look like in your area? - BBC News

In warmer winters the heaviest rains are likely to get more intense. If global average temperatures rise by 4C above pre-industrial levels, half the UK could expect at least 20% more rainfall on the wettest winter days.

What difference will climate change make?

As the world warms, the UK is likely to have hotter, drier summers and warmer, wetter winters, according to the Met Office. Extreme weather events such as heatwaves and heavy downpours could become more frequent and more intense. To some, warming weather may not seem like such a big deal. But even the smallest incremental changes in climate can have far-reaching effects. Temperatures above 30C for two or more days can trigger a public-health warning. In the 1990s, this happened about once every four years for locations in the South. By the 2070s, projections suggest it could be as frequently as four times per year - 16 times more often if we do not curb our emissions.

The impacts of climate change are already being seen within the Trust particularly at its Manor hospital site and key community facilities (Hollybank and Palliative Care Centre) which in the last three years has experienced frequent unbearable temperatures in its clinical and non-clinical areas. The Trust hired air condition units to mitigate within clinical areas and distributed water and ice lollies for both patients and staff as well implemented actions as set out in the Trust heatwave plan. Although the mitigation actions were effective in previous years, this year the extreme heat which reached 41C had negated its impact particularly in non-clinical areas.

Commented [JL1]: Unbearable needs to be qualified as mitigation has been in place to mitigate this.

Key Identified Risks

The climate change risks that the Trust faces include those to the health of the population it serves and risks to the delivery of services through changes in service patterns and to infrastructure. The risks presented in the table below have been identified by the CCC under the CCRA2 and are relevant to the Trust. Where mitigations or adaptations are not already in place, these will be assigned owners in the Action Plan, found in Annex A.

Figure 1 shows the top 6 risks to the UK from climate change (Source: UK Climate Risk Assessment 2017)

The UK Climate Change Risk Assessment 2017 (CCRA2) identified 56 risks to the UK from climate change. This means we must prepare for:

- the impact of heatwaves and overheating on buildings (and cold winter extremes)
- risks to health, wellbeing and productivity from high temperatures, adverse weather, and increased risks of air pollution
- increasing likelihood of flooding events, alongside impacts on service disruptions and communities
- water shortages
- food supply and agriculture production and trade disruption
- infrastructure malfunction and unavailability
- impact on natural capital and ecosystems

This will be achieved through:

- Evaluate and mitigate climate change effect on clinical services- Air pollution, Hotter, drier summers; milder, wetter winters; increased extreme weather events, including flooding and heatwaves
- review and update of the Trust Estates Strategy to take into consideration the mitigation and adaptation requirements of current and future estate
- review and update of the Trust building, mechanical and electrical standards ensuring that it is aligned with the new Net Zero Carbon Building Standards, Construction Playbook, Estates Net Zero Carbon Delivery Plan and Net Zero Carbon Modern Methods of Construction
- Utilisation and careful application of several tools, including UKCP18 and the EA climate change risk assessment toolkit, among others.

The Trust's key priorities - risks and mitigation/adaptation

For the purposes of this plan, mitigation is defined as any action taken, or to be taken, by the Trust to reduce emissions or to reduce the likelihood of the risk. Adaptation is defined as actions taken or to be taken to maintain safety, integrity, and security in the context of an already changing environment. Adaptation will need to encompass changes to the existing estate as well as choices to ensure all future sites or buildings will be prepared for the consequences of up to 4ºC of global warming.

Risk	Effect	Mitigation	Adaptation
Health effects of climate change	Ground-level ozone (a key component of smog) is associated with many health problems, such as diminished lung function, increased hospital admissions and emergency room visits for asthma, and increases in premature deaths	Implement Trust Emergency Preparedness, Resilience and Response policy and Trust Business Continuity Policy Identify and put in place appropriate business continuity measures to ensure continuity of service provision during severe weather events: • as a priority, identify service users who are vulnerable in	Trust EPRR team to work closely with national and local estates teams to identify, prioritise, and implement local adaptation plans. Work with Health Education England and other national, regional, and local bodies in developing and implementing tailored training materials to educate Trust staff on climate change mitigation and adaptation.
	Increases in respiratory and asthma-related conditions due to exposure to toxic air pollutants and allergens		
	Increased hospital		

Commented [JL3]: We have looked at certain issues regarding the estate and significant investment is required to be able to manage how we need to work. Will the proposed collaboration bring joint resources to the table to assist in the works needed?

Commented [JL4]: Who will lead on this piece of work – will the current WHT staff be part of this works or will it be a joint venture across the 2 organizations?

	admissions for cardiovascular, kidney, and respiratory disorders associated with heat waves	severe weather events; and • during severe weather events, continue to work with the national and local partners and other Departments to develop effective public safety messaging.	Assess all service delivery plans to ensure they are climate resilient and climate change mitigation and adaptation is embedded within the plan
	Increase in diseases carried by vectors such as fleas, ticks, and mosquitoes, which spread pathogens that cause illness		
Extreme weather events such as flooding, storms and droughts	Temporary loss of use of buildings or parts of buildings or buildings are lost entirely.	Ensure that future building is designed to cope with and mitigate climate change and associated risks e.g., extreme heat	All sites and buildings have wider climate impact assessments including flood risk
	Increased financial costs from repairing and making good		All sites have an emergency plan that manages extreme heat, flood risk and other risks identified through the assessment
	Increased financial cost of finding alternative accommodation		New builds and refurbishment are designed to cope with extreme weather events
Overheating in buildings	Buildings (or areas of buildings) become too hot and are unusable.	Increase use of green (trees, hedgerows, etc.) and blue infrastructure (water treatment facilities, ponds, etc.) to absorb CO2 emissions and support climate resilience, as well as improving insulation	Conduct site survey and use the result to inform adaptation plans/actions.
	Increased cost and CO2 emissions from the use of temporary portable cooling systems		Build in more natural ventilation, solar shading, and natural cooling. Improve Building Management System (BMS) controls.
	Compromises the health and welfare of patients, staff and members of the public using Trust buildings	Implement Trust heatwave plan	Build in more natural ventilation, solar shading, and natural cooling.
			Ensure that emergency plans are in place that consider the likely intensity and frequency of heat.
Underheating in buildings	Buildings becomes too cold and unusable	Ensure that future building is designed to cope with and mitigate climate change and associated risks e.g., extreme cold	Conduct site survey and use the result to inform adaptation plans/actions.
	Increased cost and CO2 emissions from the use of temporary portable heating systems		Improve building insulation and improve Building Management System (BMS) controls.
	Compromises the health and welfare of patients, staff and members of the public using Trust buildings	Implement Trust severe weather plan	Ensure that emergency plans are in place that consider the likely intensity and frequency of heat.

Commented [JL2]: This work has been done and we need significant investment to further manage the environment for this group of people – mitigation current will involve further increases in energy that will adversely affect the carbon foot print.

Commented [JL5]: Will this piece of work be done with the clinical division especially with medicine and community colleagues?

Commented [JL6]: Assume that this will be part of the work the Capital team will identify and give assurance?

Commented [JL7]: Assume that this will be the plans that we currently hold. There was a flood risk assessment as part of the ED works. As Comment [JL1] flooding does not feature as a significant risk for this acute site.

Commented [JL8]: Assume that this will be built into any planning for the site including works done by the PFI partner? Who will control/manage/assure these schemes as part of the planning and business case process?

Commented [JL9]: Who will be doing these?

Commented [JL10]: These issues are significant in the Modular Ward Block. Solar shading was considered but was extremely expensive and so curtains and mechanical air conditioning units were hire which is not sustainable in the long term.

Commented [JL11]: This is part of the lifecycle programme that requires funding.

Commented [JL12]: As comment [JL12]

Commented [JL13]: Improved plans need to be in place but there is not the capital to do the works that are required and so the heatwave plan includes the hire of air conditioning units which is not sustainable but necessary until sufficient capital is allocated to improve the current systems or build new compliant facilities.

Commented [JL14]: As over heating comments

Commented [JL15]: As comment [JL13]

Commented [JL16]: As over heating comments.

Disruptions to transport and other critical infrastructure	Compromises Trust facilities capacity due to reduced ability to move or discharge patients.	Increase the use of digital services such as webinars/ video conferencing or telephone use to reduce the need to travel. Implement Trust Business Continuity Plan	Ensure that the Trust business continuity plans include measures to reduce effects.
	Safety compromises due to impacts on staff movements		Work collaboratively with Local Authorities and other infrastructure bodies to anticipate and prepare for eventualities
	Cascading failures or interdependencies across infrastructure systems causes disruption of delivery of essential supplies such as food and medicine to Trust premises		
Disruption to Power	Greater demand on electricity supply for heat pumps and EV charging etc. will but a strain on the electrical distribution infrastructure.	Increase MIC (Maximum Import Capacity). Increase DNO supply cables to Trust sites. Increase switchgear and cabling to handle increased loads. Implement Trust Business Continuity Plan	Model increased loads and design necessary electrical infrastructure to cope with predicted load growth.
	Potential for Blackouts or Brownouts.		Consider solar PV panels across Trust estate

Commented [JL17]: Plan in the past has included transport in severe weather. Need to work with WMAS. RWT have taken transport functions for WHT . WHT does not have a fleet.

Commented [JL18]: Relevant comms in regard to significant travel disruption as usually sent out from the Highways Authority. The hospital being between 2 junctions of the M6 can sometime be an issue if there is disruption on the M6.

Commented [JL19]: This needs to be picked up and worked through with the PFI partners and the local grid. The Trust does have generators on site but the mains power is supplied through 1 mains to site and then it is divided to provide greater resilience but enquiries to have a second feed from Bentley substation was several millions of pounds and this was a significant time ago.

Commented [JL20]: Would welcome the opportunity but would require survey and funding.

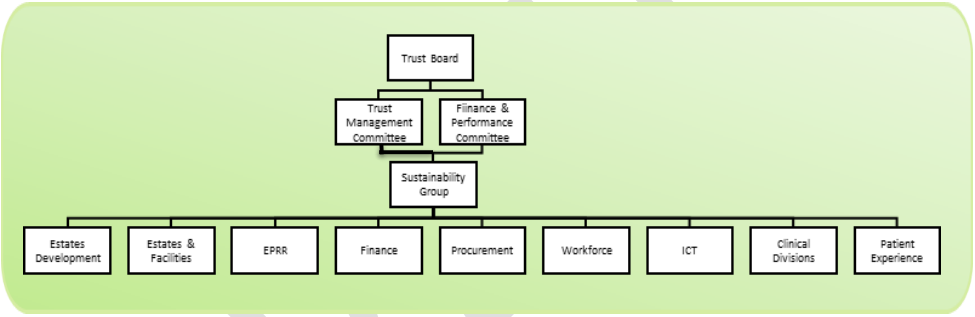
Governance

The Sustainability Group is responsible for ensuring the delivery of the Trust's Green Plan, to lead corporate activities to embrace sustainable development, tackling health inequalities and reducing the Trust's carbon footprint through value for money solutions that enable the achievement of the Trust's service and estate strategies. This Adaption Plan being a complementary plan to the **Green Plan** will follow the same reporting and governance structure as shown in Figure 1

Commented [JL21]: This is in its infancy and requires resourcing which hopefully will be available through the proposed collaboration.

Figure 1: Reporting and Governance Structure

Commented [JL22]: Will there be a pharmacy rep for sustainability group to look at med gases and medicines? There also needs to be a link to the PFI partnership.



Annex 1: Action Plan

Key Risk	Actions		Time Frame	Department/Division Responsible
	Type	Description		
Health effects of climate change	Mitigation	Implement Trust Emergency Preparedness, Resiliency and Response plan	March 2022-40	EPRR
	Adaptation	Improve public education for vulnerable populations (asthma, COPD) on the use of the EPA's Air Quality Index for Health, on the causes of air pollution and aeroallergens, and on what they can do to reduce exposure	March 2023-40	Public Health England/Walsall Together/All divisions
	Adaptation	Ensure effective health service planning for climate resilience. This includes planning for possible changes in volume and pattern of healthcare demand specifically due to climate-related impacts (Such as vector-borne diseases dengue, malaria, and Lyme; mental health needs; and increased migration). Special attention to vulnerable population groups.	March 2023-40	All Divisions – Nurse Director
	Adaptation	Identify and put in place appropriate business continuity measures to ensure continuity of service provision during severe weather events: • as a priority, identify service users who are vulnerable in severe weather events; and • during severe weather events, continue to work with the national and local government and other Departments to develop effective public safety messaging	March 2022-40	EPRR/all divisions
Extreme weather events such as extreme heat, flooding, storms, and droughts	Mitigation	Ensure that future building is designed to cope with and mitigate climate change and associated risks e.g., extreme heat	April 2022-40	Estates Development/Estates & Facilities
	Adaptation	All sites and buildings have wider climate impact assessments including flood risk	March 2024	Estates Development/Estates & Facilities
	Adaptation	All sites have an emergency plan that manages extreme heat, flood risk and other risks identified through the assessment	March 2022	EPRR/Estates & Facilities
	Adaptation	New builds and refurbishment are designed to cope with extreme weather events	April 2022-40	Estates Development/Estates & Facilities
	Adaptation	Review and update the Trust Building, Mechanical and Electrical Standards to ensure that it is aligned with the Net Zero Building Standards	March 2022-23	Estates Development/Estates & Facilities/PFI partner
	Adaptation	Review and update the Trust Drainage System Strategy. Implement required upgrade and robust maintenance of the system	March 2023-40	Estates Development/Estates & Facilities/PFI partner.
Overheating in buildings	Mitigation	Increase use of green (trees, hedgerows, etc.) and blue infrastructure (water treatment facilities, ponds, etc.) to absorb CO2 emissions and support climate	March 2040	Estates Development/Estates & Facilities

		resilience, as well as improving insulation		
	Adaptation	Conduct site survey and use the result to inform adaptation plans/actions.	March 2023	Estates Development/Estates & Facilities/PFI partner.
	Adaptation	Improve Building Management System (BMS) controls.	March 2025	Estates Development/Estates & Facilities/PFI partner.
	Adaptation	Build in more natural ventilation, solar shading, and natural cooling in new build Refurbishment of existing mechanical ventilation system Replacement of existing mechanical ventilation system with new specification aligned with zero carbon standards	March 2040	Estates Development/Estates & Facilities/PFI partner.
	Adaptation	Ensure that emergency plans are in place that consider the likely intensity and frequency of heat.	April 2022	EPRR/Estates & Facilities/all divisions
Underheating in buildings	Mitigation	Ensure that future building is designed to cope with and mitigate climate change and associated risks e.g., extreme cold	March 2022-40	Estates Development/Estates & Facilities
	Adaptation	Conduct site survey and use the result to inform adaptation plans/actions.	March 2023	Estates Development/Estates & Facilities
	Adaptation	Improve building insulation Improve Building Management System (BMS) controls.	March 2023	Estates Development/Estates & Facilities/PFI partner.
	Adaptation	Ensure that emergency plans are in place that consider the likely intensity and frequency colder temperatures	April 2022	Estates Development/Estates & Facilities
	Adaptation	Reduction of burning fossil fuel as primary source of heating Use of heat pumps	March 2023	Estates Development/Estates & Facilities/PFI partner.
Disruptions to transport and other critical infrastructure	Mitigation	Increase the use of digital services such as webinars/ video conferencing or telephone use to reduce the need to travel	March 2023	Estates & Facilities/IT/Walsall Council
	Adaptation	Ensure that the Trust business continuity plans include measures to reduce effects of critical infrastructure disruptions	March 2023	EPRR/Estates & Facilities
	Adaptation	Work collaboratively with Local Authorities and other infrastructure bodies to anticipate and prepare for eventualities	March 2023	Chief Operating Officer

Annex 2: Further Information

Agency/Government Department	Guidance/Plans
Environment Agency	Climate Change Allowances for Planners – Guidance to support the National Planning Policy Framework For businesses/organisations requiring environmental permits- new EA process (2019): Adapting to climate change: risk assessment for your environmental permit
European Union	The EU Plan on adaptation to Climate Change: 2013 Natura 2000
NHS England	Delivering-a-net-zero-national-health-service.pdf (england.nhs.uk) NHS England Third Health and Care Adaptation Report
Defra	25-year Environment Plan Second National Adaptation Programme; Climate Change Act 2008 https://www.gov.uk/government/publications/uk- climate-change-risk-assessment-2017
Met Office/DEFRA	Second National Adaptation Programme United Kingdom Climate Projections 2018
BEIS	Paris Climate Change Agreement Clean Growth Plan https://www.gov.uk/government/publications/clean- growth-plan
BEIS and HMT	https://www.gov.uk/government/publications/green- finance-plan
Adaptation Sub-Committee (ASC) of the Committee on Climate Change (CCC)	UK Committee on Climate Change; 2019 Progress Report on Adapting to Climate Change

Annex 3: Risk Assessment

A risks and impact assessment were conducted to evaluate the potential health, social and environmental consequences of climate change to Trust services, patients, and staff. The assessment considered the following:

a. Climate variability, frequency and magnitude of extremes that are relevant for climate impact.
b. Sensitivity – the extent to which services, systems, population, etc. reacts to climate variability.
c. Exposure – refers to services, systems, infrastructure, population, etc. potentially impacted by climate change.
d. Impacts – refers to observed or potential impact of climate change taking into consideration sensitivity, exposure, and adaptive capacity
e. Consequences – results from climate impact on services, infrastructure, systems, population and accounting for adaptation and mitigation capacity.
f. Adaptation and mitigation capacity – refers to the ability of the Trust to mitigate and adapt to climate change through measures to reduce the adverse impacts and take advantage of new opportunities. Factors that will contribute to the Trust adaptive and mitigation capacity includes resource availability, information and skills, and institutional capacity.

Impact Assessment

Climate variability: High temperature/heatwaves				
Sensitivity	**Exposure**	**Impacts**	**Consequences**	**Adaptation and mitigation capacity**
Patients, staff, and public	Outdoors	Increase vector survival	Increased risk of vector borne infection	Vector and vector borne disease surveillance, investigation, and control
	Indoors, outdoors	Drought	Risks to hydration, personal and environmental hygiene, food safety and potential risks to essential healthcare	Public health risk assessment, hydration and hygiene advice
		Increased environmental spread of pathogens	Increased risk of foodborne and waterborne infection, spread of anti-microbial resistance.	Improved drinking water infrastructure for all, reduction of environmental pollution
		Increased aeroallergen levels/duration	Risk of acute exacerbations of asthma, COPD	Health advice on prevention including risk monitoring, and timely treatment

		Worsening Air pollution and UV exposure	Worsening risk of premature death Worsening skin cancer risk	Health advice, public education, skin cancer prevention plan, etc.
Climate variability: Changes in precipitation				
Sensitivity	**Exposure**	**Impacts**	**Consequences**	**Adaptation and mitigation capacity**
Patients, staff, Public	Trust facilities	Flooding, disrupted sanitation leading to environmental contamination, drought, increased environmental spread of pathogens	Risk of spread of infection and anti-microbial resistance. Destruction of property, displacement, mental health effects, carbon monoxide poisoning during clean-up Risk to hydration, personal and environmental hygiene, food safety as well as potential risk to essential healthcare Destruction of critical infrastructure, resulting in service failure	Wastewater management Alerts/warning advice Prevention of flooding through flood risk assessment and mitigation Public health risk assessment, hydration and hygiene advice Provision of alternative supplies, readmission
Climate variability: Extreme cold snaps				
Sensitivity	**Exposure**	**Impacts**	**Consequences**	**Adaptation and mitigation capacity**
Patients, staff, public	Outdoors	Disruptions and unsafe roads, and other infrastructure	Risks of injuries, disrupted access to healthcare, etc.	Winter ready, health alerts, public health risk assessment and advice
Climate variability: Windstorms				
Sensitivity	**Exposure**	**Impacts**	**Consequences**	**Adaptation and mitigation capacity**
Patients, staff, public	Trust facilities	Disrupted power Supply	Loss of heating and lighting	Emergency generator with sufficient

				alternative fuel to last through power outage. Prioritisation of power return
	Trust facilities	Disrupted communications	Loss of linkages with network hospitals, other services e.g. Ambulance services	Multiple back-up communications systems
	Trust facilities	Disrupted treated water supply, through power loss, flooding etc.	Risk to hydration, personal and environmental hygiene, food safety	Implement business continuity plan
	Unsafe roads	Disrupted access to healthcare	Risk of delayed or missed essential assessment and treatment	Maximising the Capacity of patient transport
	Falling trees, flying objects	Injuries, deaths	Destruction of critical infrastructure, resulting in service failure	Implement business continuity plan

Risk Assessment

Commented [JL23]: We need to discuss the basis of the scores as I would suggest that risk 3 and 4 are the most significant and are the hardest to mitigate without worsening the carbon or requiring investment.

Key Risk	Likelihood (1-5)	Impact (1-5)	Total Score (Likelihood x Impact = Risk Score)
Health effects of climate change	5	5	25
Extreme weather events such as extreme heat, flooding, storms, and droughts	5	5	25
Overheating in buildings	5	4	20
Underheating in buildings	3	4	12
Disruptions to transport and other critical infrastructure	3	3	9

Audit Committee
Chair Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Audit Committee
Date(s) of Committee/Group Meetings	2 September 2022 – Virtual meeting
Chair of Committee/Group:	Mary Martin
Date of Report:	28 September 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• At the end of June, the Trust was subject to a Mandate Fraud. Local Counter Fraud services were alerted and have carried out internal training and are working with investigators from the NHS Counter Fraud Authority to try to recover the sum loss. An investigation plan has been approved to fully understand the sequence of events around this incident.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	. • The committee received a presentation on the CQC action plan and in particular around Medicines Management and the Respect Audit. Good progress is being made on implementing the recommendations. • The committee received a report on the Security services. These are now being managed across both WHT and RWT by the same team and the WHT provider is now being held to account to deliver the contracted service. A full report will be prepared for the December meeting. The services are due for retender in the next twelve months and the intention is to tender for both Trusts at the same time. • .
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• RSM have six internal audits in progress which are on timetable and should be complete by the next meeting. • The timetable for the 2022/23 External Annual Audit is in place.
Recommendation(s) to the Board/Committee	• Recommendation of the Standing Orders, Reservations and Delegations of Powers & Standing Financial Instruction Policy for endorsement at Private Board
Changes to BAF Risk(s) & TRR Risk(s) agreed	• A new Board Assurance Framework template is being developed and will be introduced along with the revised Strategic Objectives. A consultation process is in progress.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• A full report of the Mandate Fraud will go to Private Board as this is a Police matter • An update on the IT road map to support areas where there are paper systems which do not help the Trust manage risk is due in December. • External Audit and Internal Audit recommendations implementation are being tracked during 2022/23.

ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• RSM presented their IT infrastructure report. There were 1 high, 3 medium and 4 low recommendations all due for completion by 31 March 2023. These will be tracked along with all other Internal Audit recommendations • A verbal update on Cyber Security was received. A full paper will come to the December meeting. • An update on staff email access was received. The staff without email access has now been reduced to 465.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Counter Fraud progress report was discussed • Single Tender action report was presented • The review of Losses and Payments was presented.
Matters presented for information or noting	
Self-evaluation/ Terms of Reference/ Future Work Plan	
Issues identified potentially relating to Equality, Diversity, and Inclusion	

MEETING OF THE TRUST BOARD **Wednesday 7th December 2022**			
Schwartz Rounds – WHT Annual report April 2021 - end March 2022			
Report Author and Job Title:	Dr Esther Waterhouse Schwartz Round Clinical Lead	**Responsible Director:**	Catherine Griffiths Chief People Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• Assurance of the value of Schwartz rounds, given good engagement and positive feedback from participants and story tellers.		
Advise	The report advises the committee in terms of actions to address: • Greater inclusion in Schwartz Rounds by non-clinical staff • Greater inclusion in Schwartz Rounds by front facing clinical staff • Greater inclusion in Schwartz Rounds by members of the Board (both executive and non-executive directors)		
Alert	• None		
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	Estimated annual costs for licence and catering = £3,000 covered by People and Culture budget recurrently		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☐		

Brief/Executive Report Details	
Brief/Executive Summary Title:	Schwartz Rounds – WHT Annual report April 2021 - end March 2022

Item/paragraph 1.0	**Schwartz Rounds Purpose:**
	• Schwartz Rounds allow time and space for staff to discuss the non-clinical, social and emotional aspects around caring for patients/working in healthcare - thus supports staff wellbeing
	
	Schwartz Rounds Origins and structure:
	• Boston Lawyer (Kenneth Schwartz) was a lung cancer patient, and he was so impressed with the compassionate care he received, he asked staff what would help them most in being able to do their jobs. They came up with the concept of Schwartz Rounds as a forum to discuss confidentially and compassionately what it feels like to work in healthcare.
	• Whilst originating in the US, it has been in the UK since 2009, and strong evidence base around staff benefits has been demonstrated with >220 UK organisations taking part (including NHS, Veterinary practices, Prisons, Care homes, Education settings etc.)
	• During a Schwartz Round, 'story tellers' tell their stories and the audience is invited to reflect upon what they have heard. Facilitators work with the story tellers beforehand to hone their stories and focus on the emotions involved. During the reflection, problem solving (eg 'I would have done…', 'you could/should have done', 'next time you could/should do') is actively discouraged. Facilitators help to draw out themes from the stories.
	
	Evidence-base and recent research findings:
	• Established in many countries. USA > 20 years.
	• Schwartz Centre for Compassionate Healthcare research (Lown, 2010)- teamwork, less stress, participants more likely to attend to patients psychological and emotional needs, empathy, (also enhanced by increased attendance of Schwartz Rounds)
	• UK evidence around compassionate care – Two pilot sites, (Goodrich, 2012).
	• Qualitative evidence base is good. Around 220 NHS trusts and hospices in UK undertaking Rounds
	• Longitudinal research study highlighted benefits
	  ○ *'Rounds have been shown to offer unique support compared to other interventions. Organisational level interventions for staff wellbeing are scarce and Rounds uniquely straddle both individual and organisational levels.*
	  ○ *Providing high quality healthcare has an emotional impact on staff, which often goes unnoticed. Rounds offer a safe, reflective space for staff to share stories with their peers about their work and its impact on them. Attendance is associated with a*

	statistically significant improvement in staff psychological wellbeing. ○ *Reported outcomes included increased empathy and compassion for patients and colleagues and positive changes in practice'.* **People Plan:** • Schwartz Rounds appear in the People Plan **Benefits:** • Patient care enhanced - improved empathy. Maben J, Taylor C, Dawson J, Leamy M, McCarthy I, Reynolds E, et al. A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England. Health Serv Deliv Res 2018;6 (37). ○ Improved staff well-being: Poor psychological wellbeing reduced from 25% to 12% • Staff health and wellbeing and patient care and satisfaction linked by the Boorman report, (Boorman, 2009), reduced levels of stress. • Increased staff engagement, (West & Dawson, 2002) • Culture of compassion and promoting shared values • Greater team working • Reduced sickness absence/Turnover • 'Time out' opportunities • Networking/sharing common purpose • Organisation seen as less hierarchical • Role-modelling opportunity- especially through senior staff attending and contributing
	WHT progress:
	Schwartz Round Steering group: • A Schwartz Round Steering group has been established since May 2021 and meets monthly to support planning of future Rounds and evaluate progress. The Steering group is an important resource in establishing and maintaining a successful Schwartz Round programme in the organisation. • Esther Waterhouse took up post as Schwartz Round clinical lead in May 2022 and now chairs the Steering Group. **Schwartz Round Programme 2021-22:** • The most challenging aspect is the work involved to gain commitment to deliver Rounds, and all the preparation work leading up to successful delivery. However, a delivery plan is programmed months in advance. **Panel preparation:** • Panel preparation can be time consuming but is shared between the facilitators. **Schwartz Rounds delivered:** • Since inception, the organisation has supported 10 Rounds (from May 2021 up to end October 2022).

- Between April 2021 - end March 2022 the organisation supported 6 Rounds, with 163 individual attendances, with an average attendance at each Round of 27 individuals
- The topics delivered during April 2021 - end March 2022 are listed below, and full evaluation of each session, as well as overall evaluation of the 12 months of Schwartz Rounds is included in Appendix 1.

Date	Title	Attendees (number)
April 2021	'A year like no other' focussing on issues during COVID. This was aimed mostly at ITU staff.	13
Sept 2021	'Beep beep beep – neonatal trauma team to ED resus' telling the story of a tragic neonatal death and the impact on staff	38
Nov 2021	'The patient I will never forget' discussing patients and memories that stay with professionals, and the impact of this on them.	26
Dec 2021	'Incivility and respect - the impact on the individual'. (Exploring the impact of civility and incivility)	25
Jan 2022	Planned break for winter pressures – no Round	
Feb 2022	'The lonely leader' – senior members of the Trust talking about the emotional impact of leadership	27
March 2022	'Across the miles' – the experience of international nurses who have joined the Trust	34

Certification/CPD/Reflective practice:

- Each participant/panel member receives a CPD certificate
- Reflective practice is actively encouraged by the facilitator during the introductory briefing at the start of the Round, and reflective templates are available.

Governance:

- Governance of the Rounds is through the facilitators in terms of Round content, with the Schwartz Round Steering Group appraising the Rounds and the evaluation data. Monthly reports about each Round are discussed within the Schwartz Round Steering Group agenda, with a summary report as part of the annual report to PODC/TMC/TB.

	• Peer Governance of the Rounds has been provided by an organisational Mentor, and through the Point of Care Foundation which holds the licence to practice Schwartz Rounds in the UK and sets the organisational standards around the Rounds.
	• WHT also belongs to the Schwartz Round community, which is a group of organisations all practicing Schwartz Rounds. The sharing of good practice and lessons learnt are part of the rationale for this community of practice.
	
	Issues/Concerns:
	• Engagement - with, and for, staff not based on the Walsall Manor site.
	  ○ Plans to address this include virtual Schwartz Rounds and increased comms
	• Less than ideal mix around Round attendance from certain groups of staff - a requirement for increasing engagement. For example, no attendance from untrained nursing staff or from estates staff.
	  ○ Plans to address this include Schwartz Round steering group wider representation. Chair to attend all Employee Voice Groups.
	• Ward and other 'front line' staff find it difficult to get time out to attend
	  ○ Plans to address this through the Steering Group
	
	Future Plans:
	• To evaluate the virtual Schwartz Round (held in 2022) to determine whether this format could reach a wider audience group.
	• A Steering Group 'away day' to ensure that all members are fully engaged
	• Promote attendance by, and story telling from, senior members of the Trust including the executive team and NEDs.
	• We now ask all story tellers for their feedback.

	WHT Evaluation:
	Feedback forms and evaluation: • All audience members are encouraged to complete a comprehensive feedback form following every Schwartz Round, and the results of these from April 2021- end March 2022 have been received by PODC to include both qualitative and quantitative data plus reflective data. • Evaluation scores are high for Schwartz Rounds overall (within the last 12 months, 88% of attendees would recommend Schwartz Rounds), and thus provide quantitative data around success, although the qualitative data provided by the free text comments provide a richer dataset and provide evidence of impact of the Rounds. • The Schwartz Round Steering group examined the evaluation information to date and determine the key priorities upon which to focus on future evaluation of outcomes and the associated

	methodology. This was determined to be a mixture of qualitative and qualitative data, to provide a rich dataset.
	WHT Schwartz Rounds sustainability:
	• Finances- estimated annual costs for contract and food = £3K- a small investment given the staff benefits and staff feedback from Rounds • Active membership of Schwartz Round Steering Group to ensure positive engagement • Multiple sites – engagement. This has been explored through the Steering Group • Sustaining quality through peer review ○ Point of Care Foundation receive our feedback data every 6 months • Annual report to PODC and thence to TMC/Trust Board - to sustain Board engagement • Learn from other organisations- feedback from other organisations is that organisational support is high initially, but long-term sustainable support can be a challenge (especially around financial support and embedding Rounds)
	References:
	• Maben J, Taylor C, Dawson J, Leamy M, McCarthy I, Reynolds E, et al. A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England. Health Serv Deliv Res 2018;6(37). • Impact report 2020 - Point of Care Foundation • Boorman, S., 2009. NHS health and wellbeing review. • Goodrich, J., 2012. Supporting hospital staff to provide compassionate care: Do Schwartz Centre Rounds work in English hospitals? *Journal of the Royal Society of Medicine*, March, 105, (3), pp. 117-122 • Lown, B., Manning, C., 2010. The Schwartz Centre Rounds: Evaluation of an interdisciplinary approach to enhancing patient-centred communication, teamwork, and provider support. Academic Medicine. 85, (6), pp. 1073-1081 • West, M. A, Dawson, J. F., 2002. Employee engagement and NHS performance. Kings Fund Report • https://www.pointofcarefoundation.org.uk/

Appendix 2 – qualitative feedback

1. From Schwartz round story tellers.

- I am usually a resilient person. Being able to share my story helped me to accept that I can show my vulnerability in times of emotional trauma. By sharing my story, I was actively listened to [by] a wider audience. This made me feel that I had a wider support group around, I was not alone, my feelings were valued, and I did belong.

- I found the opportunity of being a Schwartz Round panellist a really rewarding experience. Not only was I privileged to be able to listen to other panel members' and audience members' experiences, but in sharing my own experience I was also able to reflect on leading through Covid-19, the impact it had on me personally, and what I've learnt about myself. I would wholeheartedly recommend the experience to others and would be very happy to participate as a panellist again if required.

- Excellent experience, it has made me reflect on my daily work more regularly and make changes to the way I do things.

2. From audience members

This is a word cloud from their freetext responses (which are detailed in the summary at Appendix 1)

Round 1 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	Walsall Manor		
Date	29-Apr-21		
Title of Round	A year like no other		
Number in attendance	13	**Number of forms returned**	10

	Completely disagree		Disagree somewhat		Neither agree nor		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my	0	0%	0	0%	0	0%	0	0%	10	100%
I gained knowledge that will help me to care for patients	0	0%	0	0%	1	10%	2	20%	7	70%
Today's Round will help me work better with my	0	0%	0	0%	0	0%	1	10%	9	90%
The group discussion was helpful to me.	0	0%	0	0%	0	0%	1	10%	9	90%
The group discussion was well facilitated.	0	0%	0	0%	0	0%	0	0%	10	100%
I have gained insight into how others care for patients.	0	0%	0	0%	1	10%	1	10%	8	80%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	0	0%	10	100%
I would recommend Schwartz Centre Rounds to	0	0%	0	0%	0	0%	0	0%	10	100%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	0	0%	0	0%	4	40%	6	60%

Professional affiliation (only 8 completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	2	20%	0	0%	0	0%	7	70%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcare Scientist	
	0	0%	0	0%	1	10%	0	0%	0	0%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	0	0%	1	10%		
	Other (please state)									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	8	80%	2	20%	0	0%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Excellent presentation from Critical Care team, highlights the emotional struggle suffered to both staff and patients. I feel that resources need to be avaliable for staff.
Wonderful opportunity.
I was really pleased when I heard the Trust were starting these. I researched the process previously and presented the benefits at my last interview. So well done Walsall.
Remind late comers of the rules of the confidentiality and enhance opporunity for sharing.

Diversity monitoring information:		**Responses**
How old are you?	24 or under	0
	25 -29	2
	30-44	4
	45-59	6
	60-64	0
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	1
	Black	0
	White British	8
	Mixed/Multiple ethnic background	0
	Arab	0
	White other	1
	Other	0
	Prefer not to say	0
What gender do you identify as?	Male	2
	Female	8
	Other	0
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes No	20 YES
	Prefer not to say	0
How would you describe your marital status?	Single	3
	Married, committed in civil partnership	6
	Divorced	0
	Widow	1
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes No	1 Yes, 9No
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight Gay/Lesbian Other	9 Hetrosexual
	Prefer not to say	1 Gay
Have you been pregnant or had a baby in the last 12 months?	Yes No	10 No
	Prefer not to say	

Round 1 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	Walsall Manor		
Date	30-Sep-21		
Title of Round	Beep Beep Beep Neonatal Trauma call to A & E Resus		
Number in attendance	38	**Number of forms returned**	27

	Completely disagree		Disagree somewhat		Neither agree nor		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my	0	0%	3	11%	2	7%	0	0%	22	81%
I gained knowledge that will help me to care for patients	0	0%	0	0%	3	11%	1	4%	23	85%
Today's Round will help me work better with my	0	0%	0	0%	2	7%	3	11%	22	81%
The group discussion was helpful to me.	1	4%	0	0%	0	0%	3	11%	23	85%
The group discussion was well facilitated.	0	0%	0	0%	1	4%	1	4%	25	93%
I have gained insight into how others care for patients.	0	0%	0	0%	0	0%	2	7%	25	93%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	1	4%	4	15%	22	81%
I would recommend Schwartz Centre Rounds to	0	0%	0	0%	1	4%	3	11%	23	85%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	4%	0	0%	5	19%	21	78%

Professional affiliation (only 2 did not completed this section)	**Medical & Dental**		**Student**		**Untrained Nurse**		**Trained Nurse/Midwife**		**Ancillary**	
	11	41%	1	4%	0	0%	7	26%	0	0%
	S&P		**Admin & Clerical**		**AHP**		**Senior**		**Technician/Healthcare Scientist**	
	0	0%	2	7%	0	0%	1	0%	0	0%
	Maintenance		**Non Executive**		**Other**		**Healthcare Support**			
	0	0%	0	0%	0	0%	0	0%		
	Other (please state)									
	Resus Officer, ACP. Chaplaincy									

How many Rounds have you attended before? (only completed this section)	0		1-5		5+	
	21	78%	4	15%	0	0%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
I will join future Schwartz rounds as I found it very beneficial
Thank you for sharing the event it was very emotional and immotive.
Child protection is very challenging. This work requires confidentiality. However the professionals do get affected emotionally managing severe suspected child abuse
Fantastic
Very powerful, brave presentation, what a fabulous team, who shold be very proud of the job they do
Very very good
Please explain accronyms/abbreviations, have tissues available
Child death is never easy to manage,team amazing,very emotional,could have included ambulance crew in session

Diversity monitoring information:		**Responses**
How old are you?	24 or under	2
	25 -29	4
	30-44	10
	45-59	10
	60-64	0
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	7
	Black	1
	White British	14
	Mixed/Multiple ethnic background	0
	Arab	2
	White other	0
	Other	1
	Prefer not to say	1
What gender do you identify as?	Male	10
	Female	16
	Other	0
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes No	26 YES
	Prefer not to say	0
How would you describe your marital status?	Single	6
	Married, committed in civil partnership	20
	Divorced	0
	Widow	0
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes No	0 Yes, 25 No
	Prefer not to say 1	
How do you describe your sexual orientation?	Heterosexual/Straight Gay/Lesbian Other	25 Hetrosexual
	Prefer not to say 1	0 Gay
Have you been pregnant or had a baby in the last 12 months?		1 Yes, 25 No
	Prefer not to say	

Round 3 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	Walsall Manor		
Date	16-Nov-21		
Title of Round	The Patient I will never forget		
Number in attendance	26	**Number of forms returned**	15

	Completely disagree		Disagree somewhat		Neither agree nor		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my	0	0%	0	0%	0	0%	4	27%	11	73%
I gained knowledge that will help me to care for patients	0	0%	0	0%	0	0%	5	33%	10	67%
Today's Round will help me work better with my	0	0%	0	0%	0	0%	5	33%	9	60%
The group discussion was helpful to me.	0	0%	0	0%	0	0%	4	27%	11	73%
The group discussion was well facilitated.	0	0%	1	7%	0	0%	3	20%	11	73%
I have gained insight into how others care for patients.	0	0%	0	0%	0	0%	4	27%	11	73%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	9	60%	6	40%
I would recommend Schwartz Centre Rounds to	0	0%	0	0%	0	0%	3	20%	11	73%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	0	%	2	13%	6	40%	7	47%

Professional affiliation (only 2 did not completed this section)	**Medical & Dental**		**Student**		**Untrained Nurse**		**Trained Nurse/Midwife**		**Ancillary**	
	1	7%	0	0%	0	0%	5	33%	0	0%
	S&P		**Admin & Clerical**		**AHP**		**Senior**		**Technician/Healthcare Scientist**	
	0	0%	0	0%	0	0%	0	0%	3	20%
	Maintenance		**Non Executive**		**Other**		**Healthcare Support**			
	0	0%	0	0%	1	7%	0	0%		
	Other (please state)									
	Manager									

How many Rounds have you attended before? (only completed this section)	0		1-5		5+	
	7	47%	2	13%	1	7%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
very valuable insight into different experiences
fantastic
I was touched by all of today's stories . Speakers spoke honestly and openly and with compassion
Excellent stories

Diversity monitoring information:		**Responses**
How old are you?	24 or under	2
	25 -29	1
	30-44	2
	45-59	6
	60-64	1
	65 +	
	Prefer not to say	
How would you describe your ethnicity?	Asian	3
	Black	
	White British	7
	Mixed/Multiple ethnic background	1
	Arab	
	White other	
	Other	1
	Prefer not to say	
What gender do you identify as?	Male	2
	Female	10
	Other	
	Prefer not to say	
Is your gender the same as you were assigned at birth?	Yes No	12 Yes, 0 No
	Prefer not to say	
How would you describe your marital status?	Single	2
	Married, committed in civil partnership	10
	Divorced	
	Widow	
	Prefer not to say	
Do you consider yourself to have a disability?	Yes No	0 Yes, 12 No
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight Gay/Lesbian Other	11 Heterosexual
	Prefer not to say	
Have you been pregnant or had a baby in the last 12 months?		0 Yes, 12 No
	Prefer not to say	

Round 4 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	Walsall Manor		
Date	15-Dec-21		
Title of Round	Incivility & Resp Incivility & Respect - Impact on the Individual		
Number in attendance	25	**Number of forms returned**	21

	Completely disagree		Disagree somewhat		Neither agree nor		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my	0	0%	0	0%	1	5%	8	38%	11	52%
I gained knowledge that will help me to care for patients	0	0%	0	0%	3	14%	3	14%	15	71%
Today's Round will help me work better with my	0	0%	0	0%	0	0%	5	24%	16	76%
The group discussion was helpful to me.	0	0%	1	5%	4	19%	3	14%	12	57%
The group discussion was well facilitated.	0	0%	0	0%	0	0%	2	10%	18	86%
I have gained insight into how others care for patients.	0	0%	0	0%	0	0%	6	29%	15	71%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	2	10%	6	29%	13	62%
I would recommend Schwartz Centre Rounds to	0	0%	0	0%	0	0%	1	5%	19	90%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	0	0%	0	%	12	57%	9	43%

Professional affiliation (only 2 did not completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	2	10%	0	0%	0	0%	8	38%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcare Scientist	
	0	0%	1	5%	0	0%	0	0%	1	5%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	7	33%	0	0%		
	Other (please state)									
	Manager, Clinical Link Tutor, Chaplaincy									

How many Rounds have you attended before? (only completed this section)	0		1-5		5+	
	9	43%	7	33%	2	10%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Humbled by vulnerability & courage of panel members to share their stories/experiences
Most beautiful round I have attended so far
Incredibly insightful and has given me personal learning and awareness of what others have gone through or are going through
very insightful , thank you
I think the panelist were 'brave' to discussed disparities within walsall and the wider NHS, its sad this happens in the world experiences since covid which recognised inequalities in the world. On another note though luch was a blessing I am allergic to cheese and there were no other options
Really Insightful
Thank you panel, great topic
All stories were so inspiring, its really made me think, very valuable stories shared
2 poignant heart wrenching descriptions of some staff experiences and make me wonder how I can help to have a better experience, described relationships with staff not patients

Diversity monitoring information:		**Responses**
How old are you?	24 or under	1
	25 -29	
	30-44	3
	45-59	15
	60-64	
	65 +	
	Prefer not to say	
How would you describe your ethnicity?	Asian	1
	Black	2
	White British	13
	Mixed/Multiple ethnic background	
	Arab	
	White other	3
	Other	
	Prefer not to say	
What gender do you identify as?	Male	4
	Female	15
	Other	
	Prefer not to say	
Is your gender the same as you were assigned at birth?	Yes No	19 Yes 0 No
	Prefer not to say	
How would you describe your marital status?	Single	3
	Married, committed in civil partnership	15
	Divorced	1
	Widow	
	Prefer not to say	
Do you consider yourself to have a disability?	Yes No	1 Yes 18 No
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight Gay/Lesbian Other	18 Heterosexual 1 Gay/Lesbian
	Prefer not to say	
Have you been pregnant or had a baby in the last 12 months?		0 Yes 19 No
	Prefer not to say	

Round 5 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	Walsall Manor		
Date	16-Feb-22		
Title of Round	The Lonely Leader		
Number in attendance	27	**Number of forms returned**	24

	Completely disagree		Disagree somewhat		Neither agree nor		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my	0	0%	0	0%	1	4%	4	17%	18	75%
I gained knowledge that will help me to care for patients	0	0%	0	0%	8	33%	7	29%	8	33%
Today's Round will help me work better with my	0	0%	0	0%	1	4%	6	25%	16	67%
The group discussion was helpful to me.	0	0%	0	0%	7	3%	5	21%	10	42%
The group discussion was well facilitated.	0	0%	0	0%	0	0%	3	13%	20	83%
I have gained insight into how others care for patients.	0	0%	0	0%	0	0%	4	17%	18	75%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	1	4%	2	8%	20	83%
I would recommend Schwartz Centre Rounds to	0	0%	0	0%	1	4%	0	0%	11	46%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	0	0%	1	4%	7	1%	14	58%

Professional affiliation (only 2 did not completed this section)										
	Medical & Dental		**Student**		**Untrained Nurse**		**Trained Nurse/Midwife**		**Ancillary**	
	0	0%	1	4%	0	0%	2	8%	0	0%
	S&P		**Admin & Clerical**		**AHP**		**Senior**		**Technician/Healthcare Scientist**	
	0	0%	0	0%	0	0%	0	0%	0	0%
	Maintenance		**Non Executive**		**Other**		**Healthcare Support**			
	0	0%	0	0%	6	25%	0	0%		
	Other (please state)									
	Manager, Chaplain									

How many Rounds have you attended before? (only completed this section)	0		1-5		5+	
	6	25%	2	8%	2	8%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Really enjoyed the session, found it very worthwhile. Thank you
Excellent Stories presented and reflections shared
Very moving and insightful, a privilage to listen to colleagues sharing such personal experiences
Topic for future Schwartz - Making decisions about resuscitation - It's okay to die'
Excellent sharing and honesty

Diversity monitoring information:		**Responses**
How old are you?	24 or under	
	25 -29	2
	30-44	3
	45-59	14
	60-64	4
	65 +	
	Prefer not to say	
How would you describe your ethnicity?	Asian	2
	Black	
	White British	19
	Mixed/Multiple ethnic background	1
	Arab	
	White other	1
	Other	
	Prefer not to say	
What gender do you identify as?	Male	5
	Female	18
	Other	
	Prefer not to say	
Is your gender the same as you were assigned at birth?		Yes 23 No
	Prefer not to say	
How would you describe your marital status?	Single	5
	Married, committed in civil partnership	16
	Divorced	1
	Widow	
	Prefer not to say	1
Do you consider yourself to have a disability?		Yes No 23
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight Gay/Lesbian Other	Heterosexual 21 Gay/Lesbian 1
	Prefer not to say	1
Have you been pregnant or had a baby in the last 12 months?		No 23 Yes
	Prefer not to say	

Round 6 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	Walsall Manor		
Date	28-Mar-22		
Title of Round	Across the Miles		
Number in attendance	34	**Number of forms returned**	33

	Completely disagree		Disagree somewhat		Neither agree nor		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my	0	0%	1	3%	3	9%	4	12%	26	79%
I gained knowledge that will help me to care for patients	0	0%	0	0%	6	18%	10	30%	17	52%
Today's Round will help me work better with my	0	0%	0	0%	1	3%	5	15%	28	85%
The group discussion was helpful to me.	0	0%	0	0%	0	0%	7	0%	27	82%
The group discussion was well facilitated.	0	0%	0	0%	1	3%	1	3%	32	97%
I have gained insight into how others care for patients.	0	0%	0	0%	6	3%	10	30%	16	48%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	2	6%	30	91%
I would recommend Schwartz Centre Rounds to	0	0%	0	0%	0	0%	3	9%	30	91%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	0	0%	4	12%	8	24%	22	67%

Professional affiliation (only 2 did not completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	0	0%	0	0%	0	0%	22	67%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcare Scientist	
	0	0%	1	3%	0	0%	0	0%	1	3%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	3	9%	1	3%		
	Other (please state)									
	Matron ODP, Chaplaincy, AHP									

How many Rounds have you attended before? (only completed this section)	0		1-5		5+	
	23	70%	7	21%	2	6%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
I hope these stories will be sorted as very shocking
Emotional, upsetting to hear the behaviours of staff within this trust
It was eye opening for all the wrong reasons and absolutely invaluable for us to change our practice. The speakers are exceptionally brave.
More senior people in this organisation need to be present to listen to these stories, as change is definitely needed, leaders need to lead by example and trust values.
Look forward to attending more rounds in the future
I would appreciate if this will get to the appropriate authorities of the Trust and solution to be made to these effect. I hope these stories will not lead to further victimisation of the girls who shared their stories
I am glad I was able to attend, it was insightful
I hope all the issues addressed will be looked into
Kindly follow up to ensure that some sessions are held soonest as per solutions to the issues raised here. Thank you for this beautiful session held today.
Good insight into what new staff go through when they start within the Trust
The speakers are very brave and I would like to thank them for speaking out.
Very upsetting to hear this behaviour is taking place. Brave story tellers and very brave coming here in the first place
The presentations were emotional
Very powerful testimonies shared today that will make me consider my encounters on wards
Fantastic session
More people especially the managers should be aware and come for this round always. More of this programme should be organised for International Nurses
I like to appreciate the speakers for their courage in expressing themselves. I hope all the issues raised will be addressed and positive changes be made especially for the new incoming international nurses

Diversity monitoring information:		**Responses**
How old are you?	24 or under	2
	25 -29	9
	30-44	13
	45-59	10
	60-64	
	65 +	
	Prefer not to say	
How would you describe your ethnicity?	Asian	1
	Black	21
	White British	12
	Mixed/Multiple ethnic background	
	Arab	
	White other	
	Other	
	Prefer not to say	
What gender do you identify as?	Male	5
	Female	28
	Other	
	Prefer not to say	
Is your gender the same as you were assigned at birth?	Yes No	Yes 33 No
	Prefer not to say	
How would you describe your marital status?	Single	5
	Married, committed in civil partnership	25
	Divorced	2
	Widow	
	Prefer not to say	1
Do you consider yourself to have a disability?	Yes No	Yes No 33
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight Gay/Lesbian Other	Heterosexual/Straight 31 Gay/Lesbian 1
	Prefer not to say	
Have you been pregnant or had a baby in the last 12 months?		Yes 7 No 25
	Prefer not to say	

This is the summary sheet. **Please only complete the purple fields**. All other data will be added automatically from the individual Rounds sheets.

Organisation	Walsall Manor	**Number of Rounds held in the last 6 Months**	6
Average number in attendance over the last 6 Rounds	27	**Actual number in attendance over the last 6 Rounds**	**163**
Actual number of forms returned over the last 6 Rounds	130	**Percentage of forms returned over the last 6 Rounds**	80%

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my daily work.	0	0%	4	3%	7	5%	20	15%	98	75%
I gained knowledge that will help me to care for patients	0	0%	0	0%	21	16%	28	22%	80	62%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	4	3%	25	19%	100	77%
The group discussion was helpful to me.	1	1%	1	1%	11	8%	23	18%	92	71%
The group discussion was well facilitated.	0	0%	1	1%	2	2%	10	8%	116	89%
I have gained insight into how others care for patients.	0	0%	0	0%	7	5%	27	21%	93	72%
I plan to attend Schwartz Center Rounds again.	0	0%	0	0%	4	3%	23	18%	101	78%
I would recommend Schwartz Center Rounds to colleagues.	0	0%	0	0%	2	2%	10	8%	104	80%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	1%	7	5%	42	32%	79	61%

Professional affiliation										
	Medical & Dental		**Student**		**Untrained Nurse**		**Trained Nurse**		**Ancillary**	
	16	12%	2	2%	0	0%	51	39%	0	0%
	S&P		**Admin & Clerical**		**AHP**		**Senior Manager/Executive**		**Technician/Healthcare Scientist**	
	0	0%	4	3%	1	1%	1	1%	5	4%
	Maintenance		**Non Executive**		**Other**					
	0	0%	0	0%	17	13%				
	Other (please state)									
	Resus Officer, ACP. Chaplaincy									

How many Rounds have you attended before?	None		1-5		5+	
	74	57%	24	18%	7	5%

Comments and feedback from participants at Rounds over the last six months
Excellent presentation from Critical Care team, highlights the emotional struggle suffered to both staff and patients. I feel that resources need to be avaliable for staff.
Wonderful opportunity.
I was really pleased when I heard the Trust were starting these. I researched the process previously and presented the benefits at my last interview. So well done Walsall.
Remind late comers of the rules of the confidentiality and enhance opporunity for sharing.
I will join future Schwartz rounds as I found it very beneficial
Thank you for sharing the event it was very emotional and immotive.
Child protection is very challenging. This work requires confidentiality. However the professionals do get affected emotionally managing severe suspected child abuse
Fantastic
Very powerful, brave presentation, what a fabulous team, who shold be very proud of the job they do
Very very good
Please explain accronyms/abbreviations, have tissues available
Child death is never easy to manage,team amazing,very emotional,could have included ambulance crew in session
very valuable insight into different experiences
fantastic
I was touched by all of today's stories . Speakers spoke honestly and openly and with compassion
Excellent stories
Humbled by vulnerability & courage of panel members to share their stories/experiences
Most beautiful round I have attended so far
Incredibly insightful and has given me personal learning and awareness of what others have gone through or are going through
very insightful , thank you
I think the panelist were 'brave' to discussed disparities within walsall and the wider NHS, its sad this happens in the world experiences since covid which recognised inequalities in the world. On another note though luch was a blessing I am alle
Really Insightful
Thank you panel, great topic
All stories were so inspiring, its really made me think, very valuable stories shared
Really enjoyed the session, found it very worthwhile. Thank you
Excellent Stories presented and reflections shared
Very moving and insightful, a privilage to listen to colleagues sharing such personal experiences
Topic for future Schwartz - Making decisions about resuscitation - It's okay to die'
Excellent sharing and honesty
I hope these stories will be sorted as very shocking
Emotional, upsetting to hear the behaviours of staff within this trust
It was eye opening for all the wrong reasons and absolutely invaluable for us to change our practice. The speakers are exceptionally brave.
More senior people in this organisation need to be present to listen to these stories, as change is definitely needed, leaders need to lead by example and trust values.
Look forward to attending more rounds in the future
I would appreciate if this will get to the appropriate authorities of the Trust and solution to be made to these effect. I hope these stories will not lead to further victimisation of the girls who shared their stories
I am glad I was able to attend, it was insightful
I hope all the issues addressed will be looked into
Kindly follow up to ensure that some sessions are held soonest as per solutions to the issues raised here. Thank you for this beautiful session held today.
Good insight into what new staff go through when they start within the Trust
The speakers are very brave and I would like to thank them for speaking out.
Very upsetting to hear this behaviour is taking place. Brave story tellers and very brave coming here in the first place
The presentations were emotional
Very powerful testimonies shared today that will make me consider my encounters on wards
Fantastic session
More people especially the managers should be aware and come for this round always. More of this programme should be organised for International Nurses
I like to appreciate the speakers for their courage in expressing themselves. I hope all the issues raised will be addressed and positive changes be made especially for the new incoming international nurses

Walsall Healthcare NHS
NHS Trust

MEETING OF THE QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE HELD ON FRIDAY 28th OCTOBER 2022 AT 11.30 AM HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Dr J Parkes	Non-Executive Director (Chair)
Mr K Bostock	Director of Assurance
Mrs L Carroll	Director of Nursing
Mr M Dodd	Interim Director of Integration
Mrs O Muflahi	Associate Non-Executive Director
Dr M Shehmar	Chief Medical Officer
Prof L Toner	Associate Non-Executive Director (Chair)
Mr R Virdee	Associate Non-Executive Director

In attendance

Mrs C Jones-Charles	Divisional Director of Midwifery
Mrs C King-Stephens	MLU Manager
Mrs M Metcalfe	Deputy Director of Assurance
Mr G Perry	Associate Director of Patient Relations & Experience
Mr W Roberts	Director of Operations (on behalf of Mr Hobbs)
Mrs J Toor	Senior Exec PA (observing on behalf of Mr Wilshere)
Mrs A Hill	Executive Assistant (minutes)

Apologies

Mr N Hobbs	Chief Operating Officer
Mr K Wilshere	Company Secretary

308/22	**Welcome and Introductions**
	Dr Parkes welcomed everyone to the meeting and introductions were made.
309/22	**Apologies for Absence**
	Apologies for absence, as listed above, were noted.
310/22	**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.
311/22	**Minutes of Previous Meeting**
	The minutes from the September 2022 meeting were agreed as a true record. Mrs Muflahi queried action 223/22 regarding the use of census categories for ethnic breakdown in the maternity update report and asked for clarity that the census categories were being used as this action has been marked 'closed'. Action has been reinstated until assurance given.

	Action – WCCCS Division to clarify what categories are being used in the maternity report as it states that digital mapping in line with RWT ethnicity breakdown is being used.
312/22	**Items for Redaction**
	There were no items for redaction in relation to commercially confidential information and/or staff, patient or public individual identifiable information. The minutes were approved for publication.
313/22	**Matters Arising & Action Log**
	188/22 – There are now plans in place to improve the audit data being provided and trajectory of improvement is bought through the Patient Safety Group. QPES will receive a monthly update until project is complete, and assurance given. 285/22 – no children have been referred to the Trust for long covid as there is currently no service, however the ICB have commissioned a service through the Birmingham Children's Hospital, and this is where they are referred to. It was agreed to pursue this via the health and equalities group through Walsall Together going forward. Action closed. 286/22 – Mrs Carroll now has Michelle's contact details and will share the letter with Committee in November A request was made to Committee members to ensure that any papers requiring embedding into their reports are attached as appendices and only if essential to the report as embedded papers cannot be viewed via IBABS.
314/22	**Maternity Ethnicity Update**
	Mrs King-Stephen's presented her updated report which contained data from May to September 2022. The report includes data from ATAIN (Avoiding Term Admissions into Neonatal units) and shows the percentages of women needing to use interpreters. The NNU does have information in different languages and access to interpreters. And feedback from patients using the NNU was very positive. Research shows that the percentage of blood loss of 30% or more based on BMI was higher in Indian, African and Asian groups. Shoulder dystocia was more prevalent in the Bangladeshi group and the percentage of 3rd and 4th degree tears was higher in Pakistani and Indian women. This information highlighted the need for raising awareness of these risk factors and educating patients more at risk. Professor Toner asked if the risk assessment documentation is available in the current admission documentation. Mrs King-Stephens advised that this is currently under discussion for future admissions. There are plans to apply for funding to secure a place at Nash Dom Community Hub charity in conjunction with the HIP's (Health in Pregnancy) team, which can be used for a focus group to obtain patient's views and experience of maternity care to promote collaborate working and provide maternity advice. This group will also help to provide more realistic feedback from patients at a more convenient time to them. Mrs King-Stephens visited the migrant centre in Walsall to advise that even if patients do not have a GP and are still in the process of accessing visa's they are still able to visit the health community office and receive maternity care and supplied them with contact details and signposting information. An animation on how to contact the hospital has been developed and is currently out for consultation as the current information is in written English and work is underway to develop this animation to enable it to be accessed in some format by

	all, including patients with learning disabilities, hearing or sight loss. It is hoped to expand this to include gestational diabetes and provide education and advice to help prevent gestational diabetes recurring and prevent the development of type 2 diabetes in patients. Mr Virdee sought clarity regarding using Word 360 rather than birthing partners at medical appointments and Mrs King-Stephen's confirmed this is an interpreting service. Mr Dodd's advised that the information in the report is useful for both the health and inequalities group and also the wider Walsall Together Partnership to help disseminate advice and identify gaps in service, to address these. Mrs Jones-Charles advised that work is also underway on the Trust website to ensure maternity services are accessible, even without a GP referral. The division is currently taking part in a pilot with PALS in interpreting services ensuring they are more accessible and interactive. Mrs Muflahi gave thanks to the team for the work carried out and shows excellent research into good practice that can be shared with other organisations. She asked what assurances can be given that in particular, Black and Asian midwifery staff, are able to access career progression and career opportunities being made available. Mrs Jones-Charles advised that there is currently work ongoing to support minority staff moving to senior positions and ensuring there is a clear focus on equality of access to ensure all groups have the same opportunities. Mrs Carroll advised she can pick up with Mrs Muflahi to advise further the work that is currently being undertaken in the Trust.
315/22	**Constitutional Standards & Acute Service Restoration & Recovery Report**
	The Trust has delivered 12 months of the best ambulance handover times in the West Midlands and has been the top performing organisation for 19 of the previous 20 months. In addition, the Trust took 115 out of borough ambulances to assist neighbouring Trusts with emergency calls. 74% of patients were managed within 4 hours of arrival in ED, however there was an increase in the number of non-admitted patients spending in excess of 4 hours in ED but there is work underway to improve this in both ED and AMU. There has been an improvement in Cancer treatment times with 70.2% of patients being treated within 62 days of GP referral, which is better than the West Midlands average of 51% and national average of 62%. New criteria has been introduced for referrals to the Colorectal service with updated guidance from the national expert advisory group and the teledermatology programme commences in November allowing GPs access to this e-referral service. A full capacity and demand analysis was carried out in Breast Cancer services, and this evidenced a shortfall of 38 slots per week to meet the 85th centile of variation in demand. Mitigations are in place to reduce this shortfall to 3, with one extra clinic in place and an increase in clinic from 11 patients back up to 12 patients following recent changes in infection control protocols and advice. Put in place an additional CNS with breast screening experience and nurse practitioner in training will be working independently from February. There has been a slight reduction in the national ranking in diagnostics with 22.7% of patients waiting more than 6 weeks across all diagnostic services. Cardiac Physiology have experienced some staff sickness and clearance of the backlog

	is expected by January. A business case is being developed for Endoscopy and there are mitigations in place currently with the use of locum staff and weekend working sessions. There is changing guidance with fecal immunochemical testing and expect to see fewer patients referred to colonoscopy on urgent cancer pathways and revision of 'straight to test' criteria to guide patients towards CT colon rather than colonoscopy testing should help to reduce the backlog. The Trust's 18-week RTT performance remains consistent with 58% of patients waiting under 18 weeks for treatment, continue to be on track for no patients waiting more than 78 weeks for treatment by end of March but this is the area that needs most improvement. Dr Parkes enquired if the Trust will be able to clear some of the backlog of echocardiograms and Mr Roberts gave assurance that other than Endoscopy that this will be bought back in line to 6 weeks. Mr Virdee asked if there are still plans to develop a community diagnostic centre that GPs would have access to and Mr Roberts advised that this is available and has added to the increase in referrals and the Trust is attempting to mitigate this increase. Mr Virdee also asked what was the cause for the August dip in the elective 18 week wait. Mr Roberts advised that it is not unusual to see a dip in August due to it being holiday season, but September saw an increase to normal levels. Mrs Muflahi asked if the biggest challenge is workforce and recruitment? Mr Roberts advised that there has been investment in recruitment and the majority of vacancies have been fully filled and that the Trust is operating near to pre-pandemic activity. However, to clear the backlog the Trust needs to be operating at 10-20% above normal activity and this is the current challenge. The AI tool currently in use to support decision making around expediting treatments should help in making better decisions in treatment timetables. Professor Toner advised that there is funding support available from the HEE, particularly for clinical endoscopists and Mr Roberts advised that funding is available and well supported for cancer pathways and the Trust has used this to recruit a new ACP and CNS within Medical Oncology and a Lead Pharmacist for Cancer Services.
316/22	**Community Services Report**
	There is currently a national focus on care at home and hospital avoidance and the Trust has a robust out of hospital activity with a range of services. Work is underway to try to deflect activity from WMAS (West Midlands Ambulance Service) to move more activity over to community services. Winter funding has now been secured to assist with virtual wards and caring for people safely at home including respiratory, cardiology, frailty, and paediatric services. The Trust is expanding the discharge teams, rapid response teams and care navigation centre to deal with the high level of referrals. There is a need to ensure the planned care side of the service is also improved and maintained and the locality teams continue to see significant levels of complex care needs and this is impacting on the number of hours that can be delivered by district nursing. Work has commenced with the ICB on a Black Country response to delays in hospital discharge for patients who are out of area and equitable rights for all citizens of a borough.

	Joint work continues with partnership agencies regarding the model for health visiting services and there is ongoing recruitment taking place with positive discussions taking place with Commissioners and the Local Authority. Mrs Muflahi asked if additional assurance can be given regarding the safeguarding elements of the health visiting work, particularly in relation to children. Also, regarding the District Nurses workforce, are there plans in place to mitigate workforce issues for the future. Mr Dodd advised that discussions are taking place with the Commissioners regarding safeguarding issues working collaboratively on this issue by undertaking a multi-agency case review. A rota has been developed in Community Services to train nursing associates in this area and currently working in collaboration with the care agencies to provide career progression. Mrs Carroll also advised that the Trust needs to ensure there are registered nurses working within community services and is working with higher education institutes to raise the profile of community services and provide a clear pathway for student nurses on community placements. The number of places available on the specialist practitioner course has doubled to allow more opportunity. There is a new community safe staffing tool in use to ensure staffing levels within the community are maintained. Professor Toner added that the HEE has put a tender for HEI's to develop a primary community care focus pre-registration programme and staff will spend majority of time within primary and community care which should support the district nursing programme. Dr Shehmar advised that there is ongoing work with clinicians to ensure cross site working with the community and the acute trust and raising awareness of community pathways and virtual wards so that care is covered across both with a new clinical model of working, particularly in relation to chronic case patients. Mr Virdee asked if there is data available to indicate that the integrated assessment hub is being accessed by all sections of the community. Mr Dodd advised that the service is being offered pro-actively to Walsall residents, however with out of area patients there are sometimes difficulties with referrals into the service. Dr Parkes asked for clarity on the current number of health visitor vacancies and Mr Dodd advised there are approximately 7 vacancies which are currently out for recruitment.
317/22	**Safe High Quality Care Oversight Report**
	Falls per 1000 bed days fell in September to 3.40 from 3.85 in August. There were 2 falls where moderate harm was recorded which are currently undergoing a robust review process to ensure learning is disseminated to divisions. One of the key issues identified from learning are issues with documentation and new risk assessment documentation has been introduced this month which will address some of the concerns and audit data will be included in this report to monitor improvement. There was a small increase in the total number of Trust acquired pressure ulcers in September. New hybrid mattresses have been ordered and are awaiting a confirmed delivery date which will assist in prevention and development of pressure ulcers in patients. Sepsis data for September shows that 78.29% of patients received antibiotics in ED within the first hour which is a slight improvement from 77.55% in August and inpatient area performance was 82.46% up from 80% in August. National audit

	compliance for sepsis compliance is 60-80% but the Trust will continue to try and improve compliance with the help of the Sepsis Team. The report includes medicines audit data but following the CQC inspection a detailed action plan and focus on medicines management is taking place in the Trust. A total of 6 C. difficile toxin cases have been identified in September 2 of these were deemed avoidable. Nationally there has been an increase in C. diff cases so the Trust is not an outlier, but it is above trajectory for cases. A regional 12- month campaign is planned for glove awareness as it was identified that with current changes to PPE guidance, staff were wearing gloves more than necessary. Mental Capacity Act compliance for September was 38.46% which is an increase from 26.09% in August. A more detailed audit is taking place with the Safeguarding Team and more focussed support is being given on wards by the practice educator facilitators as it appears that despite an increase in training, this is not being translated into practice. In September there were 87 Red Flags recorded for the reason of 1 to 1 not covered with challenges for staff to cover. An Eat, Drink, Dress, Move to Improve task and finish group has now been set up to look at how to do things differently to ensure less confusion and keep more normality for patients, particularly with the increase in patients being admitted with significant cognitive decline which may be due to lockdown and not having social interaction and not being able to access necessary support, but this appears to be a national trend. The results of this task and finish group will be bought to QPES at a future meeting. VTE compliance for September was 92.55% and continues to be below the 95% target for compliance. A more detailed report is included in the papers and clinical audits continue to be carried out. The 104-day harm process is now more robust, and work is being carried out on identified themes for improvement. A detailed report is now being presented to QPES monthly. The Acute Medical Unit (AMU) improvement update is included in the report with the most pertinent improvement is recruitment for substantive medical staff. The junior doctor rota was increased for general medicine by 15 WTE in response to safety concerns. These posts have been recruited to mainly with Clinical Fellows and will all be in post by end of November. A trajectory for ceasing long term locums is in place and substantive posts have been advertised. Work is underway on different models of care; there has been successful recruitment in ED consultants and there is now scope to look at leadership and supervision in AEC and same day emergency care to help with the flow through departments. Joint speciality posts are being considered such as diabetes and endocrinology where part of the role would be in AMU, and this will then bring in specialist support to AMU. Health Education England have confirmed that they plan to carry out a further review on 25th November. Junior doctor safety concerns regarding referral processes between ED and AMU have been resolved but the flow between AMU and rest of hospital is an issue. The QI team are currently looking into ways of addressing this issue.

	Dr Parkes queried the paediatric sepsis data at 47% and asked if there is a plan to look into this further. Mrs Carroll advised that paediatric sepsis is now being picked up with the project being carried out by the deteriorating patient group with some additional support being provided by an external consultant and lessons learned from national guidance. Dr Parkes queried the progress being made with Clinical Guidelines with only 51% being classified 'in date'. Dr Shehmar advised that a meeting has taken place with RWT to look at commencing a joint programme of work and the introduction of paid for web-based guidelines which would be updated regularly in line with changes in national guidance, with a local SOP in place. Dr Parkes asked about the MCA compliance and why improvements have not been seen in this area. Mrs Carroll advised that some of the initial findings of the audit currently taking place have identified that there are some issues with the detail in the documentation but she will bring a more detailed report to the next meeting once the results of the audit have been shared and for assurance there is now an action plan in place regarding MCA and DoLS and additional support is being provided to staff when completing these. Mr Virdee asked if the MCA compliance is a performance or training issue, also with sepsis compliance at 78% what happens with the remaining 22% of patients and with regards to the Safeguarding training, is this a capacity issue for training? Mrs Carroll advised that the Safeguarding training is a whole day training and there have been some issues with medical staff being able to take a day out, every division has a plan to ensure staff attend training however there is an HEE e-learning programme available and options to make this available for staff in smaller sessions is being explored. With regards to sepsis, all patients are reviewed by the Sepsis or Outreach team to ensure all patients are being clinically reviewed in a timely manner. Additional training has been provided for MCA and DoLS and translating this into practice is the challenge, there is a process in place for staff consistently not completing if this becomes an issue.
318/22	**Maternity Services Update**
	The service has recruited 14 WTE new starters, however there is continued staffing pressures particularly with on-going maternity leave pressures with 14 midwives on maternity leave and a further 2 due to start in the next few weeks. The NHSEI Insight visit took place on 13th September and is included in the report as an appendix. The feedback was very positive and areas requiring audit are being addressed via the audit action plan in place. The East Kent report was published on 19th October and outlined the care and outcomes of over 200 families. Key recommendations highlighted the need for greater support for maternity services. An away day has been planned for Band 7 staff team leaders and consultants and part of this will be to raise some of the issues highlighted in the report, particularly with regard to team dynamics and civility. Professor Toner acknowledged the excellent insight report and sought clarity for the difference between the delay in commencing induction of labour and delay in continuing induction in labour, which Mrs Jones-Charles explained. Dr Shehmar congratulated the team regarding the decline in both perinatal mortality and still birth rates and asked if the Trust rate is now within the expected

	standards. Mrs Jones-Charles advised the national aim is to half still birth rates by 2025 and Walsall are well within target to achieve this, however there is a lot of work to do particularly around smoking and scanning capacity and identifying babies at risk. Dr Shehmar advised it would be useful to know what actions need to be taken regarding scanning capacity and Mrs Jones-Charles advised she will bring this detail to the next meeting and how the service is working with Radiology.
319/22	**Serious Incident Update**
	Incident reporting numbers are broadly stable month on month but for assurance, the Trust is benchmarked in the lower quartile of reliability around reporting numbers of incidents and work is underway on an education process for when Datix is launched in January. There were no never events in September and SI numbers have reduced from 10 in August to 3 in September. For assurance, SI's appear to be occurring less frequently however there are some anomalies around declaring them against the 2015 framework but generally the trajectory is demonstrating that the Trust is getting safer and better clinically. The most reported SI actions are surgical case related and work is currently underway to check any hidden patterns in the detail. Duty of candour compliance for stage 1 has improved but not improved sufficiently for stage 2. The divisions are reporting 100% compliance for stage 1 but this needs to be tested to ensure this is reliable data. Overdue actions from SI historically were over 390 and these were reduced but they have started to increase and the Trust have employed an extra resource on a 3-month fixed term basis to focus on reducing these and this will continue until they are bought into an acceptable range. There was an incident backlog in December 2021 across all divisions in excess of 4000 where they had been reported into the system not opened or acted upon so it was unclear of the level of risk. There has been a significant effort to reduce this backlog and it has been reduced to 499 with an aim to have it cleared by the end of December in order to start with a clean slate with Datix in January. Overall assurance is given that serious incident reporting is improving but still remains sub-optimal due to data quality and data validation processes still not up to standard. Dr Parkes asked if anything in particular was picked up from the 4000 incidents investigated. Mr Bostock advised that behavioural, cultural and oversight issues were identified from these and from a clinical, quality and safety point of view there were no serious items that had gone undetected and this risk has now been mitigated with a manual process in place, enabling stronger visibility. When Datix is implemented there will be better electronic capability to pick up these issues. Mrs Muflahi advised that committee cannot underestimate the amount of effort that has gone into getting to where this project is now, even though there is a lot more work to be done. Regarding lack of ownership that was identified in the report – is this about the culture or systems within the organisation and what can be done to nurture this culture of learning. Mr Bostock advised that the analysis to date shows that historically over a number of years behaviour sets have normalised and one of the characteristics has been around specialist support functions such as governance, infection control, falls management etc not being directly linked to staff caring for patients and frontline staff to take ownership of

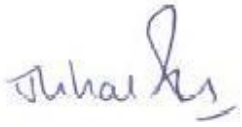
	this and use the specialist functions for support and ensure that the correct systems are in place to ensure this process runs efficiently. Mr Virdee asked if the Trust is confident that the restructuring will be completed by November and are the resources available? Mr Bostock advised that the management of change concluded at the end of September and posts are now out to advertisement. These new staff will need to be trained and ideally should be impacting on the service by March 2023. Dr Shehmar advised that the GMC have made it very clear that they wish to receive notification of any serious incidents where there has been a significant severe outcome, along with the names of the doctors involved and any identified shared learning. A system has been put in place and with the introduction of the new Datix system this information will be made available in a more timely manner. Mr Bostock advised that this process will also apply to nursing with the information being supplied to the Director of Nursing.
320/22	**VTE Assessment Audit**
	Paper included for information and was discussed at September meeting.
321/22	**CQUINS Update**
	There is now a process in place to monitor the CQUINS and this paper is an update performance report. There were 3 CQUINS that did not achieve the minimum threshold and 1 that achieved between minimum and maximum threshold. There is a tracking process in place with monthly meetings with each group to have an update and stay on track with trajectory, medical ones are chaired by the Deputy CMO and no concerns have been raised. Mrs Carroll advised that there are no current concerns with Nursing CQUINS but the CQUIN relating to flu vaccinations for frontline healthcare workers, which is not currently being reported but has a challenging target of 90%, is a concern and current data is showing 11% of staff have taken up the vaccine. Weekly meetings regarding flu and Covid vaccinations are taking place to discuss how to address this issue.
322/22	**7 Day Service Board Assurance Framework**
	This is a bi-annual report to committee. In February NHSE updated guidance to ease the burden on NHS Trusts on reporting and an audit was needed on admitting wards within the new scope. This audit found that compliance had increased with previous audits showing under 50% compliance with Standard 2 and Standard 8 and these are now at 60% and 75.5%. However, it was noted that there were some issues with the quality of the data for the audit, 120 patient notes were requested and 67 were available but only 53 had the relevant episode of care, which has been recorded on the risk register and there is a plan in place to address this. There are still concerns regarding weekend ward cover and there are still gaps with documentation and consultant job plans are being reviewed to ensure there is sufficient time to complete documentation and that this is a standard expectation. Mrs Muflahi asked if there is training available for record keeping within the Trust. Dr Shehmar advised that training is provided at doctor's induction but more work could be done to strengthen this training.

323/22	**Mental Health Update**
	Bi annual update on mental health and outlines the improvements made, risks that still remain and plans in place to mitigate these. After implementation of the improvement programme, the main red risk 2475 has been downgraded to a score of 5 following recruitment, training plan and support at ward level. There are still some challenges regarding training and releasing staff to be able to complete this, but extra support is being put in place to support ward areas. There are some remaining risks, but these are under review. There is a risk of out of area speciality patients on the adult pathway and availability of beds and the risk for the CAMHS service and availability of Tier 4 beds. The Trust is putting a structure in place to support patient safety and this is summarised within the paper, along with data collection. Mr Virdee advised that it was good to see the equalities data contained in the report and could ethnic breakdown be included. Mrs Muflahi acknowledged that this had been a large piece of work undertaken and asked if this report should be bought back to Committee more regularly. Dr Shehmar advised that this is a bi-annual report but shows how the Trust is now using data incidents through risk management and governance to drive change and to bring a risk from 25 to 5 is a good news story and gives Committee assurance. The remaining risks sit with external partners and are being taken forward via ICS and NHSEI actions.
324/22	**Patient Experience Update**
	Mr Perry took the report as read and presented highlights. The Friends and Family Test response rate has increased from Quarter 1 and the Trust is performing well at national and regional level. Inpatient response rate shows that the Trust is number 30 nationally. Maternity response rates are performing well and with the use of nudge messaging is demonstrating improvement. Mystery patient feedback is also improving, and this is used to monitor key questions from the national survey and if initiatives being put in place are having an effect. The Trust compliance rates for complaints for Quarter 2 was 78% which was a decrease from Q1 but is back on track this quarter and showing improvement. Details of national survey responses are contained in the report, including the Adult Inpatient Survey results and the action plan has been updated. Throughout the month of November there are several new initiatives launching across the organisation to support the Patient Experience Strategy and indicator of response to the national surveys. The Spiritual, Pastoral and Religious Care (SPaRC) team have been working in partnership with RWT and thanks are given to the team for their professionalism in challenging times, their support of their colleagues and ensuring continuity of their core business. The Five Wells of Chaplaincy has been implemented and results of this will be seen in future reports.

	The division continues to involve patient involvement partners, with a view to more recruitment and the last meeting was well attended. The Walsall Price event in August went very well and received good engagement particularly with young vulnerable people who often find access to services difficult. Mr Virdee acknowledged the excellent work from the team. He asked if there are volunteers involved with patients in the community. Mr Perry advised that there are volunteers within community services, and this is an area that the Trust aim to increase, particularly with the assistance of the new Volunteer Co-ordinator to strengthen partnerships in the Third Sector.
325/22	**104 Day Harm Update**
	Report is included for information. Dr Shehmar advised that the main change this month is fit testing and the national letter from NHS England and work is underway with GP's in this area. A new theme this month is the thyroid cancer pathway and streamlining discussions with RWT are taking place to link this with RWT rather than UHB. There is also work underway regarding patients who have not been referred on a cancer pathway but are sitting in patient waiting lists, particularly the dermatology pathway which has longer waits after Covid and the operational team are looking at a process to review the care group pathways and harm reviews.
326/22	**Update on CQC Inspections**
	Verbal update given from Mrs Carroll. There were un-announced inspections in the divisions of Children and Young People, Medicine and Long Term Conditions and Surgery carried out. A Well-Led inspection is due to take place on 9-10th November and a Joint Targeted Area of Inspection (JTAI) is planned for 7-9th November around Safeguarding which involves the CQC, Ofsted and Her Majesty's Inspector of Constabulary which will focus on ED, Maternity, School Nursing and Health Visiting. There will be a further inspection in Maternity Services by April next year for which the Trust will receive 48 hours notice. The Trust has been issued with a Section 29A Warning notice regarding medication management and the Trust's ability to keep patients safe and there is a high level action plan in place and regular weekly meetings are taking place to review actions and progress. Significant improvement needs to be seen by 31st December.
327/22	**Board Oversight of Health & Safety Reporting**
	Paper was taken as read and any queries to be forwarded to Mr Bostock.
328/22	**Exception Reports from Sub Groups**
	No exception reports were received for discussion.
329/22	**Any Other Business**
	Welcome was given to Mrs Metcalfe the new Deputy Director of Assurance.
330/22	**Matters for Escalation to the Trust Board**
	There were no items for escalation.

331/22	**Reflections on the Meeting**
	There were no reflections from the meeting and the meeting finished at 1.33
332/22	**Date of Next Meeting**
	Friday 25th November 2022, 11.30 – 1.30

Minutes approved as a true and accurate record

Signed ……  ……. Date ……25.11.22……

Dr J Parkes - Chair

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PERFORMANCE AND FINANCE COMMITTEE HELD ON WEDNESDAY 26th OCTOBER 2022 AT 15:00 HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Mr P Assinder	Non-Executive Director **(Chair, left during Item 107/22)**
Mrs M Martin	Non-Executive Director **(Took over as Chair during Item 107/22)**
Ms D Brathwaite	Non-Executive Director
Mr R Caldicott	Chief Financial Officer
Mr M Dodd	Interim Director of Transformation
Mr N Hobbs	Chief Operating Officer

In Attendance

Dr M Shehmar	Chief Medical Officer (Joined during item 107/22)
Miss B Edwards	Executive Assistant **(Minutes)**
Mr K Wilshere	Group Company Secretary (Joined during item 107/22)

Apologies

Mrs L Carroll	Director of Nursing
Mr D Mortiboys	Operational Director of Finance
Mr S Evans	Interim Chief Strategy Officer

103/22	**Chair's welcome; apologies and confirmation of quorum**
	Mr Assinder welcomed everyone to the meeting and apologies for absence are noted above.
104/22	**Declarations of interest**
	There were no declarations of interest raised.
105/22	**Minutes of last meeting held on Wednesday 26th October 22**
	Following the minor amendment requested by Mr Hobbs, the minutes were approved to be an accurate representation of the previous meeting.
106/22	**Matters arising and action log**
	The action log was reviewed and updated.
107/22	**Financial Reports**
	Month 6 and Forecast Outturn Mr Caldicott presented to members. It was noted financial parameters and performance for month 5 had been released by Midlands wider system and are included within the paper. The Midlands which includes 11 Integrated Care Systems (ICS's) is reporting a £160m deficit and an adverse performance against plan of £96m. The Black Country & West Birmingham ICS is reporting a £36m deficit, £27m adverse to plan.

	Mr Caldicott highlighted other providers within the BC&WB system had higher deficits, though noted the Trust had planned for flat income and therefore targeted surplus in the early part of the year to cover increased costs over winter (it was unclear if others had modelled their plans in this way). Members were informed there had been a system escalation for Chief Financial and Accountable Officers. There had been ongoing discussions in relation to the deficit through the Committee and members were advised the drivers of the deficit centred upon temporary workforce (agency remaining high) Cost Improvement delivery, with Surgery and Medicine and Long-Term Conditions significantly off plan at this time. Temporary workforce costs remain high with agency above historic levels, whilst the Trust has increased substantive staff. Members were informed agency reduction and temporary workforce reduction modelling would be key to delivery of financial plans. A recovery plan was in development that included measures to mitigate the current level of overspends. A report forecasting best / likely / and worst case will be prepared for presentation to members at the next Committee before progressing to Trust Board. Mr Caldicott advised the recovery plan will articulate projected CIP delivery and flexibility of the balance sheet. Members were informed of the Trust rating for the NHS Oversight Metrics (Operating Framework) was 3 (within a scale of 1 to 4 – 1 excellent) with the operating framework focusing upon delivery of efficiency plans, financial stability (delivery of the financial plan) and agency expenditure (the target an ICS reduction by 30% of historic actuals). There was a risk resulting from the BC & WB ICS position of reporting a high deficit, that Walsall's rating could be increased to a 4 and would be deemed to be mandatory intervention situation. Mr Caldicott expressed there was a lot of focus on the system as it was proportionally significantly higher in terms of deficit and variance to plan than any of the other systems operating. Mr Wilshere joined the meeting at 15:10. Mr Caldicott raised to members that whilst there remains a Capital risk with funding the theatres upgrade, there was two potential sources that could provide the funds, the Trust having bid for the capital from NHSE (a decision on award to be made during November 2022) and there was slippage within ICS base capital allocation from delays contained within the mental health scheme. It was also raised the decision to purchase the MAKO robot had been made through Chairs action for a total value over £1m with funding bid for from NHSE and as with the theatres funding would be known in November 2022. Members noted if the funding does not materialise then further slippage would need to be sought.

	Mr Assinder noted the capital expenditure and the push to source the finance for the schemes. Dr Shehmar joined the meeting at 15:15. Mr Caldicott noted to members there is an increasing focus placed upon the 2023/24 financial year, with indications of financial settlement centring upon a flat cash scenario whilst inflation continues at record levels. It is expected to be a difficult year financially. Whilst the Finance and Operational teams continue to work on the expenditure plans, the regime and the income allocation had not been confirmed with details to be provided within the operational framework, the expected release date being close of December 2022. Mr Assinder summarised that the Trust reported a £2.8m deficit at the half year stage with a forecast risk of a deficit of £8.7m by year end. Further modelling will be brought to the next meeting and progress to Trust Board in December 22. Mr Caldicott agreed with Mr Assinder's summary, advising that the ICB and wider ICS membership had been made aware of the Trust reviewing forecast outturn in this timeframe, with systems only able to declare movements to forecast on a quarterly basis so this would align with the return of information for December 2022 to the regulator following approval from Trust Board should the Trust re-forecast a deficit for 2022/23. Mr Assinder expressed the view that with CQC carrying out a Well Led Inspection the Trust needed to be clear that the deficit was flagged, the reason was known and that a systematic process of review was being taken. Mr Caldicott agreed and advised a briefing document was being pulled together for circulation to Board members. Mrs Martin thanked Mr Caldicott for the informative report and queried the pay deal funding. Mr Caldicott explained that the initial offer of funding to cover this excluded the increase associated with ERF funding allocation that should be included within the pay award settlement. It was confirmed the Trust and other partners were challenging the calculation and there was a view funding will be increased accordingly. Currently the Trust has a shortfall £280k. It was noted the outcome would be confirmed by the end of November 2022. Mrs Martin questioned if COVID-19 separate pathways would continue to be operated. Mr Hobbs confirmed and highlighted these were now designated as respiratory infection pathways which included COVID-19 and expressed that in his view, he did not feel the infection control guidance would change further. Mrs Martin questioned how the commissioners were going to recompense the additional spend. Mr Hobbs advised he could not answer but expressed this was national guidance and would be an issue nationally. Mr Caldicott and Mr Hobbs agreed to find out and inform members.

	Mrs Martin noted the continued spend on agency and bank staff and questioned if there was a possibility that all required staff had not been included in the budget. Mr Caldicott confirmed this unbudgeted spend was around temporary ward cover due to the demand being experienced and opening of the winter capacity early, driving an increased cost above plan in the early months of the financial year. Mr Assinder left the meeting at 15:30. Mrs Martin took over as Chair. Mr Hobbs agreed and expressed ward 14 had been over the core bed base due to emergency pressures. It was raised that Ms Carroll, Mr Hobbs and Mr Caldicott were trying to resolve budgeting issues for ward 4 and 12. Mrs Martin highlighted the WLI's were £420k over budget and suggested this was due to doing work for other organisations but noted the statement on income month by month did not show an increase for payments for the work for other Trusts.. Mr Hobbs advised he wasn't sure if the mutual aid income was accounted for but expressed there was long term sickness and consultants on restricted practice causing some of the overspend on WLIs. Mr Caldicott confirmed the income was included but was distorted due to initially more mutual aid patients being seen and blended in with Walsall patients. However, we have seen the Walsall patients targeted first and the additional sessions moving forwards focus on mutual aid patients (so the income can be recovered to offset some of these costs). Mrs Brathwaite expressed concern in relation to the use of agency and bank staff as the Trust enters the winter season and requested assurance on reduction or maintain the trajectory. Mr Caldicott confirmed it would be included within the report for the next meeting and stated that Mrs Carroll had stated new starters are due to commence and had expressed confidence there would be a move away from agency as the Trust enters December 2022. Mrs Martin expressed there was not a direct correlation between additional work and extra income and it appeared the Trust had carried out more work for the same money. Mr Hobbs agreed and added it was a problem for the Trust in relation to emergency care due to the growth in demand. Mr Caldicott advised a business case had been through to support the Emergency department in anticipation on the Midland Metropolitan activity allowing the organisation to see a further 10,000 ambulance attendees per annum. Mrs Martin questioned the opening date of the new Midland Metropolitan hospital and Mr Hobbs confirmed it was due to open in Spring 2024. **Actions** - **Mr Caldicott and Mr Hobbs to find out and inform members in relation to the Trust being compensated for the segregation pathways.**

	- **Ms Carroll, Mr Hobbs and Mr Caldicott to resolve budgeting issues for ward 4 and 12.**
108/22	**Procurement Report**
	Mr Joy-Johnson presented to the Committee. It was noted current 2022 / 23 total forecast Procurement related savings position was £1,464,757 but it was expressed there were still inflationary pressures. Members were assured all was being performed to manage inflation at local, regional and national level with 143 individual projects being identified to deliver the workplan. Mr Joy-Johnson informed members a category cell model to include a dedicated pathology category cell with the University Hospital North Midlands hosting the NATO midlands network with the Royal Wolverhampton hosting the BCPS. Members noted the electronic request for expenditure control system was being rolled out at RWT and would look to be rolled out at Walsall after. Members were informed the ISPD was 75% compliant which was the third most advanced of the 42 ICS's. Workforce was highlighted as a key challenge but acknowledged this was across all areas and departments. Members noted all senior positions were filled with internal promotions with the lower bandings vacant. Mr Joy-Johnson advised the Trust was looking at annual savings of up to £500k per annum with new contracts with various dates over the next 12 to 18 months. Mrs Martin expressed she had questioned the savings on influenceable spend as she triangulated with the Month 6 report as there was a variance of £2.1m. Mr Joy-Johnson expressed the ISPD was to measure the total procurement intervention and to add value and confirmed it does include cost avoidance. Mrs Martin raised there was extra activity with no additional income being received. Mr Joy-Johnson agreed and expressed there was inflationary pressures on non-pay that have not been able to be mitigated and have not been funded by the centre. Mrs Martin questioned if there were any areas of spend where inflation was a significant factor. Mr Joy-Johnson confirmed the issue was across all expenditure . It was added there was a degree of protection from contracts put in place last year which are not due for renewal hopefully until the market starts to go down. Mr Caldicott advised there was work on going around the cost reduction budget extractable savings with a target of £770k. It was advised the efficiency programme did not include this full savings potential and if delivered this would further support delivery of the efficiency programme, noting the current programme containing a gap.

	Mr Joy-Johnson left the meeting at 15:56
109/22	**Temporary Medical Staffing Spend**
	Mrs Martin asked why the figures presented were August 22. Dr Shehmar advised it was down to timing of when the figures were available. Dr Shehmar advised the paper was to provide members with an overview of the agency spend and the plan to be able to convert agency into substantive posts. It was highlighted the majority of the spend was in the Division of Medicine and Long-Term Conditions, Emergency Care. There was a financial drive to address this as well as a quality drive as acute medicine had the highest number of quality concerns, with a safety concern raised by Health Education England in relation to changing the Junior Doctor rota. Members noted there were professional standards issues and multiple individuals that have had restricted practice or have been excluded due to senior concerns have been backfilled. Mrs Martin questioned the timeframe for a resolution around these back filled positions. Dr Shehmar explained she could not confirm or advise the outcome of the various personnel issues but advised there were timelines in place to progress each case but these often took in excess of a year. Mrs Martin questioned the annual cost to the Trust of the requirement to backfill senior posts Dr Shehmar agreed she could provide a cost and Mr Caldicott confirmed it could total c£500k for 3 consultants, whilst in the past the Trust could earn greater income to offset some of the cost (locums undertaking higher DCC's) in the current funding regime this was not possible. Dr Shehmar expressed there had been several substantive business cases for service expansion and development, with a large jump in substantive appointments filled over the summer months. Members were informed overseas doctors arriving in the UK have their competencies assessed to ensure they can work within the UK and NHS at the level expected of them. It was expected these doctors would be in post by the end of November 2022. Dr Shehmar advised she and Mr Hobbs had worked closely with the MLTC Division around filling posts due to the limited workforce available and limited talent pool to recruit from. Mrs Martin thanked Dr Shehmar for an encouraging report and expressed it would be beneficial to have another report presented back in February 2023. **Actions** - **Dr Shehmar to present progress on reduction in temporary workforce back to the February 2023 Committee.** - **Dr Shehmar agreed to provide a cost of backfilling senior posts covered by locum consultants.**
110/22	**Performance Constitutional Standards Report**
	Community

	Mr Dodd highlighted the profile of high demand had continued in relation to out of area patients and medically fit for discharge. It was confirmed the funding, £1.7m worth of expenditure, had been received and would allow for the out of hospital capacity to expand the virtual ward and discharge teams. Mr Dodd noted that the demand seen had manifested into pressures on the Community equipment stores and the utilisation of step-down beds across Walsall. This had been funded through the Better Care fund, but the Trust has been informed their funds had gone into other expenses. It was noted there was a funding gap and the system was looking for trajectories. Mr Dodd confirmed he was due to meet with Mr Evans and Mr Caldicott to discuss contingency measures. Mr Caldicott expressed it was a key issue and he would be meeting with Mr Dodd and Mr Evans to ensure there was an adequate provision for beds outside of the hospital the challenge to maintain the existing baseline to facilitate the flow. <u>Acute</u> Mr Hobbs presented to members. It was noted ambulance handover times continued to be strong and the cancer referral to treatment times measured through the 62-day standard. Diagnostic access performance had stabilised but challenges remained in cardiac physiology and endoscopy. Members noted there was a credible cardiac physiology recovery plan in place and evidence was being seen during October 22. Mr Hobbs advised the endoscopy challenge was larger and there was not a sustainable recovery plan in place, but a business case was being drafted and would be ready within 3 weeks. It was raised to members the number of 52-week waiters patients was increasing but was consistent across the country with 78 week waiters reducing and Mr Hobbs was confident there wouldn't be any by the end of the financial year. Mrs Martin stated there had been an improvement but activity levels f the BCPS, however it appeared that demand exceeded the capacity of the service and questioned if there was a mitigation plan in place. Mr Hobbs advised there were early signs of improvement in relation to histopathology turnaround, the main area of concern. It was highlighted the solution was for an additional consultant which had been recruited to. Mrs Martin further questioned whether the cost savings predicted were being achieved. Mr Caldicott confirmed there was a targeted level of savings from efficiency. However, we are partners in the Pathology service and in the current economic environment it was highlighted there was an active debate around increasing the cost from the existing baseline. **<u>Action</u>** - **Mr Dodd and Mr Evans to report back on the meeting to ensure there was an adequate provision for beds outside of the hospital for discharge.**

111/22	**Efficiency Programme Update**
	Mr Hobbs highlighted to members the Trust had identified £5.9m of Cost Improvement Programme (CIP) against the £6.3m target and work continues to close the remaining £400k gap. Mrs Martin questioned if the CIP transacted was tracked and split between recurring and non-recurring. Mr Hobbs advised there was hesitation from the divisions to declare whilst their forecast was being completed in relation to non-recurrent. Mr Caldicott advised the savings were captured as recurrent and non-recurrent with the savings split into these categories. Mr Caldicott added that £2.3m of the savings were expected to be non-recurrent and this was modelled into the normalised position, variation from this value would impact on that expected normalised outturn. **Action** - **Future reports to include the split of delivered CIP between recurring and non-recurring.**
112/22	**Terms of Reference for Efficiency Programme**
	The Efficiency Programme Terms of Reference were approved.
113/22	**Financial Strategy**
	Mr Caldicott presented the financial strategy to members. It was advised the enabling strategy had been pulled together for Walsall Well Led review but there was a view to have a WHT and RWT joint strategy. Mrs Martin commented that it was a great document that needed to be used to encourage people to work together. Mrs Brathwaite agreed and questioned how often the strategy would be reviewed. Mr Caldicott confirmed it would be reviewed every 12 months but would look to bring back within 6 months upon their being a unified position.
114/22	**PFI Update**
	Mr Caldicott provided members with an PFI update and it was agreed would remain on the agenda as a verbal update for at least the next 4 months. **Action:** - **PFI Verbal Update to remain on the agenda for 4 months.**
115/22	**Board Assurance Framework and Corporate Risk Register**
	Members noted the BAF was being reviewed to move in line with the new Trust Strategic Objectives. Mr Hobbs requested the dissolution of SO 03, Working with Partners, following approval at Risk Management Executive. It was agreed SO 03 was no longer a strategic risk.
116/22	**Annual Cycle of Business**
	Members noted the Annual Cycle of Business.
117/22	**Any Other Business**
	There was no other business discussed.

118/22	**Matters for escalation to the Trust Board**
	The following items were agreed to be escalated to Trust Board. - Financially the Trust remains in deficit and adverse to plan, forecasting a deficit with a revised forecast, the deficit position to be reviewed in Novembers Committee and sent to Board for endorsement in December 2022. - Good progress was being made on recruitment, but agency costs remain above historic periods. - Medical staffing temporary workforce expenditure was presented to members with controlled reductions planned. However, some areas may continue to incur costs owing to workforce availability - Continued provision of Intermediary beds within Community was highlighted as a key risk to winter flow. - ED performance was strong but remained challenged.
119/22	**Date and Time of the Next Meeting: Wednesday 30th November 2022**

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

HELD ON MONDAY 26TH DAY OF SEPTEMBER2022 AT 13:30
HELD VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Mr Paul Assinder (CHAIR)	Non- Executive Director
Ms Catherine Griffiths	Chief People Officer
Mrs Lisa Carroll	Director of Nursing
Mrs Sabrina Richards	Equality, Diversity and Inclusion Lead

In Attendance

Dr Tamsin Radford	Occupational Health Consultant
Mrs Pat Usher	Joint Staff Side Lead
Mrs Rosemary Adams	Human Resources Administrator
Mrs Maninder Kaur	Staff Nurse – Occupational Health
Mrs Jay Osbourne	
Mrs Hannah Davis	Human Resources Representative
Mrs Jaswinder Toor	Senior Executive Assistant & Senior Operational Co-Ordinator
Mr Brad Allen (Minutes)	Executive Personal Assistant

Apologies

Mrs Dawn Brathwaite	Non-Executive Director
Mr Junior Hemans	Non-Executive Director
Mrs Jane Wilson	Joint Staff Side Lead
Mrs Maria Arthur	Deputy Joint Director of Assurance

83/22	**Chair's welcome, apologies, and confirmation of quorum**
	Mr Assinder welcomed all members to the meeting and passed on his thanks for their attendance. Mr Assinder declared the meeting to be inquorate due to the apologies received, therefore reports could not be formally approved. Formal apologies were received and noted as above.
84/22	**Declarations of Interest**
	There were no declarations of interest raised by members for noting.
85/22	**Minutes of Previous Meeting – August 2022**
	There were no points of accuracy raised by members.

	Mr Assinder advised that due to the lack of quoracy, committee would not be in a position to approve the minutes as set out, therefore contents of the report were noted for review and approval at the next committee.
86/22	**Matters arising and Action Log**
	The Action Log was reviewed and updated by action owners as necessary by utilising the iBabs service.
87/22	**Staff Story – Occupational Health Staff Development**
	Dr Radford began by introducing Mrs Kaur to the committee and gave a brief overview of her development journey. Mrs Kaur then addressed the members and gave a step-by-step experience story of her development opportunities, as well as the challenges she faced. Mr Assinder thanked Mrs Kaur for her presentation. There were no further comments or questions from members.
88/22	**Corporate Risk Register and Board Assurance Framework**
	Mr Assinder introduced the report and referred members to the first risk relating to recruitment and retention issues. He advised members that this risk carried a proposal to increase from a total of 8 to 16 following recommendation from colleagues. *MS Griffiths joined the meeting.* Ms Griffiths advised that the slight increase in risk rating was a result of recruitment requesting the increase following escalations from Divisions. She advised that an investment case had recently been approved to increase recruitment staffing figures t0 support various projects. In addition to this, it was reported that overall vacancy rates were decreasing but turnover and retention rates require improvement to maintain a stable workforce. There were no further comments or questions from members therefore committee noted the report.
89/22	**Progress in Strategic Wellbeing**
	Dr Radford introduced the report and advised members of the following points, beginning with assurances: Points to assure committee: • Strategic Health and Wellbeing as measured by the NHSE/I Framework, which is the gold standard measure, is progressing well • All elements measured by the tool have improved since it was last presented to the Committee

	• Walsall Healthcare Trust is participating in Black Country ICS work to share best practice, resource and ideas to advance progress • This work supports achievement of the Healthy Attendance Project (see other paper) • Occupational Health and Wellbeing services have now received National Accreditation (SEQOHS) after an extensive service improvement programme Points to advise committee: • There is a monthly review of all strategic elements and operational elements of staff Wellbeing • At times the operational need has been prioritised above the strategic progress – notably with the Trust response to the cost of living crisis Points to alert to the committee for any required intervention: • Resources to continue work to prevent poor health in the workplace is not yet fully funded by the Trust (currently under consideration at investment Group). Without this there will be a ceiling for health related improvements which may impact other areas of wellbeing. Dr Radford then went on to advise committee of the next steps for the project, as well as funding elements. She advised committee that members of the Senior Leadership Team to meet and discuss improve methods of collaborative working across Walsall and Wolverhampton sites. Mr Assinder thanked Dr Radford for her report and expressed his support for the number of Mental Health First Aiders the Trust has achieved. Dr Radofrd that the Occupational Health Team continues to deal with counselling needs as required, and is looking to introduce a substantive Counsellor to their team to work on preventative measures to support staff with sickness absence, in particular, musculoskeletal-related illness. Mr Assinder express his support for the wide range of activities and projects that have been initiated within the team. There were no further comments or questions from members, therefore committee noted the report.
90/22	**Safe Staffing Report**
	Mrs Carroll introduced the report as read and reported the following highlights for the committee's information: - The Trust's overall vacancy position is improving, boats recent increases have been experienced following the approval of the staffing business case for the Emergency Department.

	- Overall vacancy usage continues to fall despite recent increases to positive coronavirus cases. - A further 214 clinical fellowship nurses have completed their assessments, with 195 of these being formally registered with the Nursing and Midwifery Council. - Clinical Support Worker recruitment drives are underway, with a total of 67 interviews yet to take place. - A further 5 Nursing Associate programme candidates are due to fully qualify in September 2022. - virtual safe staffing meetings continue to meet twice per day, in order to mitigate any foreseen issues to prevent escalation. - Bank Mandatory Training Figures remain low. Staff have all received written communication to remind them to update their competencies. - Agency usage continues to remain high within Endoscopy to reduce waiting list capacity. - A dedicated Mental Health Team has been recruited to support staff following issues raised following lockdown. Mr Assinder queried how staff were being supported with the completion of mandatory training completion amongst Bank and substantive staffing levels. Mrs Carroll advised that staff are being given opportunities to complete their training by being released from Wards to undertake within the Manor Learning and Conference Centre. There were no further comments or questions from members. Committee resolved to note the report.
91/22	**Trust Workforce Metrics**
	Ms Griffiths introduced the report as read and highlighted concerns to retention and exit monitoring figures.

	Mr Assinder queried progressions being made to the retention plan for committee oversight. Ms Griffiths advised that the report was due to be presented to members of the Trust Board on Wednesday 5th October 2022. There were no further comments from members, therefore the report was noted.
92/22	**Sickness Absence Report**
	Dr Radford introduced and gave an overview of the rationale behind the report. She then went on to update members on the following points: • A centralised team in People and Culture has commenced work on the Healthy Attendance project and will continue to update committee accordingly. • Initial metrics have proven recent successes to sickness absence reduction. • Access to Wellbeing interventions is a key priority in addition to sickness reduction for the Occupational Health Team, and managers will continue to follow sickness policy to support staff in their return to work. • The project was reported to be at an early stage and there is ongoing work to best target resources appropriately. • The project is co-dependent on all Health and Wellbeing work, with data being captured from the NHSE/I framework paper. • Reduction in resource remains the primary factor of hindrance to project delivery. • The Chief Executive has agreed posts to aid sickness prevention, but have not yet received approval at Investment group. Mr Assinder thanked Dr Radford for the report. Mrs Davis expressed her support for recent changes, in particular additional clinics which has aided the team in managing each case individually.

	Ms Griffiths thanked Dr Radford for the report and emphasised the need for staff being encouraged to lead healthy lives at work, and that staff being allocated protected time to undertake duties has proven successful in recent reviews. As a result, Ms Griffiths advised that short-term sickness figures had reduced following efforts from teams. Mr Assinder suggested that a review of progress takes place within the next 3 months for committee to monitor progress. There were no further comments from members therefore committee resolved to note the paper.
93/22	**Medical Revalidation Report**
	Dr Shehmar introduced the report and advised colleagues that following approval, the paper would be submitted to the General Medical Council for oversight. Dr Shehmar then went on to summarise the performance figures of the Trust of which were reported to remain between 96 and 98%. Dr Shehmar emphasised that on-going efforts from colleagues have ensured that these remain stable, whilst other Trusts in comparison have not achieved such ratings. Dr Shehmar advised committee that a number of Appraisers had been recruited to support for Medical Revalidation figures, and provided with sufficient training as such. In addition to this, Dr Shehmar also stated that Clinical Fellowship colleagues would also require the completion of an appraisal, thus increasing the overall completion target. Dr Shehmar informed members that to support this, a new process had been established to ensure the recruitment of Clinicians who are both safe to practice and possess the required skill set. Dr Shehmar updated colleagues on 2 recently undertaken reviews of the Trust's appraisal process in partnership with wider review undertaken in Medical Governance. This will allow all feedback to be centralised into one report for committee oversight. Dr Shehmar stated that despite numerous examples of good practice being highlighted within the report, a number of issues need to be resolved. Dr Shehmar gave examples of some Locum Bank clinicians had not been aware of gaps in training. Dr Shehmar advised that in such instances, mitigatory measures had been implemented to help resolve issues quickly. Other examples included connection to Allocate, resulting in some appraisals being missed.

	Dr Shehmar advised committee that revalidation meetings have been established, where she and other colleagues review staff records by five years to allow teams to highlight issues as required. Mr Assinder referred members to section 6 and expressed his support for the review detailing what actions had been taken but queried how members of the board could monitor the pace of progression with these. Dr Shehmar responded to Mr Assinder and advised of a recently established Task and Finish Group put in place to identify gaps in practice, with one being Medical Governance and Medical Human Resources. Dr Shehmar advised of a newly created position due to be put in place to ensure Board oversight, as well as other progress elements. There were no further comments from members. Committee resolved to approve the paper in principal, but note the lack of quoracy.
94/22	**LGBTQ + Report**
	Mrs Richards introduced the report as read and began by updating members on the second phase of the Rainbow Badge scheme for their reference. Mrs Richards then advised members of the circulation of a new survey to all areas for staff to complete and return to feedback on their thoughts as to how inclusive we are as an organisation. Mrs Richards summarised the report and stated that overall, the Trust is in a good position compared to others, but has also provided insight as to where the organisation needs to improve and gave examples of training opportunities for staff to improve the patient experience of same sex and transgender members of the community. Mrs Richards concluded by updating members on the newly recruited Chair of the Trust's LGBTQ Board; Mr Andrew Rice as well as Trust representation at the recent Birmingham Pride. There were no comments from members, therefore committee resolved to note the report.
95/22	**People Culture Towards Excellence**
	Ms Griffiths introduced the report as read and highlighted the below points to committee for their reference:

	- Following a recent survey, a total of 67.1% of colleagues agree that Managers take their Health and Wellbeing seriously and that figures were above the national average. In addition to this, the report highlights what areas are in need of improvement. - Indicators from the recent Staff Survey highlight that staffing levels are continuing to improve from a low poing and continue to improve following recent recruitment drives. Areas are being reviewed with necessary Line Managers by linking in with elements of compassionate leadership, the Equality, Diversity and Inclusion Strategy and staff wellbeing. - Positive improvements have been experienced following the update of corporate risks, in particular the work of Cultural Ambassadors during recruitment campaigns, which have shown a significant increase in the representation of black Asian and minority ethnic staff at senior levels within the trust. . There were no comments from members, therefore committee resolved to note the report.
96/22	**Items for Information**
	There were comments or questions from members relating to items tabled for information, therefore it was resolved by committee that reports be noted.
97/22	**Escalations to the Trust Board**
	It was agreed by committee that the following escalations be submitted to Trust Board for oversight and further comment as required: - Positive staff experience within Occupational Health. - Safe Staffing which highlights ambition to the reduction of agency work - Workforce metrics report's highlight to positive action taken to retention and vacancy management. - Alteration to risk 2072 - Healthy attendance project plan. - Revalidation report approval.
98/22	**Date and Time of the Next Meeting**

	The next People and Organisational Development Committee will take place on Monday 24th October 2022 at 13:30 via Microsoft Teams.

Walsall Healthcare NHS Trust

MEETING OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

HELD ON MONDAY 24TH DAY OF OCTOBER 2022 AT 13:30
HELD VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Mr Junior Hemans (Chair)	Non- Executive Director
Mrs Dawn Brathwaite	Non-Executive Director
Mr Paul Assinder	Non-Executive Director
Ms Catherine Griffiths	Chief People Officer
Mrs Lisa Carroll	Director of Nursing
Mrs Sabrina Richards	Equality, Diversity and Inclusion Lead

In Attendance

Mrs Louise Nickell	Group Director of Education Services
Mrs Sophie Stephenson	Partner – Deloitte
Mr Keith Wilshere	Group Company Secretary
Miss Mushal Naqvi	Guardian of Safe Working
Mrs Patricia Usher	Joint Staff Side Lead
Ms Jane Wilson	Joint Staff Side Lead
Mrs Catherine Wilson	Deputy Director of Nursing
Mr Brad Allen (Minutes)	Executive Personal Assistant

Apologies

Mr Kevin Bostock	Group Director of Assurance
Ms Clair Bond	Deputy Director – People and Culture

99/22	**Chair's welcome, apologies, and confirmation of quorum**
	Mr Hemans welcomed all members to the meeting and passed on his thanks for their attendance. Mr Hemans declared the meeting to be quorate in line with committee terms of reference. Formal apologies were received and noted as above.
100/22	**Declarations of Interest**
	There were no declarations of interest raised by members for noting.
101/22	**Minutes of Previous Meeting – August and September 2022**
	Mr Hemans advised that due to lack of quoracy at the committee meeting held in September 2022, minutes for both August and September 2022 would require formal approval from members.

	There were no comments or amendments from members therefore committee **resolved** to approve both sets of minutes from August 2022 and September.
102/22	**Matters arising and Action Log**
	The Action Log was reviewed and updated by action owners as necessary by utilising the iBabs service.
103/22	**Staff Story**
	Committee **noted** there was no Staff Story tabled for discussion
104/22	**Trust Workforce Metrics**
	Ms Griffiths introduced the item and advised that all Divisional Workforce Metrics were being discussed in individual Divisional Performance Reviews on a monthly basis, where staff are given the opportunity to highlight trends and update Executive Leads on any mitigatory measures where appropriate. Ms Griffiths advised that in terms of trends, attendance at work had been highlighted in some areas and that best practice would be shared with wider colleagues for learning and implementation. Ms Griffiths then went on to summarise overall decrease in sickness absence figures across the Trust and acknowledged the efforts of staff in supporting colleagues back to work following long-term sickness absence in particular. Ms Griffiths updated committee of recent appointment of Counsellors whom would support staff with a variety of issues including mental health with cases of work related stress and anxiety being reviewed on a case-by-case basis. There is additional physiotherapy resource to support musculoskeletal health concerns, including manual handling team training. Ms Griffiths followed on by addressing concerns relating to retention rates across the organisation and advised that recently published figures indicated that the Trust was not in a different position to others across the Country. Ms Griffiths stated that a retirement workforce tool had been implemented to support colleagues in forward planning for their retirement, as well as management ensuring vacancies are filled to ensure service continuity. Ms Griffiths summarised the Trust's Mandatory Training position and advised figures had improved, with overall appraisal figures remaining at the same level as previously reported figures. Mr Assinder raised concern with administrative and clerical mandatory training figures as this staff group was less impacted by Covid-19 restrictions that of clinical colleagues who could not work from home. Mr

	Assinder then referred members to staff vaccination rates and raised concern that up-take figures were low at 10%. Mrs Carroll responded to Mr Assinder and assured him that weekly vaccination meetings and vaccine hub had been implemented to mitigate this as well as suggest means of encouragement for staff to uptake their vaccination. Mrs Carroll also advised committee of scheduled twilight clinics that had been established to capture night staff to have their vaccine. Mrs Carroll then went on to update members on the increased effectiveness of this year's Influenza vaccine due to it being designed to target the most common variant currently impacting the population. Mrs Brathwaite queried why there had been an increased level of hesitance amongst colleagues to uptake their vaccines and queried if any trends in reasoning had been identified. Mrs Carroll responded to Mrs Brathwaite to suggest reported side effects from the recently introduced Moderna vaccine may be contributing towards staff anxiety. Mr Wilshere followed on from points raised by Mrs Carroll and advised that following conversations with staff, elements of vaccination fatigue had been identified. Ms Griffiths advised members that task force focussing on staff engagement had been established to increase staff survey take up by staff. There were no further comments or questions from members therefore committee **noted** the report.
105/22	**Safe Staffing Report**
	Mrs Carroll introduced the report and advised members of the following points for their information: • 224 international Nurses had arrived in the Trust, with 135 now being registered with the Nursing and Midwifery Council. • 35 Student Nurses who were due to qualify in September 2022 had been accepted into roles across the Trust with another one member of staff due to commence employment in January 2023. • Registered Nurse/Midwife vacancy rates for August 2022 had remained static at just over 10%. • September 2022 prior to consideration of escalation to off framework agency, Matrons redeployed 1100 hours of Registered Nurses and 1096 hours of Clinical Support Worker time.

- Off framework agency usage within Nursing had decreased during September 2022 to 641 hours; a reduction of 333 hours.

- The lowest fill rate for September 2022 was for Registered Nurses on day shifts at 90.51%. The overall fill rate for September 2022 was reported at 98.15%, with the previous month being reported at 96.40%.

- Mandatory Training compliance for Bank Staff had increased to 48.7% from 47.1% reported previously and an action plan has been devised to monitor progress. It was reported that a process had been established for the Recruitment Department to confirm that all new Bank only starters are compliant before they commence employment.

Mr Hemans informed Mrs Carroll that several colleagues had not been re-imbursed their fees when attending out of hours nursing recruitment drive and requested that this be resolved as a matter of urgency.

Mrs Carroll advised committee she had recently received several accommodation concerns relating to new members or staff and stated that Mrs Richards undertaking a review of housing stock options in the local area.

Mrs Richards responded to Mrs Carroll to advise she had conversed with the Chief Executive of Walsall Housing Group to explore options. However, it was reported that the waiting list within Walsall exceeded over 16,000 applicants therefore conversations with private Landlords had commenced to resolve this issue.

Mrs Carroll suggested that to resolve issues relating to housing for new members of staff that conversations take place with Ms Zoe Marsh. In response to this, Ms Griffiths advised she would liaise with Mr Alan Duffell, Chief People Officer at The Royal Wolverhampton NHS Trust, to pick this up as a policy action.

ACTION:
Ms Griffiths to liaise with Mr Duffell to discuss housing issues for new members of staff.

Mr Hemans suggested that a collective meeting be held with all social housing providers in Walsall to determine a way forward.

There were no further comments or questions from members, therefore committee **noted** the report.

106/22	**Schwartz Round Annual Report**
	Mrs Nickell introduced the report as read and began by providing members with a brief overview of the Schwartz Round rationale and gave examples of how learning points had improved the working lives of staff. Mrs Nickell advised committee that Dr Esther Waterhouse had recently been appointed to lead on Walsall based Schwartz rounds and an average attendance figure 22 colleagues had been achieved in terms of engagement, with 88% of staff recommending them to their colleagues. Mr Hemans queried what engagement figures were for Administrative and Clerical staff and requested that a dedicated session for this staff group be arranged. Mrs Nickell responded to Mr Hemans to emphasise that these staff groups were under represented, but plans were in place to encourage staff to attend including Estates and Facilities colleagues. Mrs Richards suggested that a dedicated session be held relating to a topic identified from staff concern trends to encourage attendance. There were no further comments or questions from members. Committee resolved to **note** the reports.
107/22	**Staff PULSE Survey Update**
	Ms Griffiths introduced the report and began by acknowledging the efforts of colleagues across the Trust in encouraging staff to undertake their survey, of which had resulted in increased response rates. Ms Griffiths then gave an overview of steps taken to communicate the survey with colleagues, efforts to highlight patient experience initiatives, approaches to robust conversations with Managers to create inclusive cultures within their teams as well as the promotion of an anti-discrimination culture within departments. Ms Griffiths referred members to appendix 2 of the report should colleagues require any further information. Mr Hemans queried whether efforts had been made to look across wider networks to identify supportive methods relating to pending industrial action. Mr Hemans then raised concern relating to on-going cultural and racial abuse cases evidenced from a recent event that he attended. Mr Hemans stressed the need for the Trust to continue tackling cases of racial abuse and emphasised the number of Clinical Fellows who had recently experienced this. Mrs Richards followed on from this and advised that a collective survey had been devised to capture the feelings and experiences of staff and that face-to-face meetings would be arranged to take place in clinical areas to assure staff. Mrs Usher advised that there had been some positive reports relating to staff treating one another positively but the Trust does need to improve on its methods when dealing with negative cases of behaviour. Mrs Usher stated that further assurance to staff was required as to how the

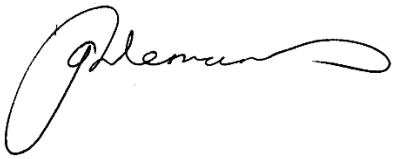
	Trust is dealing with negative behaviour and that staff must be provided with examples. Mr Hemans stated that there could be various ways in which we could improve staff experiences relating to dealing with poor behaviour and expressed the need for early intervention to prevent un-necessary escalation. Mr Hemans suggested utilising Freedom to Speak Up Guardians and Schwartz Rounds to support with this. Mrs Brathwaite referenced a successful event where over 100 members of staff attended to support with behaviours and queried whether future events would be held. Mrs Richards responded to this and advised that recently held Race Fluency Workshops had proven successful when looking to eradicate poor behaviours across the organisation. **ACTION:** **Ms Griffiths to collate assurance document to share with staff detailing how the Trust has and continues to deal with examples of poor behaviour.** There were no further comments from members. Committee **resolved** to **note** the contents of the report as set out.
108/22	**Leadership and Talent Management Report**
	Ms Griffiths introduced and welcomed the report as set out. Mrs Nickell advised committee of a new, collaborative approach to Leadership and Talent Management and advised that a document would follow for member reference. Mrs Nickell stated that she would report back to committee on its delivery plan and that an estimated 80 staff are due to attend the upcoming programme. Mr Assinder expressed his satisfaction with the Learning and Development opportunities offered at Walsall and summarised some positive feedback he had been given when speaking to junior clinical colleagues but queried whether enough was being done to promote this. Mrs Nickell placed on record her thanks to Mrs Griffiths following her vision to implement a collaborative leadership approach. Mr Hemans requested a piece of spotlight work to be completed on this subject to highlight career opportunities for staff to attend. There were no further comments from members therefore committee **resolved** to **note** the paper.
109/22	**Guardian of Safe Working**

	Miss Naqvi introduced the Guardian of Safe Working report and gave a summary of the content of the report. Miss Naqvi assured committee that one identified risk had been identified from the Acute Medical Unit and referred members to details set out in the report for their information. Miss Naqvi then outlined details of quarterly Junior Doctor forums and that work schedules had been established for colleagues in both Medicine and Long-Term conditions, as well as the Division of Surgery, both of which had provided assurance that concerns were being addressed where necessary. Miss Naqvi concluded by advising committee that a sufficient handover had taken place with the new Guardian of Safe Working and thanked members for their contributions during her tenure. Mr Hemans thanked Miss Naqvi for her contributions as Guardian of Safe Working. There were no further comments from members. Committee **resolved** to **note** the report.
110/22	**Health and Safety Oversight Report**
	Committee **resolved** to approve the proposed transition as set out but were not able to discuss the report content due to the lack of representation from the Health and Safety department.
111/22	**Equality, Diversity and Inclusion Progress**
	Mrs Richards introduced the item and updated members on progressions made to Equality, Diversity and Inclusion objectives as set out. **Workforce, Race, Disability and Equality Standards Reports** Ms Richards advised committee of the annual requirement for the Workforce, Race, Disability and Equality Standards reports to have committee oversight and approval prior to implementation. Mrs Richards then gave members an overview of improvements made to each and paid tribute to the Trust's positive attitude to working with Cultural Ambassadors during recruitment processes. Mrs C. Wilson thanked Mrs Richards for the reports and expressed satisfaction with increased recruitment figures and recommended that committee continue to monitor the number of requests for Cultural Ambassadors to ensure this practice continues. Ms Griffiths expressed her support increases to the employment of Black and Minority Ethnic (BAME) to senior management positions and stated that the Trust was in a better position compared to figures published in

	2019, of which indicated the Trust was 3 times more likely to appoint a white applicant. The position now is one of parity (no more or less likely) and there has been an 8% increase in the number black, Asian and minority ethnic colleagues appointed to senior positions (8a and above) – within the Agenda for Change workforce. There were no comments from members. Committee **resolved** to **approved** both the Workforce, Race, Disability and Equality Standards Reports as set out.
112/22	**Retaining Generation Z Report**
	Mrs C. Wilson introduced the Retaining Generation Z Presentation and gave an overview of its rationale including the various eras of workplace culture generations and their preferred ways of working. Mrs Wilson emphasised the need for colleagues to respond to the requirements of the Generation Z Workforce to ensure recruitment retention rates. Ms Griffiths queried whether enough was being done to prepare Managers and Leaders to be able to deal with the levels of flexibility in which Generation Z workers request. Mrs Wilson responded to this to advise a series of discussions had taken place with Ward Managers, of which were met with positive outcomes. Mr Assinder queried how under new working methods requested by members of Generation Z, the Trust could ensure personal levels of accountability when working. Mrs Wilson responded to Mrs Assinder and recognised why people would be hesitant to new ways of working, but advised this could be achieved by something as simple as amending start and finishing times for colleagues. Mrs Brathwaite advised that from her own personal experience of working with members of Generation Z, that she did not experience a change in commitment but advised their preference was to establish boundaries between work and homelife and express how things make them feel to ensure things work for both themselves and the service. Mr Wilshere added that to meet the needs and requirements of Generation Z colleagues, colleagues would initially need to amend their perceptions of their ways of working as initially staff could be quite dismissive. Mr Hemans agreed with points raised by Mr Wilshere and advised that organisations would need to undergo a culture shift as to how to understand and respect the choice of new colleagues. There were no further comments from members. Committee **resolved** to **note** the contents of the report as set out.
113/22	**Items for Information**

	There were no comments or queries to the items tabled for information, therefore committee **resolved** to note the following reports: • Health and Wellbeing Group. • Joint Negotiating and Consultative Committee. • Local Negotiating Committee (report to follow). • Education Steering Group. • Equality, Diversity and Inclusion Group.
114/22	**Escalations to the Trust Board**
	Committee **resolved** that the following items be referred to the Trust Board for further discussion and information: - Staff Turnover Concerns - Schwartz Round Engagement - Equality, Diversity and Inclusion Progress Report - Leadership and Talent Management Report
115/22	**Any other Business**
	Mr Hemans requested an update on proposed industrial action. Mrs Usher responded to Mr Hemans to advise that the general consensus of Registered Nursing Staff would be to vote in favour of strike action and stated a task and finish group had been established to ensure business continuity. There were no further comments from members.
116/22	**Date and Time of the Next Meeting**
	Committee **noted** that the next committee meeting is due to take place on Monday 28th November 2022 via Microsoft Teams.

Signed:



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Date: 28th November 2022