# Bundle Public Trust Board 8 February 2023

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

*Lead: Prof. Steve Field, Group Chair*
*Welcome: Ms Fiona Allinson and Ms Rachel Barber, Associate Non-Executive Directors who commenced at the Trust on 1st February 2023.*
*Apologies Received:*
*Prof. Louise Toner, Non-Executive Director*
*Mr Russell Caldicott, Director of Finance and Performance*
*Quoracy: Meeting is quorate*
*TO NOTE FOR AGENDA:*
*Report from Prof. Patrick Vernon, Chair of Walsall Together has been itemed as Item 9 on the agenda as Prof. Vernon needs to leave the meeting by 11am.*

2 09:35 - Declarations of interest

*Lead: Prof. Steve Field, Group Chair*
*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 - Feb 2023 - v1.pdf

3 09:40 - Minutes of the last meeting

*Lead: Prof. Steve Field*
*Action: To RECEIVE and APPROVE as an accurate record*

Final DRAFT Public Trust Board Minutes 071222.docx

4 09:45 - Matters Arising (as noted in description box)

*Lead: Prof. Steve Field, Group Chair*
*Action: To Review and Approve the Matter Arising pertaining to Minute of the Meeting 448/22 noted below:*
*Matter Arising:*
*< b>Minute of Meeting held 7 December 2022: 448/22 Post-Meeting Minute< /b>*
*Mr Hemans advised that following a recommendation by the People and Organisational Development Committee held in November 2022, the intention had been to share the 'Pledge on Flexible Working' with the Trust Board held on 7 December 22, for approval. He said that as this discussion had not taken place as intended, the Pledge would be shared for approval, under Matters Arising at the Trust Board meeting scheduled for 8 February 2023.*
*ACTION: To Approve the 'Pledge on Flexible Working'*

4.1 09:50 - Covid-19 National Enquiry

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

WHT Trust Board Covid-19 National Inquiry Update January 2023.docx

Appendix 1 - Covid-19-Inquiry-Terms-of - Reference-Final.pdf

Appendix 2 - Module-3-Provisional-Outline-of-Scope-in-English.pdf

Appendix 3 - 2022-11-28 - M3 letter_questionnaire for Trusts_ICBs.pdf

Appendix 4 - WHT Response - Task46464 - Module 3 Public inquiry request for initial information from Trusts.docx

5 10:00 - Action Log

*Presenter: Prof. Steve Field, Group Chair*
*Lead: Prof. Steve Field, Group Chair*
*Action: To review, update and close actions as relevant.*

Action items.docx

6 10:05 - Trust Values and Nolan Principles

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

Nolan Principles of Public Life - Jan 23.docx

7 10:10 - Chair's Report - Verbal

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

8 10:15 - Chief Executive's Reports

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

Chief Executive report, 08.02.23.docx

8.1 10:20 - Trust Management Committee - Chair's Report

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

TMC 08.02.23, Report for Trust Board, 26.01.23.docx

9 10:25 - Walsall Together - Chair's Report

*Presenter: Prof. Patrick Vernon, Chair, Walsall Together*
*Lead: Patrick Vernon, Chair, Walsall Together*
*Action: To Inform and Assure*

Walsall Together Partnership Board Highlight Report December January - Final.docx

10 10:30 - COMFORT BREAK (10 mins)

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

*Presenter: Dan Mortiboys, Interim Director of Finance*
*Lead: Dan Mortiboys, Interim Director of Finance*
*Action: To Inform and Assure*

11.1 10:40 - Performance & Finance Committee - Chair's Report

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

PFC Chair's Report January 23 (1).docx

11.1.1 IQPR - Performance & Finance (Reference Pack for Information)

TB_202212_PFC.pdf

11.2 10:45 - Quality, Patient Experience and Safety - Chair's Report

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

QPES Chair's report Jan 2023.docx

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

TB_202212_QPES.pdf

11.3 10:50 - People and Organisation Development - Chair's Report

*Presenter: Junior Hemans, Chair, PODC*
*Lead: Junior Hemans, Chair, PODC*
*Action: To Inform and Assure*

TB PODC Chair's Report - Feb 2023.docx

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

TB_202212_PODC.pdf

11.4 IQPR - Executive Summary

*Presenter: Dan Mortiboys, Interim Director of Finance*
*Lead: Dan Mortiboys, Interim Director of Finance*
*Action: To Inform and Assure*

TB_202212_ExecutiveSummary.pdf

12 Provide Safe, High Quality Care (section heading)

12.1 10:55 - Director of Nursing Report

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

DoN report to Public Trust Board February 2023 Final.docx

12.2 11:00 - Hospital Mortality Report

*Presenter: Dr Manjeet Shehmar, Chief Medical Officer*
*Lead: Dr Manjeet Shehmar, Chief Medical Officer*
*Action:*

Mortality Report.docx

12.3 11:05 - Patient Voice Report - Q3

*Presenter: Garry Perry, Associate Director, Patient Relations and Experience*
*Lead: Lisa Carroll, Director of Nursing*
*Action: To Approve*

Quarter 3 2022 (002) Patient Voice report v2.docx

12.4 11:10 - Quality Improvement (QI) Team Update

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

WHT QI Q3 Report TB 8.2.23 merged.pdf

12.5 11:15 - Midwifery Service Report

*Presented by: Carla Jones-Charles, Director of Midwifery*
*Lead: Lisa Carroll, Director of Nursing*
*Action: To Inform and Assure*

Maternity Trust Board Feb 2023.docx

CQC maternity Survey 2022 presentation.pptx

Experience of maternity care at Walsall Healthcare NHS Trust.pdf

Patient Experience Strategy Maternity ver 1.pdf

12.6 11:20 - Director of Infection Prevention and Control Report -Q3

*Presenter: Amy Boden, Head of Infection Prevention and Control, Deputy DIPC*
*Lead: Lisa Carroll, Director of Nursing*
*Action: To Inform and Assure*

IPC BAFupdate report Q3 Jan 23- 1.docx

12.7 11:25 - Care Quality Commission (CQC) Report

*Presenter: Kevin Bostock, Group Director of Assurance*
*Lead: Kevin Bostock, Group Director of Assurance*
*Action: To Inform*

Trust Board CQC Inspection Report Feb 2023.docx

Appendix 1  13188868461 - RBK Walsall Healthcare NHS Trust - 2023-01-17.pdf

12.8 11:30 - Mental Health Report

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

Mental Health Report - 6 month.docx

12.9 11:35 - Pharmacy and Medicines Optimisation Report

*Presenter: Dr Manjeet Shehmar, Chief Medical Officer*
*Lead: Dr Manjeet Shehmar, Chief Medical Officer*
*Action:*

Medicines Management Report.docx

12.10 11:40 - Safeguarding Adults and Children

*Presenter: Fiona Pickford, Head of Safeguarding*
*Lead: Lisa Carroll, Director of Nursing*
*Action: To Inform and Assure*

Safeguarding Quarter 3 Update.docx

Appendix 1 WHT_Safeguarding Policy Proforma_DEC 22 update.pdf

Appendix 2 WHT safeguarding MCS implementation action plan Oct 2022 (003) (1).pdf

Appendix 3 Safeguarding Plan January 2023.pdf

Appendix 4 safeguarding Quality of Health Review.pdf

13 11:45 - COMFORT BREAK (10 mins)

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

*Section Heading*

14.1 11:55 - Care at Home Executive Report

*Presenter: Matthew Dodds, Interim Director of Integration*
*Lead: Matthew Dodds, Interim Director of Integration*
*Action: To Inform and Assure*

Care at Home Report Feb 23 MM.docx

Appendix 1 - WT Partnership Operational Performance Pack January 2023.pdf

14.2 12:00 - Charitable Funds - Chair's Report

*Presenter: Paul Assinder, Chair, Charitable Funds*
*Lead: Paul Assinder, Chair, Charitable Funds*
*Action: To Inform*

CF Chairs Report 16 Dec 2022.docx

14.3 12:05 - Update from the Black Country Provider Collaboration Programme

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

WHT TB Provider Collaboration Rep Feb merged 2023.pdf

14.4 12:10 - Sustainability Report

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

WHT TB Sustainability Rep Feb 2023.pdf

15 Use Resources Well (Section Heading)

15.1 12:15 - Audit Committee - Chair's Report

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

WHT Audit Committee Chairs Reports 05.12.22.docx

WHT Audit Committee Chairs Reports 06.02.23.docx

16 Value our Colleagues (Section Heading) (No specific items for this section this month)

*Lead: Ms Catherine Griffiths, Director of People and Culture*

17 12:20 - Reports for Information - Minutes of Committee Meetings (Section Heading)

*The minutes from the Committee meetings are provided for information only.*
*Action: To Inform*

17.1 Quality, Patient Experience and Safety Committee (Nov 22)

Minutes of QPES Committee Nov APPROVED.pdf

17.2 Performance & Finance Committee

3. Minutes of the PFC 30.11.2022.docx

17.3 People, Organisational Development and Culture Committee

3. Minutes - People and Organisational Development Committee, December 2022 - Approved 30-1-23.pdf

18 12:25 - Any Other Business

19 12:30 - Date and Time of Next Meeting

20 12:35 - Questions from the Public/Commissioners

21 12:40 - 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<br>Group Company Secretary | **Responsible Director:** | Prof. Steve Field<br>Chair of the Trust Board |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>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 | Current Role | 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 | The 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 and Al Bahah Health Cluster, Kingdom of Saudi Arabia | Health Holding Company, Kingdom of Saudi Arabia |
| Professor Stephen Field | Chairman | Outside Employment | UK Special Representative for Healthcare to Saudi Arabia | British Embassy Riyadh |
| 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 | Outside Employment | 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 | Group Chief Finance Officer & Director of IT and SIRO | Outside Employment | Treasurer West Midlands Branch | Healthcare Financial Management Association |
| Mr Kevin Stringer | Group Chief Finance Officer & Director of IT and SIRO | Loyalty Interests | Brother-in-law is the Managing Director | Midlands and Lancashire Commissioning Support Unit |
| Mr Kevin Stringer | Group Chief Finance Officer & Director of IT and SIRO | Loyalty Interests | Member | CIMA (Chartered Institute of Management Accounts) |
| Mr Kevin Stringer | Group Chief Finance Officer & Director of IT and SIRO | Gifts | Spade used for 'sod cutting'. | Veolia |
| Mr Kevin Stringer | Group Chief Finance Officer & Director of IT and SIRO | Loyalty Interests | Chief Financial Officer and Deputy Chief Executive | Royal Wolverhampton NHS Trust |
| Mr Kevin Stringer | Group Chief Finance Officer & 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 |
| Prof Louise Toner | Non-Executive Director | Outside Employment | Non-Executive Director | The Royal Wolverhampton NHS Trust |
| Prof Louise Toner | Non-Executive Director | Outside Employment | Professional Advisor | Birmingham City University |
| Prof Louise Toner | Non-Executive Director | Outside Employment | Trustee | Wound Care Alliance UK |
| Prof Louise Toner | Non-Executive Director | Outside Employment | Trustee | Birmingham Commonwealth Society |
| Prof Louise Toner | Non-Executive Director | Outside Employment | Teaching Fellow | Advance HE (Higher Education) |
| Prof Louise Toner | Non-Executive Director | Loyalty Interests | Chair of Education Focus Group and Member of Board of Directors | Birmingham Commonwealth Association |
| Prof Louise Toner | Non-Executive Director | Loyalty Interests | Member | Greater Birmingham Commonwealth Chamber of Commerce |
| Prof Louise Toner | Non-Executive Director | Loyalty Interests | Member | Bsol Education Partnerships Group |
| Prof Louise Toner | Non-Executive Director | Loyalty Interests | Member/Advisor | Health Data Research UK |
| Prof Louise Toner | Non-Executive Director | Loyalty Interests | Royal College of Nursing | Member |
| Prof Louise Toner | Non-Executive Director | Outside Employment (Ended 30/4/22) | Associate Dean | Faculty of Health, Education and Life Sciences at Birmingham University |
| Prof Louise Toner | Non-Executive Director | Loyalty Interests | Required Registration to practice | Nursing and Midwifery Council |

| | | | | |
|---|---|---|---|---|
| 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 |
| Dr Manjeet Shehmar | Chief Medical Officer | Outside Employment | Private Practice | Little Aston Hospital Spire |
| 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 (Ended 08/12/22) | 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 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 | Group 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 | Group Chief Strategy Officer | Loyalty Interests | Group Chief Strategy Officer | Royal Wolverhampton NHS Trust |
| Mr Alan Duffell | Group Chief People Officer | Loyalty Interests | Member (unpaid) | UK and Ireland Healthcare Advisory Board for Allocate Software (Trust Supplier) |
| Mr Alan Duffell | Group Chief People Officer | Loyalty Interests | Member | Chartered Management Institute |
| Mr Alan Duffell | Group Chief People Officer | Loyalty Interests | Member | CIPD (Chartered Institute for Personnel and Development) |
| Mr Alan Duffell | Group Chief People Officer | Outside Employment | System Workforce Lead | BC&WB System Workforce SRO |
| Mr Alan Duffell | Group Chief People Officer | Outside Employment | Interim Chief People Officer | The Dudley Group NHS Foundation Trust |
| Mr Alan Duffell | Group Chief People Officer | Outside Employment | Group Chief People Officer | The Royal Wolverhampton NHS Trust |
| Dr Jonathan Odum | Group Chief Medical Officer | Loyalty Interests | Group Chief Medical Officer | The Royal Wolverhampton NHS Trust |
| Dr Jonathan Odum | Group Chief Medical Officer | Outside Employment | Private out-patient consulting and general medical/hypertension and nephrological conditions | Wolverhampton Nuffield |
| Dr Jonathan Odum | Group Chief Medical Officer | Outside Employment | Chair | Black Country and West Birmingham ICS Clinical Leaders Group |
| Dr Jonathan Odum | Group Chief Medical Officer | Outside Employment | Fellow of the Royal College of Physicians | Royal College of Physicians |
| Mr Daniel Mortiboys | Interim Director of Finance | No interests to declare | | |
| Ms Claire Bond | Deputy Director of People and Culture | No interests to declare | | |
| Ms Carla Jones-Charles | Director of Midwifery | No interests to declare | | |
| Ms Fiona Allinson | Associate Non-Executive Director | Outside Employment | Exam Invigilator | St Benedicts High School, Alcester |
| Ms Rachel Barber | Associate Non-Executive Director | Outside Employment | Non Financial Professional - Lay Member | Walsall ICB (Walsall Place) |
| Ms Rachel Barber | Associate Non-Executive Director | Outside Employment | Non Financial Professional | Onward |
| Ms Rachel Barber | Associate Non-Executive Director | Outside Employment | Non Financial Professional | Housing Plus Groups, Homes Board |
| Ms Rachel Barber | Associate Non-Executive Director | Outside Employment | Non Financial Professional | Customer Service Committee, A2Dominion |

| | | | | |
|---|---|---|---|---|
| Ms Rachel Barber | Associate Non-Executive Director | Outside Employment | Non Financial Professional | OPCC NWP Join Audit Committee |
| Ms Rachel Barber | Associate Non-Executive Director | Outside Employment | Non Financial Professional - Magistrate | Ministry of Justice |
| Ms Rachel Barber | Associate Non-Executive Director | Indirect | Health Assistant | Sister in Law - Wolverhampton Royal Hospital Health NHS Trust |
| Mr Rajpal Virdee (tenure of contract ended 31/12/22) | Associate Non-Executive Director | Loyalty Interests | Lay Member | Employment Tribunal Birmingham |
| Mr Rajpal Virdee (tenure of contract ended 31/12/22) | Associate Non-Executive Director | Loyalty Interests | Vice President of Pelsall Branch Conservative Party Association (from 19th June 2021) | Conservative Party Association |
| Mr Rajpal Virdee (tenure of contract ended 31/12/22) | Associate Non-Executive Director | Loyalty Interests | Deputy Chair | Aldridge-Brownhills Conservative Association |
| Ms Glenda Augustine (Appointment has now ended) | Director of Planning and Improvement | No interests to declare | | |
| Mr Mike Sharon (Appointment has now ended) | | Interim Strategic Advisor to the Board | Strategic Advisor to the Trust Board - RWT | The Royal Wolverhampton NHS Trust |
| Mr Mike Sharon (Appointment has now ended) | | Interim Strategic Advisor to the Board | Member of the Liberal Democrat Party | Liberal Democrat Party |
| Mr Mike Sharon (Appointment has now ended) | | 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 |

NHS
Walsall Healthcare
NHS Trust

# MEETING OF THE PUBLIC TRUST BOARD
# HELD ON WEDNESDAY 7TH DECEMBER 2022 AT 09.30AM
# HELD VIRTUALLY VIA MICROSOFT TEAMS

## PRESENT

Members

| | |
|---|---|
| Prof. S Field CBE | Group 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 RWT/WHT |
| Prof. L Toner | Non-Executive Director RWT/WHT |
| Dr J Parkes | Non-Executive Director |
| Mr R Virdee | Associate Non-Executive Director |
| Prof. D Loughton CBE | Group Chief Executive |
| Prof. A-M Cannaby | Deputy Chief Executive/Group Chief Nurse and Lead Executive for Safeguarding |
| Mr D Mortiboys | Interim Director of Finance |
| Mr N Hobbs | Chief Operating Officer |
| Ms L Carroll | Director of Nursing |
| Ms C Griffiths | Chief People Officer |
| Mr K Bostock | Group Director of Assurance |
| Mr M Dodd | Director of Transformation |
| Mr S Evans | Group Chief Strategy Officer |
| Ms S Evans | Group Director of Communications and Stakeholder Engagement |
| Mr A Duffell | Group Chief People Officer |
| Dr J Odum | Group Chief Medical Officer |
| Mr K Stringer | Group Chief Financial Officer |
| Dr M Shehmar | Chief Medical Officer |

In attendance

| | |
|---|---|
| Mr K Wilshere | Group Company Secretary |
| Ms J Toor | Senior Operational Coordinator |
| Ms E Stokes | Senior Administrator to Group Company Secretary |
| Mr T Nash | Communications Team |
| Mr A Rice | Patient Experience and Voluntary Services Manager |
| Ms A Wallett | Head of Infection Prevention |
| Ms F Pickford | Head of Safeguarding RWT |
| Ms P Boyle | Head of Research and Development RWT/WHT |
| Ms R Joshi | Clinical Director for Emergency Department / Deputy Director for Medicine |
| Ms L Moseley | Business Manager – Medical Directorate |
| Ms R Virk | Divisional Director of Nursing – Medicine and Long-Term Conditions |
| Ms C Hill | Medical Directorate Programme Lead |
| Ms C Jones-Charles | Divisional Director of Midwifery, Gynaecology and Sexual Health WCCSS |
| Ms A Boden | Head of Infection Prevention |
| Ms N Gallagher | Lead Nurse Emergency Medicine |
| Ms C Bond | Deputy Director of People and Culture |
| Ms F Allinson | External |

Apologies

| | |
|---|---|
| Ms O Muflahi | Associate Non-Executive Director |
| Ms S Rowe | Associate Non-Executive Director |
| Prof. P Vernon | Chair, Walsall Together |

| | |
|---|---|
| 407/22 | **Welcome and Apologies** |
| | Prof. Field welcomed all to the meeting and noted the apologies received. He highlighted that Prof. P Vernon had been appointed as Interim Chair of Birmingham and Solihull ICS (Integrated Care System). He confirmed that the meeting was quorate. |
| 408/22 | **Declarations of Interest** |
| | Prof. Field reported that Prof. Toner had new declarations of interest to register but that these did not affect any business that was to be discussed in the meeting.<br><br>**Resolved: that amendments to Prof Louise Toner declarations of interest be noted.** |
| 409/22 | **Minutes of Last Meeting** |
| | Prof. Field confirmed the minutes of the meeting held on 5 October 2022 was approved as an accurate record.<br><br>**Resolved: that the minutes of the last meeting be received and approved.** |
| 410/22 | **Matters Arising and Action Log** |
| | Prof Field confirmed there were no matters arising.<br><br>Prof Field noted the action log and updates were received as follows:<br><br>**Action 542 – Mr Hobbs to provide an update to Board on the funding for option 2.** Mr Hobbs confirmed funding had been received to bridge the gap between option 1 and option 2.<br>**It was agreed that this action be closed.**<br><br>**Action 485 – Health and Inequalities Strategy** - Mr Dodd confirmed the health and inequalities Report was on the agenda.<br>**It was agreed that this action be closed.**<br><br>**Action 541,465,470 –** Prof Field confirmed these actions would be discussed in January 2023**.**<br><br>**Action 466 – Infection Control Report –** Prof field confirmed that a walkabout of the wards was to take place 23rd December with Prof Loughton and Ms Wallet.<br>**It was agreed that this action be closed.**<br><br>**Action 467 – Learning Disability Training -** Ms Carroll confirmed that the Oliver McGowan learning disabilities level 1 training was to be implemented in Quarter 4.<br>**It was agreed that this action be reviewed June 2023.**<br><br>**Action 540 – Medical Records Relocation -** Mr Stringer asked for this action to be extended to March 2023. Mr Hemans commented that Medical Records needed to be relocated due to safety concerns for staff in the current working environment. Prof Loughton agreed that the medical records needed to be relocated and commence digitizing medical records. Prof Loughton asked that Mr Stringer produce a strategy for across both Walsall and Wolverhampton Trust.<br><br>**Action 539 – To be combined with action 540 and for a strategy to be presented to the Board by the meeting April 2023.**<br><br>**Action 416 – Hospital Mortality Report –** Dr Shehmar confirmed the Hospital Mortality Report would be on the agenda.<br>**It was agreed that this action be closed.** |

| | |
|---|---|
| 411/22 | **Trust Values and Nolan Principles** |
| | Prof Field reminded the Board of the Trust Values and that the Board operated in line with the Nolan Principles.<br><br>**Resolved: that the Trust Values and Nolan Principles be received and noted.** |
| 412/22 | **Chair's Report** |
| | Prof Field reported he had received feedback from a Senior Civil Servant colleague regarding treatment a relative had received at Walsall Manor Hospital. Prof Field said that his colleague praised the excellent treatment his father received on Ward 3 and extended his gratitude to the medical staff who provided excellent care and support.<br><br>**Resolved: that the Chair's verbal Report be received and noted.** |
| 413/22 | **Chief Executive's Report** |
| | Prof Loughton reported on the good working relationships between the staff side bodies and Walsall Healthcare NHS Trust (WHT) and that maintaining these relationships was key with imminent strike action. Prof Loughton advised that the Trust was working closely with staff side regarding low pay and community services and he highlighted the potential impact of industrial action on patient flow particularly non-emergency patient transport as there were discharges that required completion before Christmas 2022.<br><br>Prof Loughton commented that he remained concerned about the funding allocation to social care whist Nursing Home beds continued to be closed due to shortages of staff.<br><br>Prof Loughton reported on the strategy that The Royal Wolverhampton NHS Trust (RWT) had in place working with several Universities and that he, Dr Shehmar, Dr Odum and Dr McKaig had met with Aston University and their students had integrated well with medical students from Birmingham and he looked forward to this extending across WHT.<br><br>Prof Loughton commented that HEE (Health Education England) had visited WHT and recommend the Trust as a place for trainees in medicine to attend. He thanked his colleagues for their efforts in obtaining this recommendation through changes that had been brought into place. Prof Loughton highlighted the Care Quality Commission (CQC) Well-Led review had commenced.<br><br>Prof Loughton said WHT had continued to recruit high-quality consultants to positions at the Trust. Ms Martin asked that why there had not been any recruitment of new consultants in the last two months. Dr Shehmar said that there had been recent consultant panels but that the candidates had not been suitable for recruitment.<br><br>Mr Virdee asked if the Trust was providing financial support for staff with inflationary pressures. Prof. Loughton reported that a loan scheme was available through a third party at WHT and RWT as an alternative to reliance on payday loans with high interest rates, that a staff food bank was to be opened, and that staff meals for £1.50 had been made available by the RWT catering department. Ms Evans highlighted the drink and food service was free of charge or staff could make a small donation, she added that the Trust also had links with the Black Country food bank and staff could anonymously request food vouchers.<br><br>**Resolved: that the Chief Executive's Report be received and noted.** |
| 414/22 | **Chair's Trust Management Committee Report (October & November 2022)** |
| | **Resolved: that the TMC Chair's Report be received and noted.** |

| | |
|---|---|
| 415/22 | **Patient Story** |
| | Ms Virk summarised Linda's patient story of her care on three different Wards that had recognised good care and that she had praised the staff on Ward 1. She then said that following her move to a Covid-19 bay, she had felt isolated, and this had an adverse impact on her confidence and that she had felt vulnerable in that setting.<br><br>Ms Virk reported that the Ward staff had been made aware of the concerns raised by Linda following her stay, that staff had been asked to improve introductions and engagement with patients and undertaking care and comfort rounds.<br><br>Ms Jones-Charles reported that Nursing representatives had attended the appreciative enquiry training programme to support the analysis of good care when given, and rectification where it was not.<br><br>**Resolved: that the Patient Story be received and noted.** |
| **INTEGRATED** | **QUALITY AND PERFORMANCE (IQPR)** |
| 416/22 | **Performance and Finance Committee (P&FC) Chair's Report** |
| | Mr Assinder highlighted that the Trust financial performance had mirrored the performance of Acute Trusts across the country, and that in the first seven months of the financial year had reported a deficit of £3.6m, being £6.5m adverse to plan. He said the key drivers had been the use of temporary staffing, the streaming of patients with respiratory conditions, and additional costs associated with required Covid-19 operation that had had to remain in place for Infection Control purposes. He said conversations had taken place with the Integrated Care Board (ICB) and with some potential additional income to offset some of the funding pressures.<br><br>Mr Assinder reported that the operational performance remained good in many areas, and he praised the Emergency Care Stream who had continued to perform amongst the best locally and nationally.<br><br>Mr Assinder reported that 98% of buildings at the Trust had achieved a 'Category B' rating, qualified as operationally acceptable, a good position testimony to the additional investments that had been approved.<br><br>Mr Assinder highlighted that the Trust had received feedback from NHS England (NHSE) on the emergency preparedness planning that had been deemed 'partially compliant' and that plans were in place that would move the Trust to 'substantially compliant'.<br><br>Mr Assinder highlighted that the P&FC would be focusing on issues in diagnostic services in endoscopy, cardio physiology, and breast cancer care at the next meeting. He said staff vacancies and sickness issues had caused additional waiting pressures, but the Trust had a good recovery strategy in place and improvement was being seen month to month. He reported that the committee had approved a business case to support outpatient pathway validation for the reminder of the financial year.<br><br>Mr Assinder reported that the committee had considered the digital strategy update for the Trust which showed achievement of the national NHS digital maturity standards by March 2025. He said the committee had asked for detailed plans to see how the strategy was to be implemented.<br><br>**Resolved that the Performance and Finance Committee Chair's Report be received and noted.** |

| | |
|---|---|
| 417/22 | **Quality, Patient Experience and Safety – Chair's Report** |
| | Dr Parkes reported that the Trust had received a section 29A notice from the CQC regarding breaches in medicines management and that significant work continued to improve this and report plans and actions as per the notice. He highlighted that breast cancer patients were still not being seen within the two-week target, an area that still required improvement.<br><br>Dr Parkes commented that the national shortage of health visitors was a problem with 50% vacancy rate and that work was underway to address the vacancies.<br><br>Dr Parkes reported a rise in *C-Difficile* cases in November 2022 with levels above trajectory. He said overall performance for diagnostics had improved despite some outlying areas, with a reduction from 22.7% to 17.7% of patients waiting more than six weeks. He said there had been improvement in timely antibiotic application to sepsis with the Trust achieving the national performance level of 80% in the Emergency Department and Inpatients areas.<br><br>Dr Parkes reported that falls remained low as they had for the past 28 months at 3.3 per thousand bed days.<br><br>**Resolved: that the Quality, Patient Experience and Safety Committee Chair's Report be received and noted.** |
| 418/22 | **People and Organisation Development Chair's Report** |
| | Mr Hemans reported the challenges with retention rates, particularly staff aged 56-60 who had left due to 'work life balance issues', and whose retirement plans had been deferred by Covid-19. He commented that the recruitment of overseas nurses was showing positive signs but that there had been housing challenges and that discussions had taken place with housing associations for assistance.<br><br>Mr Hemans highlighted that winter vaccination rates remained low with actions to try and increase levels. He commented that the Trust had received a report from the guardian of safe working and that previous concerns reported to the committee had been addressed, and the assurance provided.<br><br>Mr Hemans reported on the library and knowledge service delivery plan which was improving access for staff, with the improvement of library services helping junior doctors to continue their academic and reference work.<br><br>Mr Hemans reported that a recent board evaluation session had looked at the challenges around 'Generation Z' recruitment and retention, and how the Trust might work with flexible working to support staff with their work life balance.<br><br>**Resolved: that the People and Organisational Development Chair's Report be received and noted.** |
| 419/22 | **IQPR Executive Summary** |
| | Mr Hobbs highlighted the significant pressures that the urgent and emergency care services was under and that performance over time had been declining nationally and locally. He commented that a challenging winter was ahead, and colleagues would continue to build as much resilience as possible in the emergency care pathways. Ms Brathwaite asked what assurance there was of the Trusts preparedness and readiness for the impending ambulance strikes to ensure the Trust didn't lose the good position regarding ambulance handovers. Prof. Loughton said the Trust would have extended Christmas days due to the service the Trust could provide on the strike days being like a bank holiday. |

| | |
|---|---|
| | Prof Loughton the Trust would provide an emergency service and ITU (Intensive Therapy Unit) services with a tried and tested plan for delivery.<br><br>Mr Virdee asked why the targets surrounding temporary staffing and Cost Improvement Programme (CIP) had not been delivered on time. Mr Assinder reported that the key drivers of overspends had been reviewed and this issue was being resolved over time. He said the Trust had recruited 230 additional clinical fellows to help manage the dependency on temporary staffing and he highlighted issues in relation to CIP due to productivity challenge during Covid-19 and further work was underway to drive greater efficiency. Mr Hobbs agreed with Mr Assinder's comments and highlighted that the Trust had a £200k shortfall against the £6.3m plan and work continued month on month.<br><br>Prof Loughton reported that the Trust had a plan to reduce dependency on agency staff and that the Trust would continue to employ high calibre consultants and was heading in the right direction. He commented on the use of overseas nurses and that the Trust had to accept there were required changes in cultures and differential qualifications. He said the Trust had to accept that nursing was delivered differently in different countries and that overseas nurses had to receive UK correct training and qualification to meet Trusts standards.<br><br>Mr Virdee said the number of staff who had received the covid and flu vaccines was quite low, and he asked if the public would be confident in having vaccinations if staff had not been immunised themselves. Prof. Field highlighted that the Trust was protecting people by giving them vaccines and reducing the transmission and that unvaccinated staff did not necessarily present a risk for patients, but that unvaccinated patients presented a considerable risk to each other and staff. Ms Carroll reported that work in the education and presentation of staff and patient stories regarding flu and covid to try and raise the profile and positive impact of vaccination. She said the Trust was offering mobile vaccinations to staff including at home, with a recent increase of take up of 4% flu vaccinations and 3% of covid vaccinations of staff.<br><br>Ms Martin commented that the sepsis report showed red alerts at 39.4% of the performance targets and the detailed graph showed 77.8%. She asked why these were different and whether they included the figures for November 2022. Ms Carroll said the report was September and October 2022 figures and confirmed the Emergency Department (ED) sepsis performance for antibiotics within one hour was 77.8% in October 2022 and 80.17% in inpatient areas with the national aim for between 60 to 80%. She confirmed that November and December data was to be provided at the January 2023 Board.<br><br>**Resolved: that the IQPR Executive Summary Report was received and noted.**<br><br>The Board had a 10-minute break 10.45-10.55am. |
| **PROVIDE SAFE, HIGH-QUALITY CARE** | |
| 420/22 | **Director of Nursing Report** |
| | Ms Carroll highlighted that in November 2022 the Trust was part of a joint targeted area of inspection by the CQC and Ofsted covering health, education, the local authority, and police services focussed on the care of vulnerable children and young people and access to multi-agency safeguarding hub (MASH). She said the report was expected imminently by the local authority as the lead agency. She said no priority actions had been identified at the time of the visit and the ED, Maternity, Health Visiting and School Nursing had been part of the comprehensive inspection. |

| | |
|---|---|
| | Dr Shehmar reported that the Trust had a HEE visit in November 2022 and that formal feedback confirmed no patient safety concerns but the Trust was awaiting the formal feedback letter.<br><br>Ms Carroll reported 6 *C-Difficile* cases in September 2022, and 7 in October 2022, an increase from the previous year. She said this financial year the Trust was above trajectory with 21 cases to date and the Trust had continued to scrutinize anti-microbial prescribing. She highlighted that the Trust had continued with education and focus on *C-Difficile*, with the Infection Prevention and Control (IPC) team had worked closely with clinical areas and clinicians to ensure everything required was in place.<br><br>Prof. Field asked if *C-Difficile* was a reporting trajectory issue or an increase in *C-Difficile* cases. Ms Carroll said there was an increase in cases nationally. She added that due to Covid-19, there had been increased antibiotic use that had started to play a significant part in an increased risk of developing *C-Difficile*.<br><br>Ms Carroll said that in January 2023, the Trust was launching the new clinical systems framework for the Trust nursing, midwifery, and Allied Health Professionals (AHP) staff for the next two years in collaboration with RWT. She said this would be shared with the Board in January 2023 with reporting on a quarterly basis monitoring progress.<br><br>Ms Carroll said there had been several Band 7 'quality-focussed' away days across community and acute services and at all levels giving time away to focus on quality and 'what good looks like' and that the feedback received was very positive. She reported that the Trust was focussed on delivering the same structure for advanced Band 6's and developing the next generation of leaders.<br><br>Ms Carroll reported that as of 4 November 2022, the Trust launched it's 'back to the floor' initiative that ensured no meetings took place on Friday's allowing senior nursing staff to work and walk around clinical areas to support quality improvement and staff support. She reported that 230 clinical fellows had been recruited and 198 were already on the Nursing and Midwifery Council (NMC) register and since the last Board Meeting 11 nursing associates had joined the NMC. Prof. Toner asked if a confirmed delivery date of the hybrid mattresses had been received. Ms Carroll reported that she was chasing a confirmation date.<br><br>**Resolved: that the Director of Nursing Report be received and noted.** |
| 421/22 | **Hospital Mortality report** |
| | Dr Shehmar highlighted the data arrears in the report due to the way it was reported at a national level. She said the Summary Hospital-level Mortality Indicator (SHMI) data for July 2021 to June 2022 was 0.99, which was within the expected range. She said there had been two 'LeDer*' *(*death of a person with learning disabilities or autism)* deaths in this reporting cycle and the Trust continued to do structured judgment reviews (SJR's) in each case. She reported that there had been concern that notes had not been available at the time of some of the reviews. Prof. Toner asked what impact the notes not being available for a structured judgment reviews had on the Trust. Dr Shehmar said that although the outcomes of SJR's were not externally reported, a lack of information for a review adversely impacted on the ability to demonstrate learning.<br><br>Mr Hemans reiterated the importance of a new location for medical records and the records digitization.<br><br>Dr Shehmar commented that the Hospital Standardised Mortality Ratio (HSMR) data was reported from the database rather than NHS Digital (NHSD) due to the way |

| | |
|---|---|
| | national reporting was done.<br>Dr Shehmar said this included all Trust sites with palliative care currently included in the deaths within the 30 days of discharge. Dr Shehmar said she had been asked to provide a breakdown of the ethnicity of Covid-19 patients and Covid-19 deaths. She said that 70% of deaths were of the white British with the next largest group at 4% of Asian Indian and Asian Pakistani.<br><br>Prof Field asked how these figures compared to the local population ethnicity breakdown. Dr Shehmar said that analysis could be undertaken across the whole cohort of Covid-19. Prof. Field said that would inform future discussions about vaccinations and any fears of attending hospital for people in diverse groups and communities. Mr Virdee asked if age could also be included in any breakdowns, and by ward or geography or relative deprivation if possible. Prof. Loughton said that was the role of the Public Health Team and asked Dr Shehmar to concentrate on the comparative age and ethnicity related to the local population.<br><br>**Action: Dr Shehmar to provide ethnic and age-related data analysis of Covid-19 Deaths.**<br><br>Dr Shehmar reported that the medical examiner team continued to review all eligible cases and that the community medical examiner pilot had been completed successfully and was to be rolled out across the Integrated Care System (ICS) as required from April 2023.<br><br>Dr Shehmar said that alerts that came from the database looked at the Trust observed rates of death. She said that where these were in line with the expected rates they were accepted, where the Trust was an outlier, it received patient level details that the relevant specialty care group audited the notes and shared any learning with the mortality surveillance group (MSG) and she said that the main cause of potentially avoidable deaths and alerts on causes of death was respiratory related alongside deaths from acute kidney injury and the renal team had been asked to provide an update following significant changes to the structure of the team. She added that the acute kidney injury nurses had been recruited so a 7-day service was to be offered from January 2023 in collaboration with RWT and extending the work into the community to optimize care. She highlighted an improvement in the culture and governance in learning from deaths in several areas including the ED. She said the MSG was considering the shared learning to be communicated across the Trust.<br><br>Dr Shehmar said the quarterly perinatal mortality report, part of the required Ockenden board level discussions, showed 1 under 27-week death and all actions required had been completed. She said the quarterly child deaths review, a national system that the Trust contributed to along with a regional update, had confirmed the actions had been completed. Ms Brathwaite asked if the child death reviews were the regional or WHT figures and Dr Shehmar confirmed they were for WHT and that these investigations had been completed by the regional child deaths investigation team.<br><br>**Resolved: that the report from the Hospital Mortality Report be noted.** |
| 422/22 | **Patient Experience (& Complaints Report)** |
| | Mr Rice highlighted that the Trusts complaints timely response compliance rate for quarter 2 was 78%, a reduction of 5%, impacted by contributory factors including statement delays, complex cross divisional area complaints and a lack of complaint handling engagement in some areas, although there had been signs of improvement in some areas noted through October and November 2022. Mr Rice reported that Woman's and Children's and Community had a 100% response compliance. |

| | |
|---|---|
| | Mr Rice reported that the Trust had improved response rates for patient experience and friends and family test in quarter 2 in in-patients, out-patients, ED, and slightly lesser degree in maternity. He highlighted that these response rates compared nationally showed that the Trust was a high performer and received robust feedback. Finally, he commented that the top three trending issues for patient relations were appointments, clinical care assessment and treatment, and call handling.<br><br>Mr Rice said the patient experience team had attended Walsall Pride during the summer, spoken with a variety of different people in the community and engaged with members of the public about the Trusts strategy and listened to feedback.<br><br>Mr Rice highlighted the parliamentary health service ombudsman update that showed the Trust had attended the Parliamentary and Health Service Ombudsman (PHSO) complaints handling seminars as the Trust was an early adopter pilot for the new national complaint standards. He said there was to be a rollout of the support materials in January 2023. Mr Rice reported that a learning management system would also be available on PHSO website to allow staff access to digital learning modules.<br><br>Mr Rice spoke about the mystery patient programme and the 4 keystone questions and during quarter 2 had improved month on month to the current 8.2 out of 10. He highlighted that the draft findings from the Maternity 2022 survey had been shared internally and the Trust was awaiting the CQC report expected January 2023.<br><br>Mr Rice reported that there had been a 48% response rate from the cancer patient experience survey result with six areas were identified as being excellent. Prof. Toner asked who would pick up the learning from National Cancer Strategy as there were three areas highlighted in the report that the Trust had not done so well in. Mr Rice reported that the Trust had produced a tumour group specific analysis to help each specific area in identifying required support for excellence and improvements.<br><br>Mr Rice said the welcome hub received 18,168 ‘visits’ in quarter two, all being booked through the Trust Visitor system that made it easy for visitors to make contact and visit their loved ones whilst they were in hospital.<br><br>Mr Rice highlighted there had been 71 new volunteer applications, up by 27% from quarter 1, and the total logged hours by volunteers in quarter 2 was 3,155. He reported that the Trust had recently recruited a volunteer coordinator and a family career support officer to support unpaid carers.<br><br>**Resolved: that the Patient Experience (& Complaints Report) be received and noted.** |
| 423/22 | **Continuous Quality Improvement (CQI)** |
| | Mr Evans highlighted the quarterly updates from the quality improvement team and identified the three priorities of building capacity and capability within the organisation, focusing on patient flow, and on patient safety. He said that building capacity and capability during Covid-19 had meant the Trust adapting approaches with virtual training offered. He said that face to face training had been recommenced and therefore recommenced. He reported that the programs would be based in the specific areas required. He added that there was now a single quality improvement team across WHT and RWT. He went on to report that the first Improvement, Innovation and Research Group (JCIIRG), a subgroup of the Joint Committee (JC), had formed its quality improvement plan. He reminded the Board that it had undertaken the NHSE quality improvement training with the action plan to develop a quality management system to underpin improvement learning. |

| | |
|---|---|
| | Mr Evans highlighted that in future the Trust ensured anything data driven used appropriate Statistical Process Control (SPC) charts.<br><br>**Resolved: that the Continuous Quality Improvement report be received and noted.** |
| 424/22 | **Director of Midwifery Service Report** |
| | Ms Jones- Charles highlighted staffing issues in Maternity reported within the Ockenden summary report. Mr Assinder asked if the health visitor vacancy rate impacted the community midwifery team. Ms Jones-Charles said that collaborative work between health visiting colleagues and community midwifery was working well, and through Walsall Together the Trust had secured a community base that would allow closer working with health visitor colleagues.<br><br>Ms Jones-Charles commented on the continuing culture review in the Ockenden and East Kent reports regarding the importance of having the right culture within the Maternity service. She said the Trust was looking at areas to strengthen and improve.<br><br>Dr Shehmar reported that the Trusts Foetal Monitor/Cardiotocograph (CTG) training was commended by the recent NHSE post-Ockenden review. She said that where there had been any serious incidents or concerns about standards of care training, a report was produced looking at individual needs and trends relating to individual training profiles.<br><br>Ms Jones-Charles reported on the QI (Quality Improvement) work undertaken and the improvement of triage flow. She commented that since the implementation of the Trusts Standard Operating Procedures (SOPs) system a quarterly report was issued to look specifically at how quickly women were being seen and the response times.<br><br>Dr Shehmar highlighted the importance of the SOPs, a national program of work underpinned by research but difficult to apply consistently. She congratulated Ms Jones-Charles and the maternity team for implementing and embedding them.<br><br>Ms Jones-Charles commented that the Trust now used a new telephone system from October 2022 that helped ensure that no calls were lost and monitored any that rang off. She reported that the early response data for triage was good. Prof. Toner asked what protocols were in place for abandoned calls. Ms Jones-Charles said that when triage was called, caller could choose an option to discuss their concerns but there was currently no way of tracking abandoned calls back but patients were encouraged keep calling if they had any concerns.<br><br>Ms Jones-Charles reported on Clinical Negligence Scheme for Trusts (CNST) Maternity Scheme evidence gathered and provided in line with what had been requested compliant with CNST Year 4. Prof. Toner asked Ms Jones-Charles view of the change in oversight that had moved from NHSE to the Black Country LMNS. Ms Jones-Charles said the more local oversight gave the Trust greater influence as the Black Country LMNS consisted of the four directors of midwifery and helped provide system cross assurance and shared learning.<br><br>Prof. Toner asked if there had been any untoward consequences of delaying patients' induction. Ms Jones-Charles commented that this was a semi-elective process, and that the delay of induction in labour was risk assessed on an individual basis, and only delayed if a patient wasn't in labour and requiring urgent care. Ms Jones-Charles reported that incidents reported were reviewed in a robust manner. |

| | |
|---|---|
| | Ms Carroll asked for approval of CNST (Clinical Negligence Scheme for Trusts) Maternity Year 4 evidence so that it could be submitted. Prof Field confirmed approval of the CNST submission.<br><br>**Resolved: that the Midwifery Services report be received and noted, and that the CNST 4 submission be approved.** |
| 425/22 | **Safeguarding Adults and Children Quarter 2 Report** |
| | Ms Pickford highlighted that the Trust had completed the expansion of the safeguarding team with successful recruitment of new staff that allowed focus on improving systems and processes. She said that the Trust was moving the learning disability work forward in collaboration with RWT.<br><br>Ms Pickford commented on the CQC concerns raised regarding mental capacity assessments and she had met with inspectors who had said they were confident that the Trust was improving compliance. She went on to highlight the MASH arrangements and the Trust's part therein.<br><br>Ms Pickford reported that the Trust was reviewing the safeguarding training program over the next 12 months to ensure that safeguarding adults and children was embedded in care for meeting the requirements of the Oliver McGowan Learning Disability issues, part of a greater piece of work to prepare for this across the ICB.<br><br>Mr Hemans noted that safeguarding had dramatically improved and commented on the high-profile child incidences referred to in the report and asked what analysis the Trust had completed and what assurances could be given that the Trust was addressing the concerns flagged up in the report. Ms Pickford said the ICB had reviewed the MASH arrangements and the key information from the report regarding the identification of hidden fathers or hidden partners that may not be known to frontline staff and the Trust was completing work to address this as part of the assessment processes.<br><br>**Resolved: that the Safeguarding Adults and Children Quarter 2 Report be received and noted.** |
| 426/22 | **Trust Risk Register Report** |
| | Mr Bostock highlighted that section 3.1.2 the BAF (Board Assurance Framework) covered the period August 2022 and September 2022 and that of the 8 strategic objectives, 6 had remained static in risk rating and the assurances relating to them.<br><br>Mr Bostock reported on the Trust Corporate Risk Register (TCRR) in section 3.3, 10 red risks had been identified with an additional 2 risks that had moved from red to amber rating. He said of the 10 risks, 8 had remained static, 2 had moved up and 2 had moved down.<br><br>Mr Wilshere commented that the Board Assurance Framework had been redesigned and the new template was being implemented ready to be shared by the February 2023 Board in its revised, simplified form. He said there was part of the board development session in January 2023 scheduled for the BAF risks confirmation.<br><br>**Resolved: that the Trust Risk Register Report be received and noted.** |
| 427/22 | **Director of Infection Prevention and Control Report** |
| | Ms Boden reported that elements of the infection prevention BAF (Board Assurance Framework) risks had been heightened because of association with surveillance data from the increase in *C-Difficile* infections. She said the Trust was reviewing several infection prevention related issues and that national data showed Trusts across the nation were experiencing increased *C-Difficile* infections. |

| | |
|---|---|
| | Ms Boden highlighted that corresponding data showed that the reduction in Covid-19 restrictions had increased mixing in community settings and a resulting increase in viral illnesses and susceptibility to secondary bacterial infections. She reported that only 5% of the adult population that carry *C-Difficile* reported to hospital for treatment and this presented an increased risk factor. She said that the Trust had presented 'glove awareness' campaigns and the reduction of gloves within healthcare settings during a recent sustainability lunch. She said that this had provided a full sense of security for staff.<br><br>Ms Boden said that staff who reported any signs or symptoms of Covid-19 still had access to free lateral flow tests and support from the Covid team line with risk assessments prior to returning to work.<br><br>Ms Boden said that an increase in MRSA colonization had been reported on a Ward in the medicine division with 5 positive cases but none of the patients had gone on to develop an infection. She said these cases had been picked up through routine screening and met the case definition for an incident. Ms Boden said that she was awaiting the report on the infection 'types' and the clinical situation had been managed with additional measures at the time.<br><br>**Resolved: that the Director of Infection Prevention and Control be received and noted.** |
| 428/22 | **Pharmacy and Medicines Management Optimisation** |
| | Dr Shehmar highlighted that a section 29A notice had been served in the division of medicine and long-term conditions following a recent CQC review. She reported that an improvement group led by Prof Cannaby and the MMG she chaired was addressing the immediate actions in the notice and all medical and non-medical prescribers had received a letter from her, Ms Carroll and the Trust Chief Pharmacist that set out the prescribing standards required of staff linked to their professional regulatory bodies and registrations.<br><br>Dr Shehmar said an E-Learning health program was offered to all medical and non-medical prescribers, and compliance with this was monitored by the MMG. She said that a new prescription chart was to be launched across the Trust in January 2023, that would be consistent with the prescribing training and guidance set out. She added that a review of patient notes highlighted in the CQC report had been resolved and that no safety issues, actions or changes in medication had been required.<br><br>Prof. Toner praised all the work that the MMG and Medicines Division had completed. She asked if Dr Shehmar was confident the Trust had completed the immediate actions required by the CQC for the 31 December 2022 deadline. Dr Shehmar she in her view the appropriate actions to address the concerns in the section 29A notice had been taken or initiated but would not all be completed across all Wards by 31 December 2022.<br><br>Dr Odum asked what time scale was to implement electronic prescribing to address the issues surrounding that process. He highlighted that there was clinical agreement on the system need for the procurement process that required a lead time to implementation of 6 to 12 months.<br><br>**Resolved: that the Pharmacy and Medicines Management Optimisation Report be received and noted.** |
| 29/22 | **Health Inequalities Strategy** |
| | Mr Dodd reported that the Trust was developing a 'place' strategy to meet local needs with high levels of deprivation and health inequalities within the borough congruent |

| | |
|---|---|
| | with the approach at RWT. Mr Virdee asked how the Trust ensured that all business plans, policies, and procedures adhered to the equality requirements. Mr Dodd reported that the Trust had been working with Mr Evans to ensure that the documentation and paperwork had been put through to the improvement group and that steps were needed to ensure the Trust quality assessed what people were returning.<br><br>Mr Dodd highlighted that the Trust, through the ICB had been successful in bidding for resources to support outreach work for vulnerable women in improving their access to antenatal care.<br><br>Mr Dodd said the Trust had undertaken work to support patients who needed surgery but were not fit for anaesthetic. He said these patients were often left to navigate their own way through the system and that the Trust was to begin to support them through the process.<br><br>Mr Hemans asked if the Trust had any connections with the local authority to ensure that families attending health centres had access to balanced meals. Mr Dodd said that the Walsall Together inequalities group had discussed with community members the rising cost-of-living impact and shared information on the resources the local community was offering.<br><br>**Resolved: that the Health Inequalities Strategy be received and noted.**<br><br>The Board convened for a 5-minute break at 12.25pm. |
| 430/22 | **Patient Safety Incident Response Framework** |
| | Mr Bostock referred to the 12-month implementation program changing the approach to Patient Safety incident reporting and investigation nationally that was in 6 phases and that the Trust was at phase 1 moving to phase 2 from April 2023 with monthly system meetings ensuring that the Trust was on track. He confirmed the Trust was on schedule to deliver the changes over the next 12-month period and he highlighted the Trusts next 6-month plan on slides 8 and 9 of the report that included the Board agreed commitment.<br><br>**Resolved: that the Patient Safety Incident Response Framework be received and noted.** |
| **CARE AT HOME, WORK CLOSELY WITH PARTNERS** | |
| 431/22 | **Walsall Together - Chair's Report** |
| | Mr Dodd highlighted a key operational pressure from out of area patients and delayed transfers and work was underway with the ICB to influence the position. He said there was a great deal of discharge pathways activity putting pressure on community-based systems and work was being completed regarding potential risk share arrangements. He said the Trust had become a national pilot for the intermediate care recovery service that gave opportunity to work out how to move patients to home quicker and assess their care in their home. He reported positive responses to a recent Walsall Together engagement event with GP's and primary care staff with over 100 people in attendance and he highlighted that a Walsall Together partnership board development day was taking place in December 2022 looking at communications and the future structure for moving into place-based partnership arrangements.<br><br>Mr Dodd said the Trust was formalising the delegation of services from 1 April 2023 and Walsall Healthcare Trust staff were involved in the risk share arrangements and the Trust board would be sighted on the changes.<br><br>**Resolved: that the Chair of Walsall Together Partnership Board report be** |

| | |
|---|---|
| | **received and noted.** |
| 432/22 | **Care at Home Executive Report** |
| | The Care at Home Executive Report was combined with the Walsall Together presented with the Chairs Report by Mr Dodd.<br><br>**Resolved: that the Care at Home Executive Report be received and noted.** |
| 433/22 | **Trust Board Delegation to Charitable Funds Committee** |
| | Mr Mortiboys highlighted that Trust Charity needed to file the accounts by the end of January 2023 and as there wasn't another Board meeting before the deadline, he asked for approval to delegate the approval of the accounts to the Charitable Funds Committee.<br><br>**Resolved: that the Trust Board Delegation to Charitable Funds Committee be received and approved.** |
| 434/22 | **Digital Strategy** |
| | Mr Stringer presented the Digital Strategy for approval having been shared with the Medical Advisory Committee (MAC) and P&FC. He said that the strategy would run until the end of 2024/2025 to enhance Electronic Patient Records (EPR) and give better access for clinicians to patient information. Dr Shehmar said the Trust needed to complete the work on EPR that Mr Stringer had advised of. Mr Stringer highlighted that the strategy followed the requirement for a minimum digital foundation with a nominal £7.8m investment plan, subject to national funds being approved. He reported that risks surrounding delivery had been raised and addressed by Mr Pearson.<br><br>**Resolved: that the Digital Strategy be received and approved.** |
| 435/22 | **Black Country Integrated Care System Update** |
| | Mr Evans highlighted the detailed key components on how the Integrated Care System Operating Framework would work together encompassing the ICP, ICB, provider collaboratives and Place-based partnerships – Walsall Together. He said the proposed timeline was though to 2023/2024. Prof Field confirmed Walsall Healthcare NHS Trust Board as a sovereign board that required to receive and approve any such proposals prior to implementation. Mr Evans confirmed this.<br><br>**Resolved: that the Black Country Integrated Care System Update be received and noted.** |
| 436/22 | **Black Country Partnership Collaboration** |
| | Mr Evans reported on updates to the Black Country Provider Collaboration from October and November 2022 and detailed in the report the clinical work streams and work that had commenced, and the initial governance work on the future scheme of delegation. He commented that the Trust was hoping to get consistent pathways across all 4 acute providers in the Black Country but that there should be no requirement for delegated authority through the provider collaborative until late 2023 and that regular updates would be presented to the Board.<br><br>**Resolved: that the Black Country Partnership Collaboration be received and noted.** |

| | |
|---|---|
| 437/22 | **Sustainability Report Including Green Plan Update** |
| | Mr Evans commented on the positive results the Trust had for changing anaesthetic gases. He said there had been national supply problems requiring short-term and replacement in some cases until availability resumed. He said that the Trust was planning for the requirements to achieve the remainder of the carbon neutral initiatives and to be presented to the Board in early 2023.<br><br>Mr Evans reported that the national funding for PPE (Personal Protective Equipment) would end in March 2023 and the Trust had been receiving additional funding to cope with Covid-19 requirements. He said this would result in an £850k cost pressure and staff were exploring possible reduction in usage of gloves in a sustainable yet safe way.<br><br>**Resolved: that the Sustainability Report including Green Plan Update be received and noted.** |
| **USE RESOURCES WELL** | |
| 438/22 | **Audit Committee Chair's Report** |
| | Ms Martin reported an intense focus on cyber security matters and counter fraud issues. She highlighted the international scale targeting of NHS and other large organisations and this was recommended as a new risk for the new BAF.<br><br>**Resolved: that the Audit Committee Chair's Report be received and noted.** |
| **VALUE OUR COLLEAGUES** | |
| 439/22 | **Staff Voice – Acute and Emergency Services – Verbal Update** |
| | Ms Joshi highlighted that the new emergency care building was welcomed by staff and the journey to completion of the new building had been very interesting. She said the old department catered for only 45k patient attendances and the Trust was seeing double that figure.<br><br>Ms Joshi reported there had been a successful recruitment process with the new expected number of patient attendances. She highlighted that new equipment had been purchased for the new building that was fit for purpose.<br><br>Ms Martin asked what training staff were receiving for the transition into the new Emergency Care building. Ms Gallagher highlighted there was a 2-week period where EPR and simulation training was to be given to help familiarise staff with the new systems and building. Mr Hobbs confirmed handover of the new Emergency Care Building was expected to be 16 January 2023 with services to transfer in early February.<br><br>**Resolved: that the Staff Voice – Acute and Emergency Services – Verbal Update be received and noted.** |
| 440/22 | **Schwartz Rounds Annual Update** |
| | Ms Griffiths highlighted that Schwartz Rounds had been embedded well within the Trust under the leadership of Dr Waterhouse. She reported that the Trust continued to increase access for clinical and non-clinical staff and feedback had been well received.<br><br>**Resolved: that the Schwartz Rounds Annual Update be Received and Noted.** |
| **REPORTS FOR INFORMATION – MINUTES OF COMMITTEE MEETINGS** | |
| 441/22 | **Quality, Patient Experience and Safety Committee (QPES)** |
| | The Board Members received, for information, the confirmed minutes of QPES held in October 2022.<br><br>**Resolved: that the minutes of the Quality, Patient Experience and Safety Committee held in October 2022 be received for information.** |

| | |
|---|---|
| 442/22 | **Performance and Finance Committee (PFC) – October 22** |
| | The Board Members received, for information, the confirmed minutes of PFC held in October 2022.<br><br>**Resolved: that the minutes of the People and Organisational Development Committee held in October 2022 be received for information.** |
| 443/22 | **People and Organisational Development Committee (PODC) – September 22 & October 22** |
| | The Board Members received, for information, the confirmed minutes of the Audit Committee held in September and October 2022.<br><br>**Resolved: that the minutes of the People and Organisational Development Committee held in September and October 2022 be received for information.** |
| **CLOSING ITEMS** | |
| 444/22 | **Any Other Business** |
| | Prof. Field welcomed the newly appointed Group directors working for Walsall Healthcare NHS and The Royal Wolverhampton Trust.<br><br>Dr J Odum Group Chief Medical Officer, Mr A Duffell Group Chief People Officer, Mr K Stringer Group Chief Financial Officer, Mr K Wilshere Group Company Secretary, Mr S Evans Group Chief Strategy Officer, Ms S Evans Group Director of Communications and Stakeholder Engagement, Prof. A-M Cannaby Deputy Chief Executive WHT/Group Chief Nursing Officer and Mr K Bostock Group Director of Assurance. |
| 445/22 | **Date and time of the next meeting** |
| | Prof. Field confirmed that the next meeting was to take place on Wednesday 8 February 2023. |
| 446/22 | **Questions from the Public/Commissioners** |
| | Prof. Field confirmed that no questions had been raised by the Public. |
| 447/22 | **Resolution** |
| | **The meeting concluded at 1pm** |
| 448/22 | **Post-Meeting Minute** |
| | Mr Hemans advised that following a recommendation by the People and Organisational Development Committee held in November 2022, the intention had been to share the 'Pledge on Flexible Working' with the Trust Board held on 7 December 22, for approval. He said that as this discussion had not taken place as intended, the Pledge would be shared for approval, under Matters Arising at the Trust Board meeting scheduled for 8 February 2023. |

| MEETING OF TRUST BOARD AND ANY APPROPRIATE ASSOCIATED COMMITTEES | | | |
|---|---|---|---|
| Covid – 19 National Inquiry Update | | | |
| **Report Author and Job Title:** | Steph Poulter<br>Assurance Team Support | **Responsible Director:** | Kevin Bostock<br>Director of Assurance |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☐ Discuss ☐ Inform ☒ Assure ☒<br>For information only, not discussion | | |
| **Assure** | • Members of the Trust Board are asked to note the progress to date in participation in the National Inquiry into Covid-19 specifically Module 3 – '*The impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland*'. | | |
| **Advise** | • The National Inquiry was established on 28 June 2022 to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future.<br>• Module 3 relates to the specific impact on healthcare systems and commenced on 8 November 2022. | | |
| **Alert** | • The Trust has complied with the Inquiry's requirement to notify all staff of their legal duty in relation to record-keeping to support the Trust's preparation for the Inquiry. This is called a 'STOP Notice' and the requirement is for colleagues to ensure that all records are saved, whether they are/were working directly on Covid-19 recovery, or as part of business-as-usual activities. | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | No | | |
| **Resource implications** | People and technology to deliver against the inquiry will be utilised from current teams and technology. | | |
| **Legal and/or Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | | |
| **Strategic Objectives** | Effective Collaboration | a) Improve population health outcomes through provider collaborative<br>b) Improve clinical service sustainability<br>c) Implement technological solutions that improve patient experience<br>d) Progress joint working across Wolverhampton and Walsall<br>e) Facilitate research that improves the quality of care | |

# Covid-19 National Inquiry Update

## 1. PURPOSE OF REPORT

The purpose of this report is to inform the Trust Board and its associated committees that all appropriate and necessary steps have been taken in preparation for Walsall Healthcare NHS Trusts (WHT) and Royal Wolverhampton NHS Trusts (RWT) involvement in the Covid-19 National Inquiry which opened in June 2022 and is due to complete by June 2024. The Inquiry will hold its first preliminary hearing for its third investigation – Module 3 '*looking at the impact of the pandemic on healthcare'*, on Tuesday 28 February 2023.

## 2. BACKGROUND

On 28th June 2022 the Rt. Hon Baroness Heather Hallet DBE PC, was appointed Chair of the Covid-19 National Inquiry, which was established to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future.

In support of this a Terms of Reference for the Inquiry was published which set out the high level scope, aims, the overall response expected of the health and care sector, the economic response and impact and the overall lessons learned. Attached at appendix 1.

The approach Baroness Hallet has taken is modular and in October 2022 a preliminary hearing was held on '*Module 1- Government Planning and Preparedness'*. The group is scheduled to meet again on 14 February 2023 with '*Module 2 – Political and Administrative Decision Making'* meeting on 1 March 2023 and '*Module 3 - looking at the impact of the pandemic on healthcare'* on Tuesday 28 February 2023.

In preparation for each of the preliminary hearings an information gathering exercise needs to take place. For Module 3 this resulted in a letter from the appointed Lead Solicitor for Module 3 to Trusts, ICBs and range of organisations across the health system to voluntarily answer a range of questions against the provisional outline of scope attached at appendix 2 with the questionnaire attached at appendix 3 and WHTs response attached at appendix 4.

No further detail will be released until after the Module -3 Preliminary Hearing on 28 February 2023 and therefore it is unclear whether WHT/RWT will be asked to submit anything further or be involved in detail with the Inquiry as it progresses. However, WHT/RWT needs to be prepared to respond to the Inquiry in any way considered appropriate.

## 3. PREPARING FOR THE INQUIRY

The Wolverhampton/Walsall NHS Hospitals Group is taking a proactive approach to preparing for the requirements of the National Inquiry. Therefore, both trusts have complied with the Inquiry's requirement to notify all staff of their legal duty in relation to record-keeping to support preparation for the Inquiry. This is called a STOP Notice, requiring colleagues to save all records, whether they are/were working directly on Covid-19 recovery, or as part of business-as-usual activities.

In addition, WHT/RWT have set up a comprehensive Group-Wide Covid-19 National Enquiry Project Team for which Kevin Bostock - Group Director of Assurance is the Chair/Lead Executive and named Single Point of Contact for the Inquiry.

The Group held its inaugural meeting on 19th January 2023 and set out an agenda aimed at ensuring proportionate preparedness to respond to any information required by the Inquiry including the creation of a centralised, group accessible, file repository on SharePoint which all members of the group and their invited guests can directly file relevant information into, in order to meet the likely data and information requirements for records, whether they are/were working directly on Covid-19, recovery, or as part of business-as-usual activities.

The Project Team will meet monthly in the first instance and will respond accordingly to further information requests from the Inquiry Team.

## 4. RECOMMENDATIONS

Trust Board members are requested to note the content of the report and its appendices:-

Appendix 1 – Covid – 19 National Inquiry Terms of Reference
Appendix 2 – Module 3 Provisional Scope
Appendix 3 -- Questionnaire
Appendix 4 – WHT Responses to the questionnaire.

# Covid-19 Inquiry Terms of Reference

The Inquiry will examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the Inquiry's formal setting-up date, 28 June 2022.

In carrying out its work, the Inquiry will consider reserved and devolved matters across the United Kingdom, as necessary, but will seek to minimise duplication of investigation, evidence gathering and reporting with any other public inquiry established by the devolved governments. To achieve this, the Inquiry will set out publicly how it intends to minimise duplication, and will liaise with any such inquiry before it investigates any matter which is also within that inquiry's scope.

In meeting its aims, the Inquiry will:

a) consider any disparities evident in the impact of the pandemic on different categories of people, including, but not limited to, those relating to protected characteristics under the Equality Act 2010 and equality categories under the Northern Ireland Act 1998;

b) listen to and consider carefully the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. Although the Inquiry will not consider in detail individual cases of harm or death, listening to these accounts will inform its understanding of the impact of the pandemic and the response, and of the lessons to be learned;

c) highlight where lessons identified from preparedness and the response to the pandemic may be applicable to other civil emergencies;

d) have reasonable regard to relevant international comparisons; and

e) produce its reports (including interim reports) and any recommendations in a timely manner.

The aims of the Inquiry are to:

1. Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account, including:

a) The public health response across the whole of the UK, including

   i) preparedness and resilience;

   ii) how decisions were made, communicated, recorded, and implemented;

   iii) decision-making between the governments of the UK;

   iv) the roles of, and collaboration between, central government, devolved administrations, regional and local authorities, and the voluntary and community sector;

v) the availability and use of data, research and expert evidence;

vi) legislative and regulatory control and enforcement;

vii) shielding and the protection of the clinically vulnerable;

viii) the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings;

ix) testing and contact tracing, and isolation;

x) the impact on the mental health and wellbeing of the population, including but not limited to those who were harmed significantly by the pandemic;

xi) the impact on the mental health and wellbeing of the bereaved, including post-bereavement support;

xii) the impact on health and care sector workers and other key workers;

xiii) the impact on children and young people, including health, wellbeing and social care;

xiv) education and early years provision;

xv) the closure and reopening of the hospitality, retail, sport and leisure, and travel and tourism sectors, places of worship, and cultural institutions;

xvi) housing and homelessness;

xvii) safeguarding and support for victims of domestic abuse;

xviii) prisons and other places of detention;

xix) the justice system;

xx) immigration and asylum;

xxi) travel and borders; and

xxii) the safeguarding of public funds and management of financial risk.

b) The response of the health and care sector across the UK, including:

i) preparedness, initial capacity and the ability to increase capacity, and resilience;

ii) initial contact with official healthcare advice services such as 111 and 999;

iii) the role of primary care settings such as General Practice;

iv) the management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels;

v) the management of the pandemic in care homes and other care settings, including infection prevention and control, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, workforce testing and changes to inspections;

vi) care in the home, including by unpaid carers;

vii) antenatal and postnatal care;

viii) the procurement and distribution of key equipment and supplies, including PPE and ventilators;

ix) the development, delivery and impact of therapeutics and vaccines;

x) the consequences of the pandemic on provision for non-COVID related conditions and needs; and

xi) provision for those experiencing long-COVID.

c) The economic response to the pandemic and its impact, including governmental interventions by way of:

i) support for businesses, jobs and the self-employed, including the Coronavirus Job Retention Scheme, the Self-Employment Income Support Scheme, loans schemes, business rates relief and grants;

ii) additional funding for relevant public services;

iii) additional funding for the voluntary and community sector; and

iv) benefits and sick pay, and support for vulnerable people.

2. Identify the lessons to be learned from the above, to inform preparations for future pandemics across the UK.

UK Covid-19 Inquiry

# Module 3

November 2022

# Module 3 Provisional Scope

This module will consider the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. This will include consideration of the healthcare consequences of how the governments and the public responded to the pandemic. It will examine the capacity of healthcare systems to respond to a pandemic and how this evolved during the Covid-19 pandemic. It will consider the primary, secondary and tertiary healthcare sectors and services and people's experience of healthcare during the pandemic, including through illustrative accounts. It will also examine healthcare-related inequalities (such as in relation to death rates, PPE and oximeters), with further detailed consideration in a separate designated module.

In particular, this module will examine:

1. The impact of Covid-19 on people's experience of healthcare.

2. Core decision-making and leadership within healthcare systems during the pandemic.

3. Staffing levels and critical care capacity, the establishment and use of Nightingale hospitals and the use of private hospitals.

4. 111, 999 and ambulance services, GP surgeries and hospitals and cross-sectional co-operation between services.

5. Healthcare provision and treatment for patients with Covid-19, healthcare systems' response to clinical trials and research during the pandemic. The allocation of staff and resources. The impact on those requiring care for reasons other than Covid-19. Quality of treatment for Covid-19 and non-Covid-19 patients, delays in treatment, waiting lists and people not seeking

or receiving treatment. Palliative care. The discharge of patients from hospital.

6. Decision-making about the nature of healthcare to be provided for patients with Covid-19, its escalation and the provision of cardiopulmonary resuscitation, including the use of do not attempt cardiopulmonary resuscitation instructions (DNACPRs).

7. The impact of the pandemic on doctors, nurses and other healthcare staff, including on those in training and specific groups of healthcare workers (for example by reference to ethnic background). Availability of healthcare staff. The NHS surcharge for non-UK healthcare staff and the decision to remove the surcharge.

8. Preventing the spread of Covid-19 within healthcare settings, including infection control, the adequacy of PPE and rules about visiting those in hospital.

9. Communication with patients with Covid-19 and their loved ones about patients' condition and treatment, including discussions about DNACPRs.

10. Deaths caused by the Covid-19 pandemic, in terms of the numbers, classification and recording of deaths, including the impact on specific groups of healthcare workers, for example by reference to ethnic background and geographical location.

11. Shielding and the impact on the clinically vulnerable (including those referred to as "clinically extremely vulnerable").

12. Characterisation and identification of Post-Covid Condition (including the condition referred to as long Covid) and its diagnosis and treatment.



This publication is available at https://covid19.public-inquiry.uk/document/

Any enquiries regarding this publication should be sent to us at contact@covid19.public-inquiry.uk

**FREEPOST**

UK Covid-19 Public Inquiry

FAO: Chief Executive

28 November 2022

Dear Madam or Sir

**Module 3 of the UK Covid-19 Public Inquiry ("the Inquiry")**
**Request for initial information from your organisation**

I am writing on behalf of The Rt. Hon Baroness Heather Hallett DBE PC, the Chair of the Inquiry, in my capacity as the Module Lead Solicitor for Module 3.

As you may know, the Inquiry was established on 28 June 2022 to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future.

**Module 3**

Module 3 of the Inquiry will examine the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. Further information about what the Inquiry will consider in Module 3 is set out in the provisional outline of scope, which can be found here. Please do read this carefully and in full, but by way of summary, Module 3 will cover the following topics:

- The healthcare consequences of how the UK governments and the public responded to the pandemic.
- The capacity of healthcare systems to respond to a pandemic and how this evolved during the Covid-19 pandemic.
- Primary, secondary and tertiary healthcare sectors and services and people's experience of healthcare during the Covid-19 pandemic, including through illustrative accounts.
- Healthcare-related inequalities (such as in relation to death rates, PPE and oximeters), with further detailed consideration in a separate designated module.

The Inquiry opened Module 3 on 8 November 2022. In relation to Module 3, the Chair of the Inquiry has said:

*"The pandemic had an unprecedented impact on health systems across the UK. The Inquiry will investigate and analyse the healthcare decisions made during the pandemic, the reasons for them and their impact, so that lessons can be learned and recommendations made for the future..."*

**How your organisation can help the Inquiry - information gathering**

The Inquiry has identified around 450 organisations across the UK that are likely to have important healthcare-related information to share with it in relation to Module 3 specifically, including organisations such as yours. We are keen to hear from these organisations at an early stage of our work on this Module, so that we may consider issues they raise at this early stage while progressing the investigation. It is for this reason I am now writing to you.

I set out at **Annex A** some brief, high-level questions that will assist us with this task. To assist you in providing your answer to these questions, I enclose a Word form for you to complete.

This is not a formal request for information and we are not asking you or your organisation to provide evidence or a witness statement - it is simply an information-gathering exercise. I hope your organisation will feel able to respond, but if it does not wish to do so, please let me know so that we can update our records. If you or your organisation only feel able to answer some of the questions only, that is also fine. It may be that I contact your organisation again in due course to ask for further information in a more formal way.

Any response you do provide to this letter is intended to be for the Inquiry's information only. We are therefore unlikely to be able to address any substantive questions you raise about the scope of Module 3 or any other areas of the Inquiry's work. We are, however, very happy to help with any practical queries you may have about responding to the questions.

It is not the Inquiry's intention to share any response you provide to this letter outside of the Inquiry. If it does become necessary to share your response, we will contact you first.

**Next Steps**

Once your response to the questions in Annex A is ready, please return it to me by email to solicitors@covid19.public-inquiry.uk. Please include the reference number in the heading of this letter in the email subject of any correspondence relating to this request. This is to ensure it is forwarded to me without delay.

If you would prefer to provide your response by secure email please let me know and I will provide details of how you can do this. Please identify any matters that you consider to be particularly sensitive when providing your response.

The Chair intends to conduct the Inquiry as quickly and efficiently as possible and welcomes the assistance of all individuals and organisations with her task. Therefore, if you wish to provide a response to the questionnaire, please ensure this is returned to the Inquiry **by 10am on Monday 19 December 2022.**

**In summary**

1. **Please respond to the Annex A questionnaire by completing the form enclosed with this letter.**
2. **Please make sure you include the name of your organisation in your response.**
3. **Please send it to solicitors@covid19.public-inquiry-uk and include 'M3' in the subject line.**
4. **Please acknowledge receipt of this correspondence and confirm the best email address for us to contact you at going forward.**

If you have any questions concerning the above, please do not hesitate to contact me.

Yours sincerely

Abigail Scholefield

Module 3 Lead Solicitor
solicitors@covid19.public-inquiry.uk

**Annex A**

**Questionnaire**

**UK COVID-19 Inquiry: Module 3 - Request for information**

*The Inquiry would encourage those responding to these questions to read the provisional outline of scope in full so that they may identify any relevant areas in which they can provide information.*

*At this initial stage, please limit your response to all of the questions below to no more than **2000 words in total** - we are looking for an overview only at this stage to help us decide whether we need to make a supplementary request for more detailed information .*

*Please note that the Inquiry is unable to consider individual cases of harm or death in detail. However, you may wish to provide anonymous examples in order to illustrate any wider systemic issues that you consider to be relevant.*

In relation to the provisional outline of scope for Module 3, please provide the following:

1. A brief overview of your organisation's function and role in relation to healthcare services and systems in the area in which you are based, and specifically in relation to the Covid-19 pandemic (for example if that function or role developed or changed).

2. Specifically in relation to your organisation's role or function delivering and/or arranging for healthcare services (point 1 above) in your area, what your organisation considers to be the key issues relevant to the matters set out in the provisional outline of scope for Module 3. This could include, but is not limited to:

    A. Responses to the pandemic - what went well and what did not go so well, and what you are most proud of;
    B. Examples of how the particular healthcare systems your organisation operated in worked effectively and efficiently;
    C. Examples of how the particular healthcare services your organisation delivered and/or arranged for were adversely affected; and
    D. How particular groups of your organisation's local population, patients or staff were adversely affected.

3. Following on from the previous question, a brief summary of any key lessons learned that your organisation identified in relation to its responses to the Covid-19 pandemic, including the impact on healthcare services you operate and healthcare systems your organisation operated within, and how any lessons might apply in the future. Please tailor your response to the matters set out in the provisional outline of scope for Module 3. *If the overall word limit of 2000 words is constraining for this question and being brief would not support our understanding, please use up to by no more than a*

*further 2000 words on this particular question. Alternatively, you may wish to provide existing lessons learned reports/papers that your organisation has compiled.*

4. A **list** of key documents or categories of documents that your organisation has produced which you consider to be most relevant to points 1-3 above and the provisional outline of scope for Module 3. Please provide a brief description of the document/categories of documents and the reasons why you consider them to be particularly relevant. *For example, these could be Incident Team meeting action logs, Executive/Board minutes and reports, Serious Incident Reports, papers relating to key internal policy and/or procedure changes etc. We are not asking for day to day types of documentation relating to treatment of patients such as patient records, theatre lists or staff rotas as we know these will exist. We also do not need published guidance from public bodies such as PHE (now UKSHA) or NHS England.*

5. A **list** of any key articles or reports your organisation has published or contributed to, and/or evidence it has given in public regarding the matters set out in the provisional outline of scope for Module 3.

   *Please note that we are **not** requesting copies of the documents at points 4-5 at this stage. However, it would assist the Inquiry if you could provide hyperlinks for those documents that are publicly available.*

6. Any other points that you wish to raise in relation to the issues identified in the provisional outline of scope for Module 3 that your organisation considers would assist the Inquiry to understand those issues more effectively.

**FREEPOST**

UK Covid-19 Public Inquiry

**Form to be completed in response to Annex A questionnaire**

**UK COVID-19 Inquiry: Module 3 - Request for information**

*Please provide your organisation's answers to the questions set out in Annex A, below. Please limit the response to all questions to no more than 2000 words in total if possible.*

**Name of organisation completing this questionnaire: Walsall Healthcare NHS Trust**

**Question 1**

Walsall Healthcare NHS Trust is an integrated Trust and the only provider of NHS acute care in Walsall, providing inpatient and outpatient services at the Manor Hospital as well as a wide range of services in the community. Walsall Manor Hospital houses the full range of district general hospital services under one roof. The Trust has a state-of-the-art Critical Care Unit, Neonatal Unit, Obstetric Theatre and Integrated Assessment Unit facilities. The Trust provides high quality, friendly and effective community health services from some 60 sites including Health Centres and GP surgeries. Covering Walsall and beyond, multidisciplinary services include rapid response in the community and home-based care, so that those with long-term conditions and the frail and elderly, can remain in their own homes to be cared for wherever appropriate.

**Question 2A**

**Responses to the Pandemic – what went well and what did not go so well, and what are you most proud of.**

The build up and sudden surge in Spring 2020 presented the Trust with a significant challenge, which tested people, resources, processes and emergency arrangements to extents not previously experienced. People were at the heart of everything; showing their leadership, determination, ingenuity, flexibility and endurance. The pandemic also took an extraordinary toll and impact on people, and the many events and scenarios played out across the work place and life of all staff, patients, visitors and community partners. Whilst in the early days of the emergency, the Trust rapidly adjusted and implemented many changes, and changes again, a broader based and wider set of reflections, debriefings and reports were commissioned in the summer/early autumn 2020 period. Individual as well as collective learning, with the identified and distilled improvements for the short and medium term agreed, also placed the Trust in a very strong position to effectively handle the subsequent surges and challenges thereafter - commencing with the rapid increase of cases again in the autumn 2020 and the period right up to now. The learning and debriefing culture was central to the Trust's way of working, coupled with the proactive contingency planning and regular strategic and tactical oversight of the current situation to thus respond early and effectively, have offered the Trust confidence and the right tools to face most challenges ahead.

**FREEPOST**

UK Covid-19 Public Inquiry

**What Went Well**

- Introduction and implementation of the Trust Critical Care Surge Plan
- Introduction of the Enhanced Recovery Unit
- Command structures were established
- Setup of a Tactical Command (Silver) arrangement to provide Trust wide shared understanding of the current situation and likely future landscape, collective understanding of the risks and ability to make tactical “balance of risk” and responsive decisions in light of fast moving and extraordinary changes to IPC rules, logistical planning, and decisions regarding changes to / additional resources available.
- Strategic Command (Gold) structure to offer strategic direction, intent and appropriate decisions not delegated to Tactical Command
- Rapid introduction of the Walsall Together Mass Vaccination Centre for healthcare staff, regional health partners, and the community providing up to 1,000 vaccinations per day from mid December 2020.
- Internal IPC and Microbiology support
- Medical response e.g. cancellation of elective and outpatient activity and the redeployment of medical staff to support the inpatient wards and emergency care services.
- The social care response and IDT team; the additional funding to secure residential and nursing home placements supported low numbers of medically fit patients residing in hospital, freed up capacity and improved flow through the hospital.
- The purchase of laptops and rapid roll-out to staff working from home improved ability for support staff to work flexibility.
- Redeployment of staff in later waves to support Critical Care and the wards.
- Support and timely response from procurement and regional/national teams in getting much-needed equipment (various) e.g. pulse oximeters.
- Ability to access additional funding signed off within hours or days.
- Remote monitoring and home care programmes e.g. respiratory pathway.
- Health & wellbeing offer to staff with psychological support.
- Rapid point of care testing in ED, supporting flow and patient care.
- Ability to segregate COVID-19 positive patients onto the Modular block and establish a separate admissions pathway.
- The Trust’s response to streaming patients in ED and separating the area (although challenging) this worked well although the ageing facility and small waiting area impacted on social distancing.
- The early segregation of the hospital to a ‘hot’ and ‘cold’ site and the ability to deliver outpatient and elective services in subsequent waves.
- The way the Trust quickly changed the way it worked and could be innovative without having to go through many hoops in introducing changes e.g. virtual outpatient appointments, establishing the COVID-19 vaccination centre.
- The Trust implemented a risk assessment for BAME members of staff. This was expanded to include all staff, with a focus on prioritising risk assessments for staff with emerging at risk features (existing long term illnesses, pregnancy, age etc).

- Key stakeholders including IPC, OH, H&S, HR, EDI Advocates and Trade Unions developed the staff COVID-19 risk assessment and staff briefing process.
- Implemented a Staff COVID-19 Outbreak Management Team to advise staff and help managers deal with the implications of COVID-19 outbreaks.
- Implemented a structured risk assessment process to ensure staff not involved in the delivery of essential patient services were able to work from home and to ensure workspaces were able to meet social distancing requirements.
- Interim processes were implemented to support the workforce, particularly with regard to working from home.
- Community Services established a RAG scoring system to identify priorities within community services.
- Community Services established a daily Tactical Command with all partners to agree an integrated response to COVID-19, integrated and coordinated with the Trust Tactical Command.
- Operational initiatives around speeding up the discharge processes.
- Significant effort and energy devoted to work in Care Homes – which the Trust audited to show it was best practice – and was proactive in that the Trust then went in to support with staffing, PPE, care needs – up to 50 hospital staff at one point were helping – this was used to demonstrate the requirement for the Enhanced Care Home Support Team.
- Developed out of hospital initiatives such as acute COVID-19 pathways, expanded the Care Navigation Centre, pushed Rapid Response.
- Staff questionnaire / evaluation of lessons learned during end of first COVID-19 wave and examined what was needed to retain as part of future service planning.
- Coordinated MDT clinical training and rota response to support ICU care from all specialities.
- Easy to access guidelines updated quickly with support from library staff gathering publications via responsive literature searches to clinical teams.
- Recruitment and engagement with research programmes such as RECOVERY Trial.
- Review of COVID-19 HCAI deaths across the ICS with sharing of lessons.
- Virtual peer support groups, virtual clinics, virtual ward rounds and MDTs between organisations.

**Areas identified for Improvement**

- In the early days of the pandemic, ensuring staff understood the need for PPE and social distancing was challenging, this became easier when central messaging became clearer and more concise.
- The Staff COVID-19 Outbreak Management Team were developed following challenges mapping outbreaks of COVID-19 within teams of staff. Prior to forming, this function was led by the Occupational Health (OH) Team however this diverted valuable OH resource away from supporting the specific needs of staff.
- Fit Mask testing; limited resource/capability to meet demand.
- Important capacity required in Housekeeping (cleaning demand).

- People. As in most organisations, there were no real preparations for the significant impact on staff (clinical, management, frontline in wards and managing national emergency) across the Trust. Issues vary across each of these cohorts. Key challenges were:
    - Staff rotation in clinical areas and the impact in management / leading
    - Staff wellbeing
    - Staff exhaustion
    - Staff managing illness, impacts in their own lives
    - Volume of sickness / absence
    - Homeworking
    - Sustaining high tempo activity over long period
- Tactical Command Review suggested further analysis in the following fields:
    - Personal resilience
    - Organisational resilience
    - Staff skill set, recognising pinch-points
    - Leadership

- Support staff (HR, Governance, Finance etc) working from home and inability to contact them easily especially in the first wave of the pandemic
- Access to PPE and clear messaging, managing staff's anxieties when restricting PPE, FP3 masks etc
- Policies around visiting, slow decision making or guidance, policies then not followed. Staff had to deal with so many constantly changing policies around patient COVID-19 testing, mask wearing, PPE for certain procedures, isolating patients (7,10, 14 days etc) and then visitor guidance, end of life. In some waves opened visiting too soon and then not soon enough. It was very difficult to get messages out consistently and for these to be received and understood by staff groups.
- Ability to be in contact with patient's relatives and carers and provide regular updates to them, and vice versa - this was very time-consuming for staff and extremely worrying for relatives / carers and took too long to put arrangements in place e.g. mobile phones on the wards, tablets for patients, timed appointments to call. Further hampered with ward reception staff not being available, answering phones etc. Nursing and medical staff were so busy caring for patients, that communicating outside of this was extremely hard for them. The redeployment of non-clinical staff should have happened sooner.
- Restrictions on nursing and residential homes and inability to discharge positive patients, particularly in waves 1 and 2. Although it was known what happened during the first wave e.g. outbreaks in nursing and residential homes were devastating, the severe restrictions on testing prior to discharge and having to keep patients in hospital, severely impacted on bed capacity and flow. This improved when certain homes were identified as COVID-19+ homes for discharge.
- Planning. It is extreme to genuinely plan for an event of such scale / speed and severity and be fully prepared. The risk may have not been fully understood; both nationally and locally. There was limited planning that genuinely looked at the implications of a pandemic and the mitigating actions required. Despite the Trust

being compliant with having a plan, more should be considered going forward to include examination of likely risks, planning assumptions, responsibilities of key individuals, partners etc and using good practice in all plan development. There was very limited Divisional level planning to supplement existing Trust plan. Having ownership of a plan and testing it on a regular basis supports learning, offers confidence if activated and produces a more valuable product from which to manage any subsequent response.

- Business Continuity. Understanding, planning and response to continuity incidents at Divisional and Trust level is very mixed. Whilst understood and recognised this was a priority to address in the short/medium term. IT support and continuity of service in challenging and rapidly changing circumstances was generally seen as good.
- Volume of information. Levels were unprecedented, overwhelming and at times conflicting. However, any emergency generates information and a thirst for more information. An organisation must have robust information management structures, managing, understanding/interpreting, disseminating, and acting upon. Use of emails was considerable and distribution management at times poor. Sending an email does not mean the responsibility to see the action complete is over. Development of SOPs, managing and distributing became a significant task. The priority should always be delivery at the frontline.

**What we are most Proud of**

- Targeted support to Clinically Extremely Vulnerable (CEV) staff.
- Prioritising health and wellbeing needs of staff
- Supporting staff with accommodation needs in cases where they were worried about contact with CEV family members.
- Robust, effective and enduring command and control structures linked with community Division, Walsall Together and other external health and non-heath partners.

**Question 2B**

**Examples of how the particular healthcare systems your organisation operated in worked effectively and efficiently**

- Introduction of the Adult Critical Care Transfer Service with coordinating consultants to decompress those units with the greatest over-occupancy
- Multi-disciplinary and unified approach rapidly adopted across Trust with shared aim and objectives
- Mutual aid arrangements across the local healthcare system e.g. PPE, equipment
- Operational planning and response generated by the Walsall Together partnership, led by the Trust.

- Adjusted to a multi-agency Tactical Command forum, that allowed health and related partners a focused and joined up approach to the initial response and later, better co-ordinated planning, sharing information and real energy and trust between individuals and different teams
- The leadership in setting up and delivering national best practice mass vaccination capability servicing regional health, blue light and Walsall people from December 2020 until local model adopted in April 2022.
- Being established was quickly able to adjust to demands; it rapidly was able to get additional PPE to Care Homes, Advance Care Planning was good and the ability to data share.
- Data sharing enabled dashboard information to support good decision making; Walsall Together was early to identify ethnicity as a factor and could better target vaccination outreach programmes accordingly.
- Sharing data on mental health strengthened the recognition of COVID-19 and increased demand for services

- Walsall Council (Deputy Director Public Health) led Health Protection Forum (COVID-19) that met weekly to share surveillance data, planning, response activity and lessons. Nursing, IPC, microbiology and EPRR representation ensured excellent cross pollination of data, trends, risk, ideas and joint planning and response that allowed for efficient resource allocation.
- Eventually NHSE Regional Operation Centre offered co-ordinated information sharing and management capability
- Worked closely, although generally informally with neighbouring Trusts, particular with pre-established professional contacts on mutual aid, clarifying local interpretation of national guidance and rapid advice,

**Question 2C**

**Examples of how the particular healthcare services your organisation delivered and/or arranged for were adversely affected**

- Ventilator Supply. Shangrila 510 Ventilators. They were not adequate to provide sustained ongoing ventilation in the care of critically ill patients, with or without COVID-19, as they have inadequate flow sensitivity, inadequate capability to wean oxygen, cannot deliver adequate humidification via the provided dry circuit and thus don't have the necessary functionality to manage a deteriorating patient where precise ventilatory management is essential. Report escalated to NHSE Midlands.
- Many patients by default fell within vulnerable categories putting them at greater risk of serious illness in the case of COVID-19 infection. We needed to keep all our patients fit and well at this time above and beyond what would already normally happen.

- Critical Care capacity risk management – the relative over-occupancy of Critical Care Units had huge variation even within the Midlands region; some Trusts were running well above their 100% baseline funded capacity and managing significant clinical risk as a result, whilst others weren't. Report escalated to NHSE Midlands.
- Absence of process to allocate funding for additional Critical Care beds, accounting for those Units able to staff and open to their funded Critical Care capacity
- Equipment allocation and opportunities to source additional equipment (e.g., ventilators) did not adequately account for stock on existing sites
- Inability to continue with invasive aerosol generating procedures especially in the early waves
- Reviews of the COVID-19 impact to date have not considered:
    - Electronic Critical Care Systems allowing patients to be monitored remotely, with Consultants providing input for patients across multiple Units
    - Where access to non-invasive ventilation is limited and where it could be funded
- Returns. Their volume, nature, complexity, format, turnaround expectation. Need to improve management, quality assurance and make process significantly more effective.
- Walsall Together partnership, whilst highlighting many positives, needed to reduce usual contact/activity in the community and is still not clear on the impact of late presenting, outstanding self presenting and the impact still to come in prevention and impact on secondary and tertiary care.
- In order to meet IPC standards inpatient services patients were tested on admission and treated as positive until the result was received to protect fellow patients and staff. This meant that until results were received, they were isolated in a single room with ensuite or placed in a designated area of the ward. This meant that patients already feeling very unwell were not allowed to mix in a normal way which was found to be challenging for some service users.
- Testing Reagents. Report escalated due lack of associated reagent with testing capability, which limited local/system capacity when national remit significantly increased

**Question 2D**

**How particular groups of your organisation's local population, patients or staff were adversely affected**

- National guidance regarding the management of staff COVID-19 sickness did not reference latest literature and felt overly restrictive for some members of staff. NB: this is to be applicable after the roll out of the Vaccination Programme
- The impact of lockdown on people's mental health especially young people is a concern.
- For those facing the greatest health inequalities, who may face barriers around digital access, language, cost, there was reduced levels of access to support

- For those people with existing mental ill health, limited access to mental health support is posing a significant challenge.
- Ongoing restrictions for vulnerable staff led to frustrations and our inability to redeploy to other duties and to non-clinical areas appeared to be extremely restrictive, particularly once vaccination programme had begun and in subsequent waves
- For patients – the lack of contact with relatives and carers
- Respondents were worried about family, about caring responsibilities, the need to ask for help, home-schooling and working from home.
- Anxious carers of children with ASD returning to school
- Anxiety of staff working in health and social care sector, particularly BAME staff
- Anxiety of staff within the CEV group of caring for vulnerable family members categorised as CEV.
- Concerns arising from being redeployed into less familiar areas of work to deal with increased patient volume.
- Concerns from both substantive and temporary workers that absence related to COVID-19 would adversely affect pay

**Question 3**

**Brief Summary of any key lessons learned**

- Importance of preparedness; anticipation, contingent planning, people, testing and exercising and business continuity planning
- Robust information management; command and control arrangements, setting strategic aim, objectives and intent, pithy action setting, good decision making and record keeping

**Question 4 (Please note you are not limited to the number of rows set out below)**

| **Categories of document or key document produced by your organisation including document title and date (with link if publicly available)** | **Brief description** | **Why it is particularly relevant** |
|---|---|---|
| Trust Strategic Command Meeting Decision& Action | Logs of all key decisions and actions made with | Provides a clear understanding of strategic |

| | | |
|---|---|---|
| Logs | appropriate rationale behind decisions | intent, leadership and direction to provide effective healthcare arrangements during the pandemic |
| Trust Tactical Command Current Situation, Decisions and Action Logs | Documentation of key events, current situation, key decisions and actions made with appropriate rationale behind decisions | Provides a clear account of tactical aim, objectives, leadership and direction to deliver effective healthcare arrangements during the pandemic |
| Trust Operations Centre Daily Site / Patient Flow Report | Twice daily reports covering Site position (Patient Flow and Bed State) including fire/security or untoward occurrences, issues affecting flow, IPC status and wider site safety matters | Regular data on site/patient flow with supporting remarks |
| Trust Board Minutes and Reports | Documentation of key events, current situation, key decisions and actions made with appropriate rationale behind decisions | |
| PFIC Minutes and Reports | Documentation of key events, current situation, key decisions and actions made with appropriate rationale behind decisions | |
| TMC Minutes and Reports | Documentation of key events, current situation, key decisions and actions made with appropriate rationale behind decisions | |
| Strategic COVID-19 Mass Vaccination Current Situation, Key Decisions and Actions | Documentation of key events, current situation, key decisions and actions made with appropriate rationale behind decisions | Provides a clear account of strategic/tactical intent, aim, objectives and direction to deliver mass vaccination programme from Dec 20 |
| Trust Weekly Mortuary Data Report | Mortuary capacity and occupation | Regular pattern of mortuary occupation including surge capacity |

| | | |
|---|---|---|
| Trust Daily COVID-19 SITREP | Summary of COVID-19 patients across the Trust | Profile and location of COVID-19 patients |
| Trust Daily SITREP | Summary of Trust position (COVID-19 cases), bed capacity, mortuary capacity, discharges, staffing | Profile and regular data fields over COVID-19 pandemic |
| Executive Team Briefing Presentations | Regular Executive overviews presented to staff | Communication across Trust |
| Weekend and Bank Holiday Plans | Weekly plans, capacity and direction to on call teams | Sets direction and planning out of hours |
| Trust CPNS Data | Data of all COVID-19 deaths | Profile and data of COVID-19 deaths |
| IIMARCH Forms - IPC | Record of all Outbreak management meetings | Profile and management of all outbreaks |
| Trust Daily Workforce Absence SITREP | Record of staff absence | Profile and Impact to staffing |
| Trust Daily COVID-19 Figures | Regular number of COVID-19 patients | Profile and location of COVID-19 patients |
| Trust Daily MFFD List | Regular number of discharges | Profile and location of discharges |
| Workforce COVID-19 risk assessment process, data and guidance. | Explanation of process - number of staff that have received a COVID-19 risk assessment. | Set standard and assurance process |
| H&S Social Distancing risk assessment and audit process | | Set standard and assurance process |
| PPE SITREP | Stock levels | Our demand and management |

**Question 5 (Please note you are not limited to the number of rows set out below)**

| **Document title and date (with link if publicly available)** | **Brief description** | **Why it is particularly relevant** |
|---|---|---|

| | | |
|---|---|---|
| Trust COVID-19 Contingency Plan (8 Versions) | Trust COVID-19 Contingency Plan | Set Trust plan for anticipation, surveillance, response and recovery |
| COVID-19 Incident Escalation -Ventilator Supply Letter 11 Apr 20 | Report on significant deficiencies of Shangrila 510 ventilators | |
| COVID-19 Incident Escalation – Restricted supply of reagents for testing Letter 14 May 20 | Escalation of lack of required reagent to meet testing criteria/requirement | |
| Outbreak Management Debrief Reports (6 in total – IPC & Microbiology, Occupational Health, Capacity & Flow, Estates, Medicine Division, Surgery Division) | Lessons identified in outbreak management | Consolidated learning, lessons identified for Trist outbreak management arrangements |
| Tactical Command Reflections Report, Sep 20 | Collation of reflections from Tactical Command Individuals from March to July 2020 | Wide ranging, personal and collective reflections and learning |
| UEC and COVID-19 Resilience: Winter Plan 2020/21, Nov 20 | Winter Plan to include COVID-19 impact | Learning and planning |
| COVID-19 Pandemic Second Interim Operational Review, C19 National Foresight Group, Jul 20 | | Related to local findings. Learning and Improvement planning |
| Provider Collaboration Review, Walsall Together, CQC, Jul 20 | External Place COVID-19 Review | External review that reinforced the many positive actions and improvements witnessed across partnership led by Trust |
| Exercise MUIRFIELD, Aug 20 | Aim. Through the means of an Exercise review our tactical preparedness for the potential local/regional escalation of COVID-19 so that the Trust is ready to | Objectives<br>• Ensure appropriate plans and procedures are in place, up to date and shared; |

| | | |
|---|---|---|
| | respond in the 12 months ahead. | • Review surveillance, escalation and activation protocols;<br>• Agree and understand appropriate internal and external command and control arrangements;<br>• Prepare appropriate communicate strategy related to workforce and external stakeholders;<br>• Highlight any capability gaps. |
| Support with Trust COVID-19 ICC Report; Oct 20 | Review of EPRR arrangements supporting COVID-19 national pandemic response, March to August 2020 and future requirement | Learning, lessons identified and improvement planning |
| Exercise PATTON Report | Table Top Exercise to test Trust winter preparedness and resilience, Oct 21 | Testing assumptions and plans |
| COVID-19 Incident Escalation – Critical Care Risk Management Letter, 9 Nov 20 | Two major concerns raised; other Trusts often declining attempts by Network to facilitate transfers and imbalance of capital allocation for Critical Care | |
| Exercise PATTON 2 Key Actions Report | Through the means of a workshop scope further the Trust's preparedness and resilience in light of the Omicron variant spread in UK in order that the Trust can adapt existing plans and be ready to respond effectively to the shifting health landscape, Dec 21. | Testing assumptions and plans |
| Exercise PATTON 3 Outcomes and Key Actions Report | Through the means of a workshop take stock of the current situation in order that | Testing assumptions and plans |

| | | |
|---|---|---|
| | the Trust can refine response and adjust focus on preparedness for the next phase until the end of winter and just beyond, Jan 22. | |
| UEC and COVID-19 Resilience: Winter Plan 2020/21 Debrief Report, May 21 | Collation of reflections from all Divisions and key Departments | Lessons Identified and Improvement planning |
| UEC and COVID-19 Resilience: Winter Plan 2021/22, Oct 21 | Winter Plan to include COVID-19 impact | |
| UEC and COVID-19 Resilience: Winter Plan 2021/22 Debrief Report, Apr 22 | Collation of reflections from all Divisions and key Departments | Lessons Identified and Improvement refinement |
| UEC Resilience: Winter Plan 2022/23, Sep 22 | Winter Plan to include COVID-19 and flu impact | |
| QI COVID-19 Lessons Report | Commissioned Lessons Report | Lessons Identified, Learning and Improvements |
| Community: Learning from COVID-19 for people living with Frailty, Nov 20 | Changes in Service Provision, patterns of demand, approach to Care Homes. Risk of clinical harm and considerations for further waves | Lessons Identified, Learning and Improvements |
| Community: Reflections from ICS, Jun 20 | Immediate learning and actions | Lessons Identified, Learning and Improvements |
| Community: Review of staff questionnaire on COVID-19 response, Jul 20 | Evaluation of Divisional staff survey | Lessons Identified, Learning and Improvements |
| Care Home Audit, May 20 Care Home Interventions, May 20 | Advanced Care Planning, DNACPR, Escalation Planning | Lessons Identified, Learning and Improvements |
| Walsall Together; Response | Priorities, risks | Many examples of success |

| | | |
|---|---|---|
| to Operational Pressures, Jan 21 | | |
| EPRR Steering Group Key Decisions and Actions | | |

**Question 6**

*Any other points that you wish to raise in relation to the issues identified in the provisional outline of scope for Module 3 that your organisation considers would assist the Inquiry to understand those issues more effectively.*

None

**Thank you for providing your response! The Inquiry is grateful for the information you have provided. Please ensure you include your organisation's name at the top of the response and send it to solicitors@COVID-19.public-inquiry.uk**

Walsall Healthcare NHS
NHS Trust

31 January 2023 11:28

List of action items

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| 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 | 22/06/2023 | Pending |
| | *Explanation action item*<br>Ms Carroll confirmed that the Oliver Mcgowan Disability training would be implemented in quarter 4 - and the action would be reviewed in June 2023. | | | |
| 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<br>Stringer , Kevin | 30/03/2023 | Pending |
| | *Explanation action item*<br>Following December Board Meeting - Mr Stringer asked that this action be extended to March 2023 as discussions were still ongoing. | | | |
| Public Trust Board 07/12/2022 11.2 Hospital Mortality Report (September - October 2022) | | | | |
| 587. | Hospital Mortality Report - Dr. Shehmar CMO | Shehmar, Manjeet | 08/02/2023 | Pending |
| | *Explanation action item*<br>Minute Ref - 421/22 - Dr. Shehmar to provide ethnic and age related data analysis of Covid-19 Deaths. | | | |
| 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. | 28/02/2023 | Completed |

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| | *Explanation action item*<br>The visit to the Acute Oncology Service has been added to the Walkabout schedule for Executive and Non-Executive Directors and is scheduled to take place in March 2023. | | | |
| 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 | Completed |
| | *Explanation action item*<br>The visit to Goscote Hospice (Palliative Care) has been added to the Walkabout schedule for Executive and Non-Executive Directors and is scheduled to take place in February and March 2023. | | | |
| 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 | Completed |
| | *Explanation action item*<br>Prof. Field met with Mr Garry Perry and the Blessed to Bless Charity. | | | |
| 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 | Completed |
| | *Explanation action item*<br>Prof. Loughton confirmed that a visit had been scheduled. | | | |
| Public Trust Board 05/10/2022 8 Chief Executive's Report | | | | |
| 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<br>Nightingale, Gayle<br>Stringer , Kevin | 07/12/2022 | Completed |

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| | *Explanation action item*<br>this action has been merged with action 540 | | | |
| 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 | Completed |
| | *Explanation action item*<br>this was presented at Trust board meeting in December 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 action item*<br>Mr Dodd provided paper for December 22 public board | | | |
| | *Explanation Dodd, Matthew*<br>Paper submitted for Trust Board 07.12.22 | | | |

Walsall Healthcare
NHS Trust

| **Nolan Principles of Public Life & Trust Values** | |
|---|---|
| Committee on Standards in Public Life - Guidance<br>The Seven Principles of Public Life<br>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**<br>Holders of public office should act solely in terms of the public interest. | |
| **2. Integrity**<br>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**<br>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**<br>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**<br>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**<br>Holders of public office should be truthful. | |
| **7. Leadership**<br>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. | |

## Vision

Our vision is to 'To deliver exceptional care together to improve the health and wellbeing of our communities'. Our vision has been updated to reflect the closer working of our organisations and to focus on our core purpose of improving the health and wellbeing of our communities.

A vision is more than a few words – it reflects our aspirations, helps to guide our planning, support our decision making, prioritise our resources and attract new colleagues.

## Strategic Aims and Objectives

Our strategy is based around four strategic aims - referred to as the Four Cs.


Our strategic aims reflect our four key areas of focus and consider the key influences from the environment within which we operate.

Our aims incorporate feedback from colleagues working for both organisations as well as the public and external stakeholders, e.g. the Integrated Care Board and other providers.

Our strategic aims are underpinned by strategic objectives (detailed later in the document) – these are more specific measures which we use to judge our achievement.

| MEETING OF THE PUBLIC TRUST BOARD – 8 February 2023 | | | |
|---|---|---|---|
| Chief Executive Officer's Report | | | |
| **Report Author and Job Title:** | Gayle Nightingale<br>Executive Assistant | **Responsible Director:** | Prof David Loughton CBE, Chief Executive Officer |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☐ Discuss ☐ Inform ☒ Assure ☐ | | |
| **Assure** | • Assurance relating to the appropriate activity of the Chief Executive Officer. | | |
| **Advise** | • The paper includes details of key activities undertaken since the last Trust Board meeting. | | |
| **Alert** | • None in this report. | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | None in this report. | | |
| **Resource implications** | There are no resource implications associated with this report. | | |
| **Legal and/or Equality and Diversity implications** | None in this report. | | |
| **Strategic Objectives** | Safe, high-quality care ☒ | Care at home ☒ | |
| | Partners ☒ | Value colleagues ☒ | |
| | Resources ☒ | | |

# CHIEF EXECUTIVE OFFICER'S REPORT

| | |
|---|---|
| **1.0** | **Review** |
| | This report indicates my involvement in local, regional and national meetings of significance and interest to the Board. |
| **2.0** | **Consultants** |
| | There has been two Consultant Appointments since I last reported:<br><br>**General Anaesthetists**<br>Dr Supriya Vaibhav Antrolikar<br>Dr Lorena Iftime |
| **3.0** | **Policies and Strategies** |
| | **December 2022**<br>• Policies, Procedures and Guidelines - Quarter 3 and 4 Reports<br>• Policy Management Core Group – Terms of Reference<br>• HR968 V1 – Dispute Resolution in the Workplace Policy<br>• HS964 V3.1 – Display Screen Equipment Policy<br>• HS965 V4 – Control of Substances Hazardous to Health (COSHH) Policy<br>• MH971 V5 – Mental Capacity Act Policy<br>• OP963 V7 – Non-Emergency Patient Transport Services Policy<br>• OP966 V4 – Acute Oncology Operational Policy<br>• OP969 V3.1 – Trust Capacity Escalation Policy<br>• Trust Guidelines for the Management of Hypomagnesaemia<br>• Standing Operating Procedure – Referral Pathway for Infants less than 29 days in Paediatric Emergency Department |
| **4.0** | **Visits and Events** |
| | • Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including:<br>• 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<br>• 21 November 2022 – attended the Getting It Right First Time (GIRFT) virtual Neonatal Deep Dive meeting and attended the NHS England - Amanda Pritchard, Chief Executive and Julian Kelly, Chief Financial Officer Autumn Statement – virtual webinar<br>• 22 November 2022 – chaired the virtual Trust Management Committee (TMC)<br>• 23 November 2022 – participated in the virtual Local Medical School Liaison Committee with Health Education England (HEE) and Birmingham Medical School<br>• 25 November 2022 – participated in the virtual Walsall Proud Partnership (WPP) meeting |

| | |
|---|---|
| | • 29 November 2022 – participated in the NHS Providers – NHS England (NHS): Provider Collaborative Innovators Scheme virtual webinar<br>• 30 November 2022 – attended the Cancer Alliance Leadership Forum<br>• 1 December 2022 – met with Pat Usher and Jane Wilson, Joint Staff -side Leads<br>• 2 December 2022 – participated in the virtual NHS Black Country Quarterly System Review meeting and hosted a site visit for Eddie Hughes MP and undertook the Christmas Light switch-on<br>• 5 December 2022 - participated in a virtual Black Country Collaborative Executive Committee<br>• 6 December 2022 – attended the Walsall Council Health and Well Being Board meeting<br>• 9 December 2022 - met virtually with Mark Axcell, Chief Executive – Black Country Integrated Care System (ICS)<br>• 12 December 2022 – met with Shabina Raza, Val Ferguson and Kim Sterling – Freedom to Speak up Guardians<br>• 14 December 2022 – presented at the virtual Finance Leaders Network 'In Conversation with... David Loughton' – expectations of a Director of Finance and met with Dr Helen Paterson, Chief Executive – Walsall Council<br>• 15 December – participated in the Joint Negotiating Committee (JNC), chaired a Joint Walsall and Wolverhampton Staff Briefing, participated in a virtual Black Country Collaborative Board and participated in a Walsall Council Health Scrutiny Panel Committee<br>• 16 December 2022 - virtually meet with Eddie Hughes MP and Wendy Morton MP and participated in a staff drop-in session<br>• 12 January 2023 – participated in a feedback session following a Health and Safety Inspection and participated in a virtual Local Negotiating Committee (LNC)<br>• 16 January 2023 – participated in a virtual Walsall Proud Partnership (WPP) meeting<br>• 17 January 2023 - chaired the virtual West Midlands Cancer Alliance Board<br>• 18 January 2023 - participated a virtual in the Regional Cancer Board and chaired the virtual Staff Briefing<br>• 19 January 2023 - participated in a virtual Joint Negotiating Committee (JNC) |
| **5.0** | **Board Matters** |
| | Mr Rajpal Virdee, Non-Executive Director (NED) contract expired on 31 December 2022. |

| MEETING OF THE PUBLIC TRUST BOARD – 7 February 2023 | | | |
|---|---|---|---|
| Chair's report of the Trust Management Committee (TMC) held on 26 January 2023 – 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:<br>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<br>• Midwifery Service Report<br>• Divisional Quality and Governance Report – Medicines and Long-Term Conditions Report<br>• Divisional Quality and Governance Report – Surgery Report<br>• Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services Report<br>• Divisional Quality and Governance Report – Community Services Report<br>• Integrated Quality Performance Report (IQPR)<br>• Trust Financial Position (Revenue and Capital) - Month 9 Report<br>• Accountability Framework Report<br>• Walsall Together Report<br>• Freedom to Speak-up Guardian Report<br>• Workforce Summary Report<br>• 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** |
| | • Director of Infection Prevention Quarterly Report<br>• Safeguarding Quarterly Report<br>• Patient Experience – Quarter 3 Report<br>• Contracting and Business Development Verbal Update<br>• Provider Collaboration Report<br>• Quality Improvement Team Report<br>• Sustainability Report<br>• Tobacco Dependency Report<br>• Pharmacy and Medicines Optimisation Quarterly Report<br>• Health and Safety Annual 2021/ 22 Report<br>• Corporate Risk Register and Business Assurance Framework Report<br>• Urgent and Emergency Care Centre's Capital Build Update Report<br>• Annual Planning Guidance 2023/ 24 and Timelines for Submission to NHS England (NHSE) |
| **5.0** | **Business Cases – approved** |
| | • There were no business case for approval. |

| | |
|---|---|
| **6.0** | **Policies approved** |
| | • Policies, Procedures and Guidelines - Quarter 3 and Quarter 4 Reports<br>• Policy Management Core Group – Terms of Reference<br>• HR968 V1 – Dispute Resolution in the Workplace Policy<br>• HS964 V3.1 – Display Screen Equipment Policy<br>• HS965 V4 – Control of Substances Hazardous to Health (COSHH) Policy<br>• MH971 V5 – Mental Capacity Act Policy<br>• OP963 V7 – Non-Emergency Patient Transport Services Policy<br>• OP966 V4 – Acute Oncology Operational Policy<br>• OP969 V3.1 – Trust Capacity Escalation Policy<br>• Trust Guidelines for the Management of Hypomagnesaemia<br>• Standing Operating Procedure – Referral Pathway for Infants less than 29 days in Paediatric Emergency Department |
| **7.0** | **Other items discussed** |
| | There were none this month. |

| MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – | | | |
|---|---|---|---|
| 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:**<br>**Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☐ | | |
| **Assure** | • Immediate risks resulting from the redeployment of mental health workers within Family Safeguarding have been mitigated, with short term funding secured and a long-term financial model in development.<br>• Operational reports have focussed on the partnership response to a period of very high demand on services. Despite high numbers of complex cases, flow throughout the system is good and acute numbers are stable.<br>• There are no items for escalation to the Trust Board. | | |
| **Advise** | • The reports covers items discussed in the December and January meetings.<br>• The Walsall Together Partnership Board held an away day in December to review its strategic aims and confirm strategic objectives for the coming year and beyond. | | |
| **Alert** | • Significant financial pressures across key discharge services have been mitigated for the current financial year. The challenge now is to obtain funding post April and give focus identifying what can be done differently to manage the demands.<br>• The partnership board have approved in principle a list of ICB-commissioned services for delegation to the Place Integrated Commissioning Committee in line with the agreed place-based governance model. Clarity regarding the ICB operating model and any associated delegation to place has not been received, however arrangements to establish the place governance arrangements continue and will be operational in shadow form as a minimum. | | |
| **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
## December 2022 & January 2023

## 1. PURPOSE OF REPORT

This report provides an overview of the key items discussed at the Walsall Together Partnership Board at meetings on Friday 9th December 2022 and Wednesday 18th January 2023.

The Chair of the meetings was Professor Patrick Vernon.

## 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.

The strategic alignment is awaiting review following the publication of the new Walsall Healthcare Trust strategy.

## 3. BOARD HIGHLIGHTS

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

**December 2022**

### 3.1. Operational Update:

Due to the amended date of the partnership board the report provided included operational data from October. Board was briefed on immediate operational pressures in the system including an increased number of acutely unwell patients requiring hospital interventions and enhanced packages of care on discharge also impacting on available finances. Additional pressures are presenting in children with the strep A concerns and mitigations are being investigated with the Walsall Together tactical command meetings reviewing regularly. Board took assurance that the appropriate measures are in place to minimise operational strains.

### 3.2. Transformation Report:

The board received assurance that the transformation programme is making progress and that there are no new risks to report.

### 3.3. Communications Brief:

The monthly communication brief was approved for circulation subject to the addition of the news that whg has been shortlisted for a Health Service Journal award for the collaborative work with Walsall Together and the ICB. It is nominated in the category: best not-for-profit working in partnership with the NHS.

**3.4. Place Based Governance:**

Board was presented with an update on the place-based government arrangements. Approval was requested for a list of ICB services to be considered by the Joint Commissioning Committee and ICB for delegation on 1st April to the previously approved place-based governance arrangements. Delegation would be made to the Walsall Place Integrated Commissioning Committee (PICC), via the ICB appointed Managing Director for Walsall. Partners discussed the papers and expressed concerns in relation to resourcing the additional responsibilities associated with delegation. Board was informed that resource requirements are included in discussions with the ICB yet noted the risk was not fully mitigated at this stage. Board approved the list in principle subject to additional conversations with partners absent and noted that there would be a lot of work required in order to gain approval and ensure the relevant supporting structures are in place before 1st April. The Board agreed that, irrespective of whether formal delegation is received, the partnership will look to establish the necessary governance arrangements to operate in shadow form from 1st April.

**January 2023**

**3.5. Staff story**:

A staff story was presented to board members from the lead EDI (Equality, Diversity and Inclusion) midwife. The presenter shared some of the work done to engage with communities to try and release barriers to accessing services and increase the uptake in essential antenatal services. Board members were impressed with the work achieved by a single person and offers was made from multiple partners to collaborate on some communications, potentially extending the scope of the model and assisting with evaluating and monitoring outcomes. Formal connections will be made and the board agreed to have a dedicated session looking at EDI within all aspects of the partnership.

**3.6. Operational Report**:

Board was briefed on the last few weeks and the sustained pressures on operational services, increased due to the strep A concerns in children and the increase of covid and flu cases in adults. Board was informed of the mitigations implemented to help deal with the additional pressures as well as the ongoing active conversations to try and secure funding for those implementations to help manage demands. Board took assurance that the appropriate actions are in place to mitigate the issues.

**3.7. Transformation Report**:

The board received assurance that the transformation programme is making progress. Due to the timing of reporting therefore not included in the transformation exception report, temporary funding has now been secured for the mental health workers within the Family Safeguarding Model. February's paper will see that project deescalated back to on track.

**3.8. Communications Brief**:

The communications brief was presented to board members and key items were highlighted. A formal announcement was made to board detailing the appointment of the new Group Executive Director for Place.

**3.9. Place Based Governance**:

Board was presented the latest update on the place-based governance arrangements. Formal confirmation of the operating model is still outstanding and there is no additional update on the proposed areas of delegation on the 1st April. Good progress is being made within each of the workstreams and the board approved for the Partnership Management Committee to transition into the Joint Planning Group. The ICB has approved for funded protected learning time for general practice on a quarterly basis. Board took assurance that the partnership would be able to accept the additional responsibilities from April if required.

There were no items for escalation.

## 4. RECOMMENDATIONS

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

# 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 25th January 2023** |
| **Chair of Committee:** | **Paul Assinder, Non-Executive Director** |
| **Date of Report:** | **Wednesday 25th January 2023** |

**ALERT**
**Matters of concerns, gaps in assurance or key risks to escalate to the Board**

**Financial Position 2022/23**
**Revenue**

- The Trust continues to forecast a breakeven revenue position for the 2022/23 financial year. A performance trajectory has been produced for the Trust to measure progress. Against this revised YTD Plan the Trust is favourable by £0.138m (£4.801m actual deficit versus £4.939m forecasted).
- Month 9 Year to date the Trust is £7.288m adverse to the original annual revenue plan. The Trust is reporting a £4.801m deficit.
- The revenue position at Month 9 YTD across the ICB shows a c£29.5m deficit which is c£28.5m adverse to plan. This position contains risk for the Trust as a risk share arrangement has been agreed between the organisations of the ICB.
- There remains risk to the revenue outturn in 2022/23. Key risks are driven by the significant winter pressures the Trust is experiencing today and secondly, any impact of the ICB risk share agreement.
- The Efficiency and Cost Improvement Programme continues to remain behind on delivery of the level of savings required in the annual revenue plan.
- Temporary staffing costs remain high and require significant reduction to deliver to planned run rates in future months. Agency costs are forecast to decrease.
- The Trust enters 2023/24 with a significant underlying revenue deficit.
- The Executive Team is to hold a meeting to discuss the prioritisation list of expenditure cases for the 2023/24 financial year.

**Capital**

- The Capital Programme is fully funded but operational challenges during winter, supply chain challenges and skilled staff shortages mean that risks to delivery remain.
- Due to the new Emergency Department opening later than originally planned, there is the potential of slippage in the Capital Programme. Action has been taken to ensure that funds are utilised fully and the programme remains tightly controlled
- The Committee requested that the Trust's Quality & Patient Experience Committee examine the impact of ED service transfer clinical preparations.
- The new Endoscopy stack had been approved through Chair's action and the equipment has been received by the Trust.

| | |
|---|---|
| | • The Trust is currently 'over committed' on capital for 2023/24, based on draft capital allocations. The Trust has c£18m of capital plans in place but has so far only been notified of £9m of funding.<br><br>**Performance Issues**<br>• The Trust continues to have strong ambulance handover times throughout December 2022 and into January 2023, despite the organisation experiencing very high levels of emergency pressure.<br>• The Trust declared critical incidents on the 21st December 2022 and 4th January 2023, due to emergency pressures.<br>• Members were informed there had been an improvement in the Breast Cancer pathway with the Practitioner running their own clinics.<br>• The Committee requested that the Trust's Quality & Patient Experience Committee examine the impact of pressures on clinical quality of care. |
| **ADVISE**<br>**Areas that continue to be reported on and / or where some assurance has been noted / further assurance sought** | **Ockenden Phase 2**<br>• Following Executive level approval through Investment Committee, it was agreed that an Extraordinary Performance and Finance Committee Meeting would be arranged prior to Private Trust Board for members to review the case.<br><br>**Performance**<br>• Emergency performance remains strong relative to system peers and despite 230 out of borough conveyances in December 2022.<br>• 62 Day Cancer care continues to improve at 67.6% in December and recovery continues to be amongst the strongest locally.<br>• Also for 62-day Cancer performance, the Trust was materially better than the West Midlands average (47.0%) and the national average (61.0%) with 66.4% of our patients treated within 62 days of GP referral.<br>• For Virtual Wards, a programme of implementation has been implemented with the final virtual ward commencing operational delivery on 23rd January 2023. Since their inception the virtual wards have accepted 284 referrals for patients that have been stepped down from acute hospital beds.<br>• The service continues with its programme of recruitment in both Health Visiting and other support roles. A recovery trajectory has been developed by the service and is being considered jointly with commissioners.<br>• The Trust is expecting to achieve a position of zero 78 week waiters by 31st March 2023. |
| **ASSURE**<br>**Positive assurance & highlights of note for the Board / Committee** | **Capital & Cash**<br>• The Emergency Department remains on target for the revised handover date of 10th February 2023.<br>• The Trust has a strong cash position for the 2022/23 financial year. However, the Committee is conscious of likely pressure on cash next year and referred cash flow management in the Trust for review by the Audit Committee.<br><br>**Performance**<br>• Performance on the 62-day standard was better than the West Midlands and National average.<br><br>**Emergency Preparedness (EPRR)**<br>• NHSE validation of our self-assessment of EPRR has confirmed a 'partially compliant' status. |

| | |
|---|---|
| **Recommendation(s) for the Board** | **Board to note:**<br>• An Extraordinary Performance and Finance Committee meeting would be set up for members to review the Ockenden Phase 2. |
| **Changes to BAF Risk(s) and TRR Risk(s) agreed** | Members noted there was a draft cyber attack risk paper would be brought to the next meeting in February 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** | Medical Temporary Workforce to be presented at the February 2023 meeting. |
| **Items for Reference** | Not applicable |

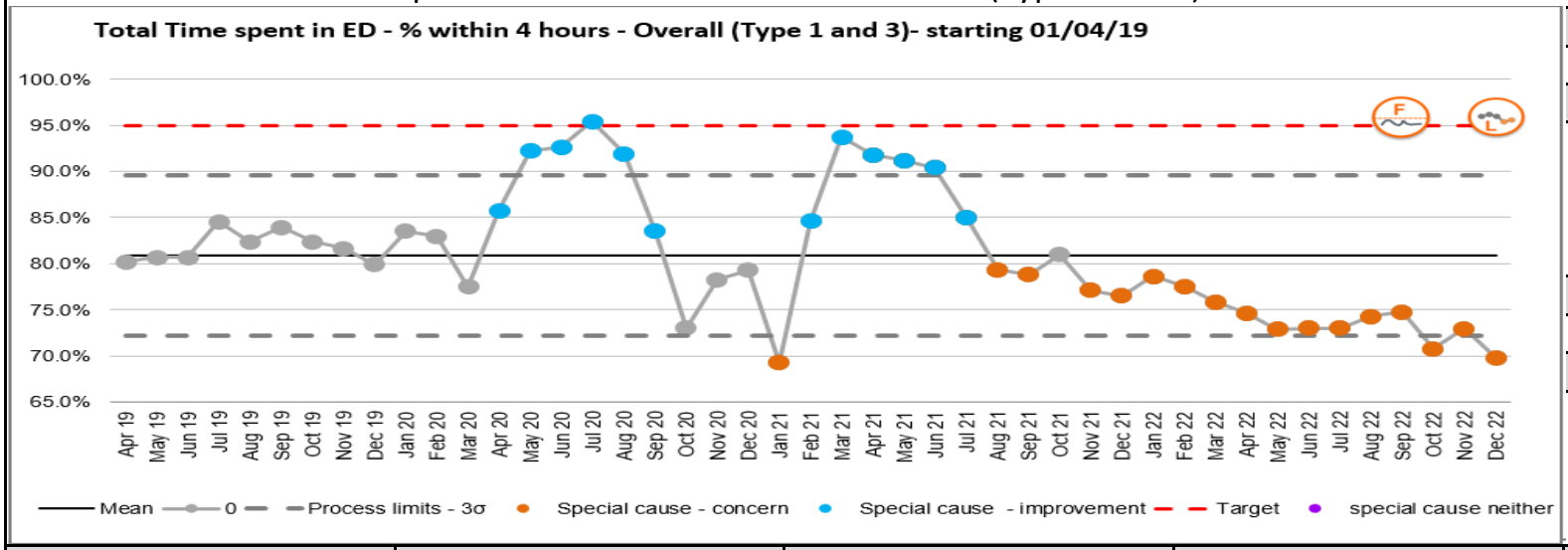
Walsall Healthcare NHS
NHS Trust

# 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 | Dec-22 | 55.95% | 59.87% | 92.00% | F | L |
| No. | 18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete | Dec-22 | 1488 | 846 | 0 | F | H |
| % | Ambulance Handover - Percentage of clinical handovers completed within 30 minutes or recorded time of arrival at ED | Dec-22 | 76.97% | | 95.00% | ? | L |
| % | Cancer - 2 week GP referral to 1st outpatient appointment | Nov-22 | 76.01% | | 93.00% | ? | |
| % | Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms | Nov-22 | 0.00% | | 93.00% | F | L |
| % | Cancer - 62 day referral to treatment from screening | Nov-22 | 85.71% | | 90.00% | ? | |
| % | Cancer - 62 day referral to treatment of all cancers | Nov-22 | 66.37% | | 85.00% | ? | L |
| % | % of Service Users waiting 6 weeks or more from Referral for a Diagnositc Test | Dec-22 | 25.23% | | 1.00% | ? | H |
| % | Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3) | Dec-22 | 69.80% | 72.00% | 95.00% | F | L |
| % | Percentage of patients spending more than 12 hours in ED | Dec-22 | 13.89% | 2.00% | 2.00% | F | L |
| % | Locality Teams - % of Hours Demand Unmet | Dec-22 | 9.74% | | 20.00% | ? | |
| Ave | MSFD - Average number of Medically Fit for Discharge Patients in WMH | Dec-22 | 50 | | 50 | ? | |
| % | Rapid Response - 2 Hour Response Rate | Dec-22 | 86.45% | | 95.00% | F | H |

| | | Reporting Period | Actual | Trajectory | 2022/23 Target | SPC Assurance | SPC Variation |
|---|---|---|---|---|---|---|---|
| % | Rapid Response - % Admission Avoidance | Dec-22 | 90.26% | | 87.00% |  |  |
| £ | Total Income (£000's) | Dec-22 | 31584 | See Financial Performance for further detail | | |  |
| £ | Total Expenditure (£000's) | Dec-22 | 33155 | See Financial Performance for further detail | | |  |
| £ | Total Temporary Staffing Spend (£000's) | Dec-22 | 3596 | See Financial Performance for further detail | | |  |
| £ | Capital Expenditure Spend (£000's) | Dec-22 | 1392 | See Financial Performance for further detail | | |  |

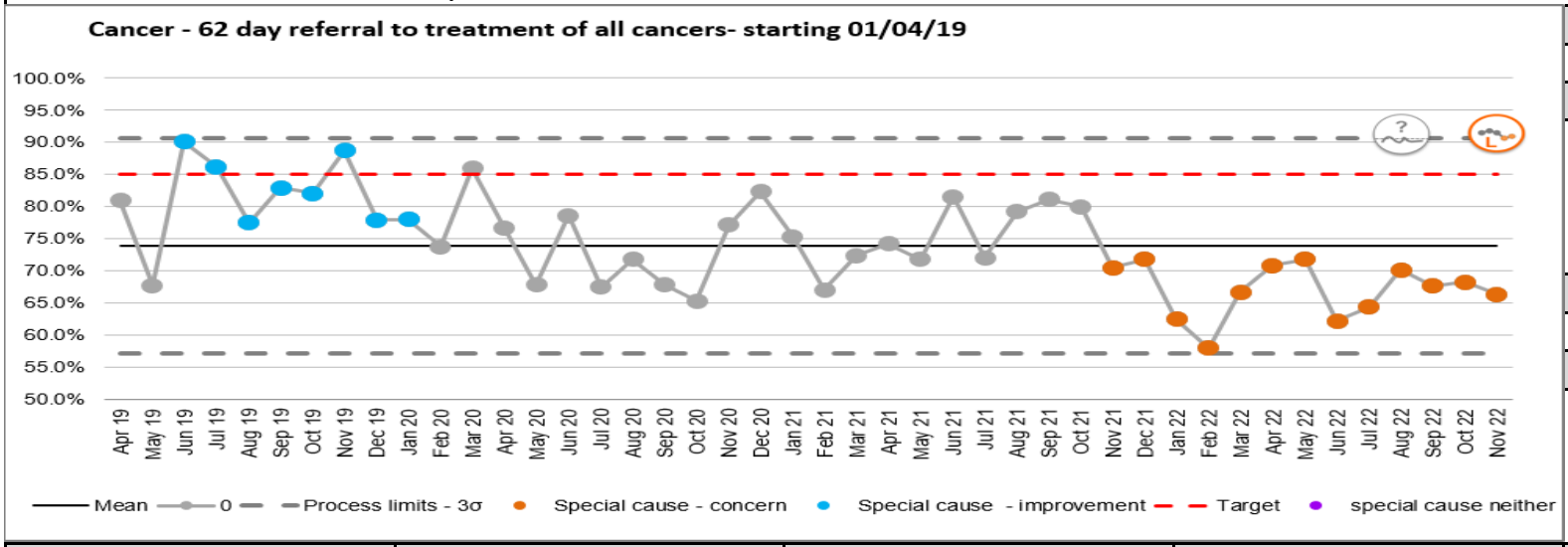
**Metric Name:** Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)




| Month |
|---|
| Dec-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<br>WHT's national ranking for the four-hour emergency access standard (EAS) was 24th of 110 reporting Acute Trusts. | Statistical special cause concern from August 2021, performance continues to be lower than average. December's reported performance is 69.80%. Urgent and emergency care remains under significant pressures with December recording highest ever type 1 ED attendances at 8,645. | December was the most challenging on record for Urgent & Emergency Care, with the highest number of out of borough intelligently conveyed ambulances (230). A declaration of critical incidents was made 21st December and on the 4th January. | 27 additional inpatients beds opened (Winter Plan) by 27th November, with a further 11 beds (in addition to the Winter Plan) in December.<br>The trial period for EDU took place in December over a week as a PDSA to review the suitability of pathways. The analysis audit is underway. | The Trust's UEC resilience Winter Plan approved by Trust Board in October commenced in November with the opening of additional beds.<br><br>The Trust is expecting 4hr performance to improve to above 74% in January 2023. |

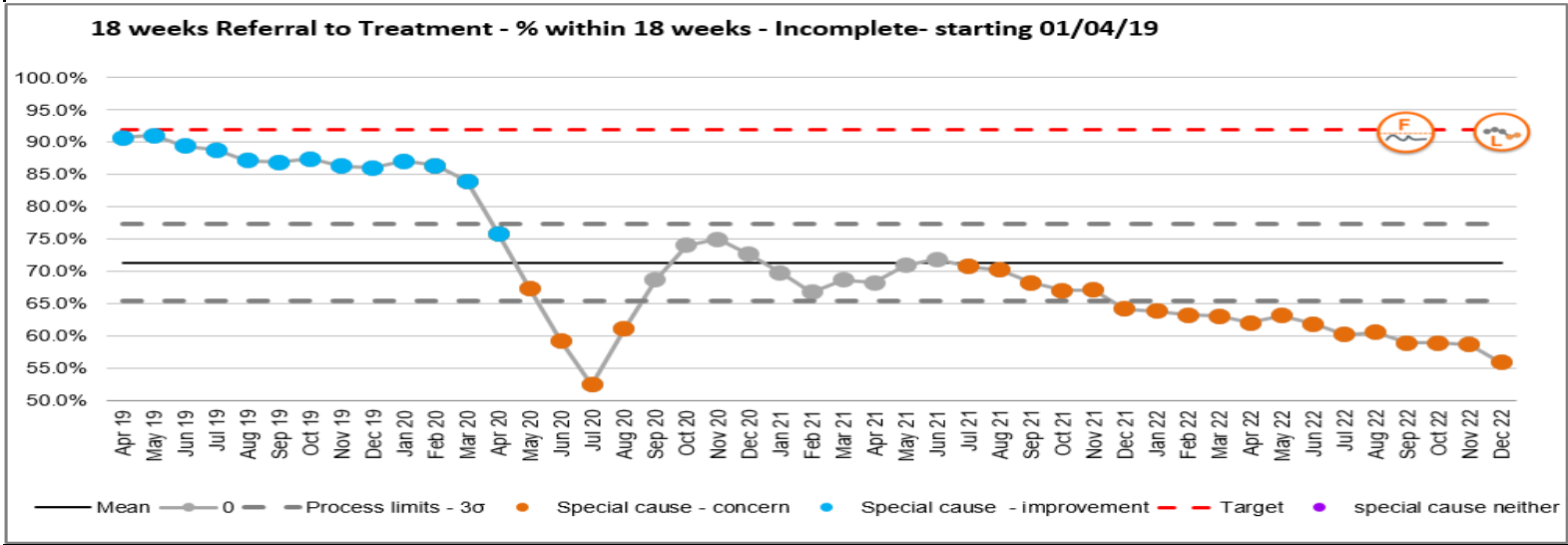
**Metric Name:** Cancer - 62 day referral to treatment of all cancers




| Month |
|---|
| Nov-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 13 data points below average. November's shows a performance level of 66.37%. However, performance was materially better than the West Midlands average (47.0%) and the national average (61.0%). | Continued challenged capacity with Breast Rapid Access Clinic. Access to urgent Imaging input is improving, owing to a new referral pathway. Demand for urgent colonoscopy has increased significantly. Access to urgent histopathology, via the BCPS, remains challenging. | Nurse led Breast Rapid Access Clinics commenced in Jan 2023. Following the revised referral criteria for Colorectal cancer correct templates have begun to be received. Tele dermatology go live planned for early 2023. Endoscopy are providing additional sessions, supported by an Insourced provider. | The Trust has received support for significant expansion in Medical Oncology. Recruitment of Oncology ACP and CNS, starting in December and January respectively. Imaging modalities have introduced new standards for the prioritisation of requests for cancer pathways. |

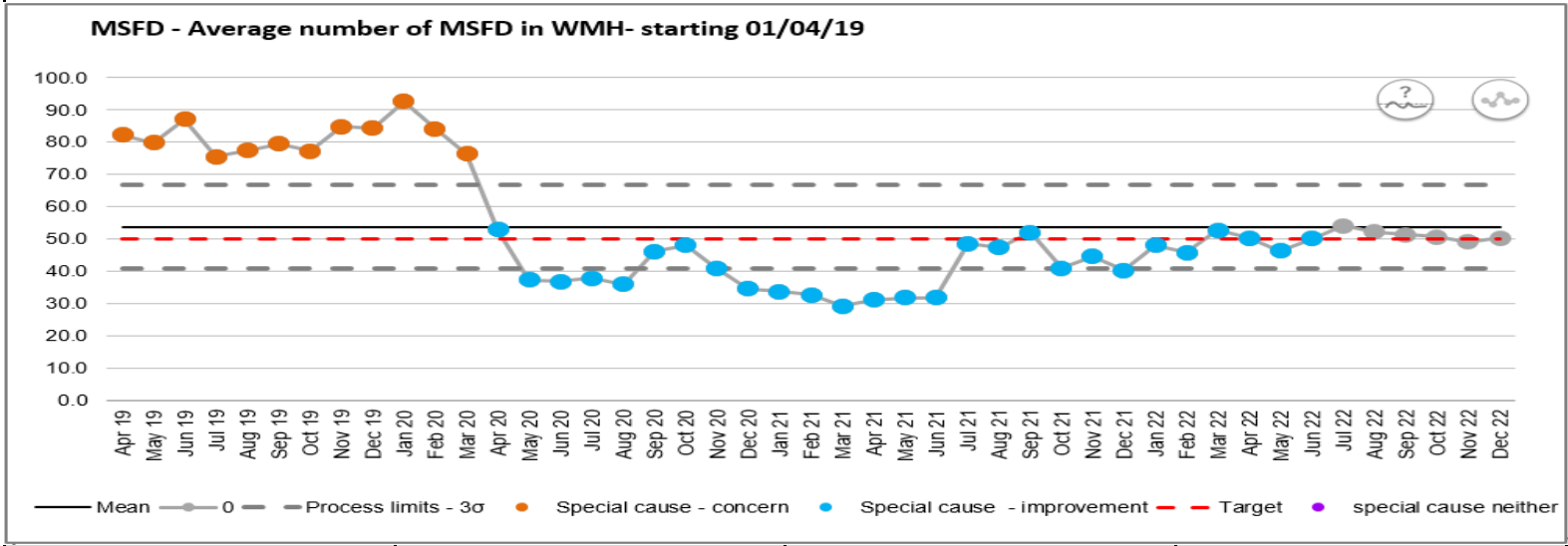
**Metric Name:** 18 weeks Referral to Treatment - % within 18 weeks - Incomplete




| Month |
|---|
| Dec-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 November and below the trajectory at 55.95%.<br><br>There were no 104 week incomplete breaches.<br>The national ranking position slightly deteriorated to 76th (out of 119 Trusts) for November 2022. | Performance has been adversely impacted by reduced uptake of elective theatre lists (Anaesthetic cover due to non-contractual pay rates).<br>This creates a risk on delivery of 0 patients waiting over 78-weeks at at 31/03/23. Revised forecast indicates 109 patients at risk of remaining over 78-weeks. | A resolution to the Anaesthetic non-contractual pay issue has been achieved so all elective lists are running again in January. | The Trust has commenced its Outpatient Improvement Programme supported by Four Eyes Insight with the explicit aim of reducing DNA rates, increasing clinic utilisation and thus reducing non-admitted waiting times too. |

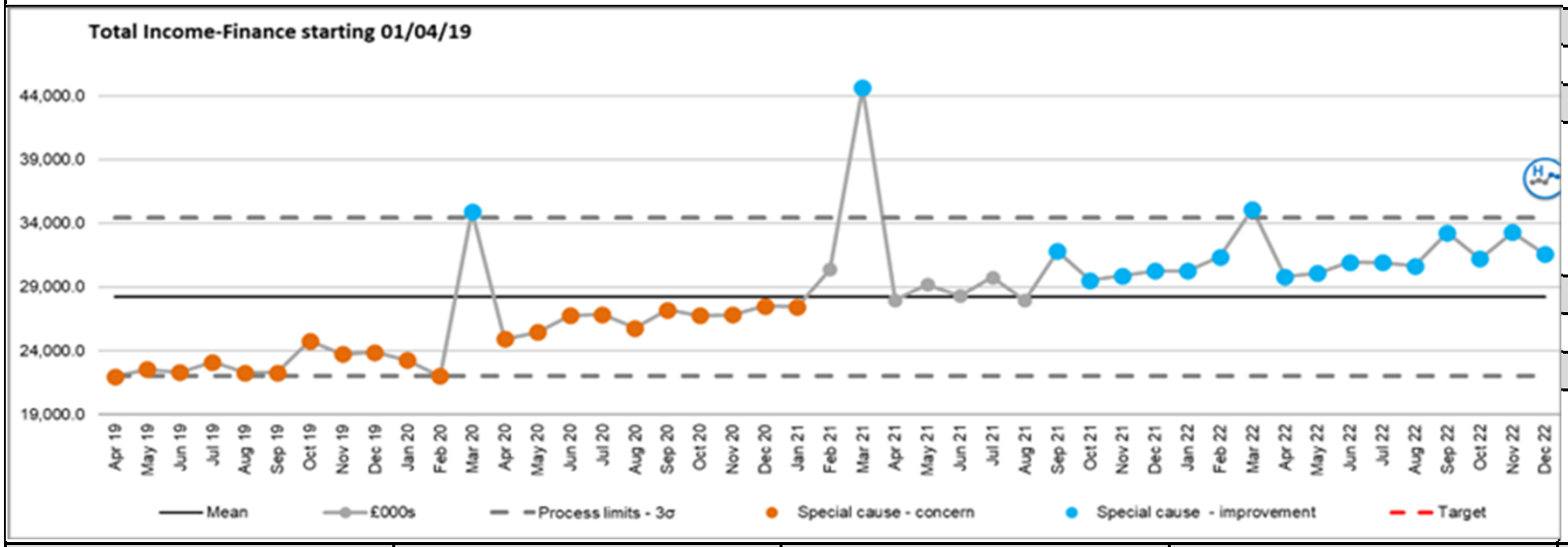
**Metric Name:** MSFD - Average number of MSFD in WMH




| Month |
|---|
| Dec-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 December with the number of MSFD patients being maintained at an average of 50. | Demand in terms of the Intermediate Care Service remains high. The Length of Stay was maintained in December at an average of 3.5days consistent with the performance reported in November | 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. |

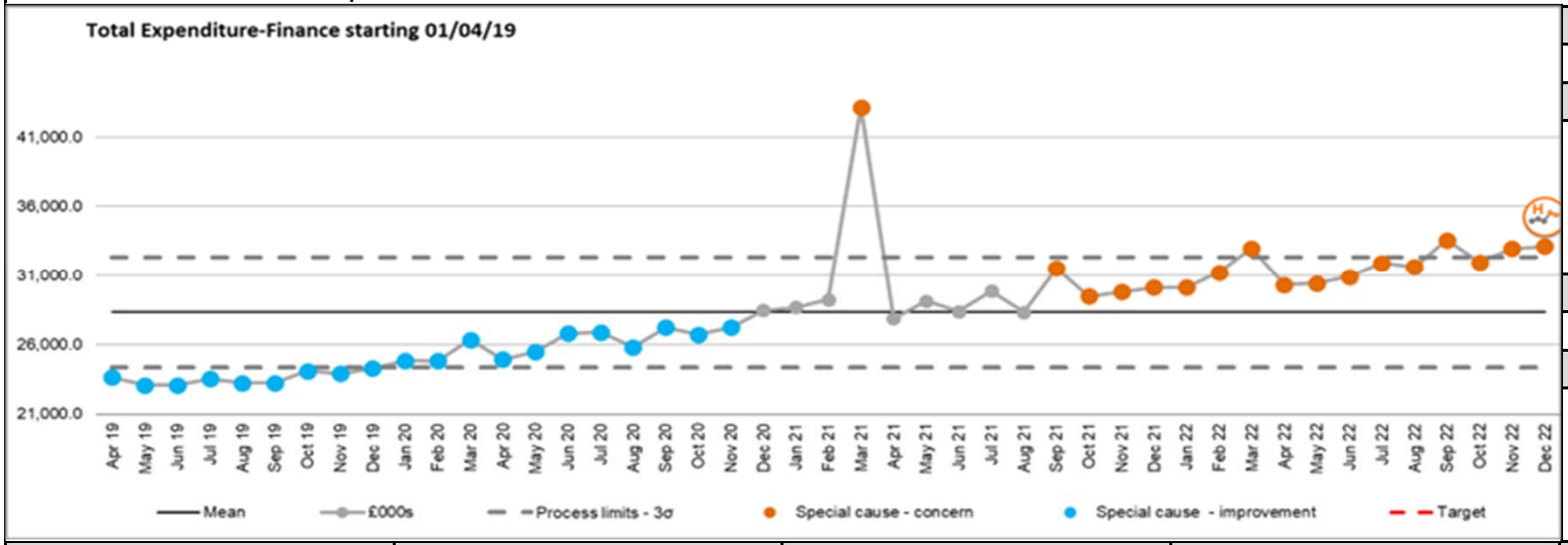
**Metric Name:** Total Income




| Month |
|---|
| Dec-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

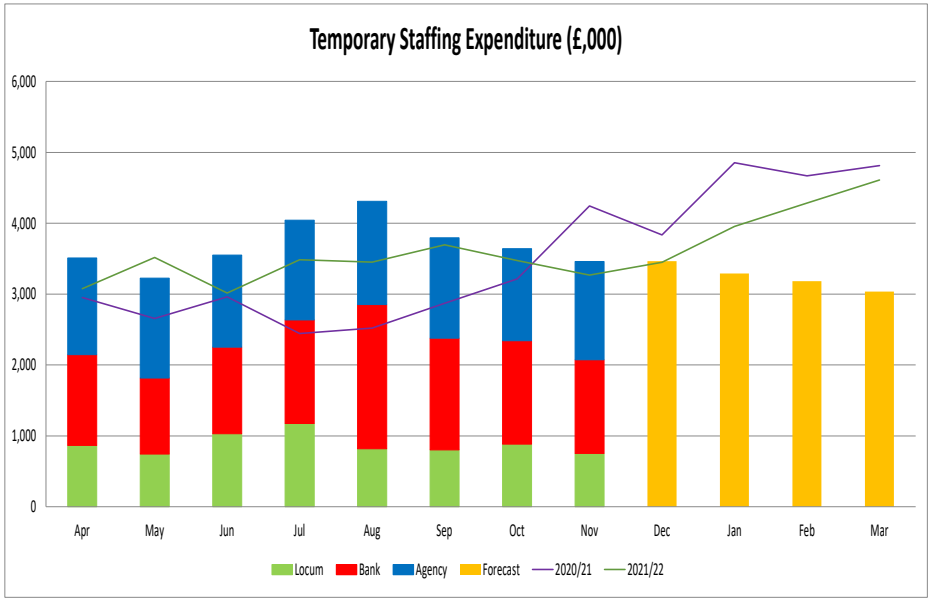



| Month |
|---|
| Dec-22 |
| **Variance Type** |
| Special Cause of Concerning Nature or Higher Pressure |
| **Target** |
| |
| **Target Achievement** |
| |

| 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.<br><br>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 December 2022 (Month 09)

| | YTD Plan £000s | YTD Actual £000s | YTD Variance £000s |
|---|---|---|---|
| | | | |
| Subtotal Income | 278,384 | 281,895 | 3,511 |
| | | | |
| Subtotal Pay Expenditure | (181,001) | (186,171) | (5,170) |
| | | | |
| Subtotal Non Pay Expenditure | (86,479) | (92,205) | (5,727) |
| | | | |
| Subtotal Finance Costs | (8,561) | (8,538) | 23 |
| | | | |
| Total Surplus / (Deficit) | 2,343 | (5,019) | (7,362) |
| Donated Asset Adjustment | 143 | 218 | 75 |
| Adjusted Surplus / (Deficit) | 2,486 | (4,801) | (7,288) |




## 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 9 the Trust reported a £1.571m deficit, which is £1.32m 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.
- Walsall is reporting 90.1% YTD ERF performance against a target of 104%. This is in line with other local providers. Dec in month was 81.9%.

## Capital

- The approved programme for the year includes the Emergency Department, ward refurbishment and theatres 1-4 upgrades
- Capital expenditure totals £25.9m YTD. This is against an annual programme of c£42m having secured additional in year funding for theatres, digital and diagnostics

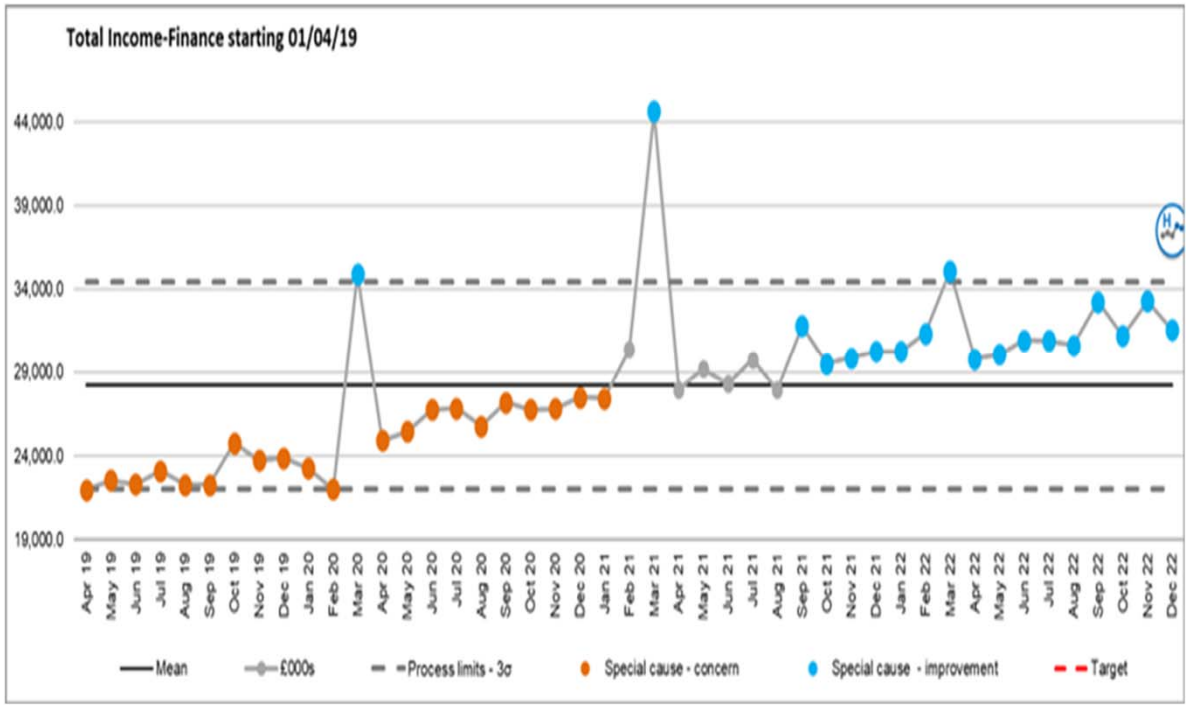
## Cash

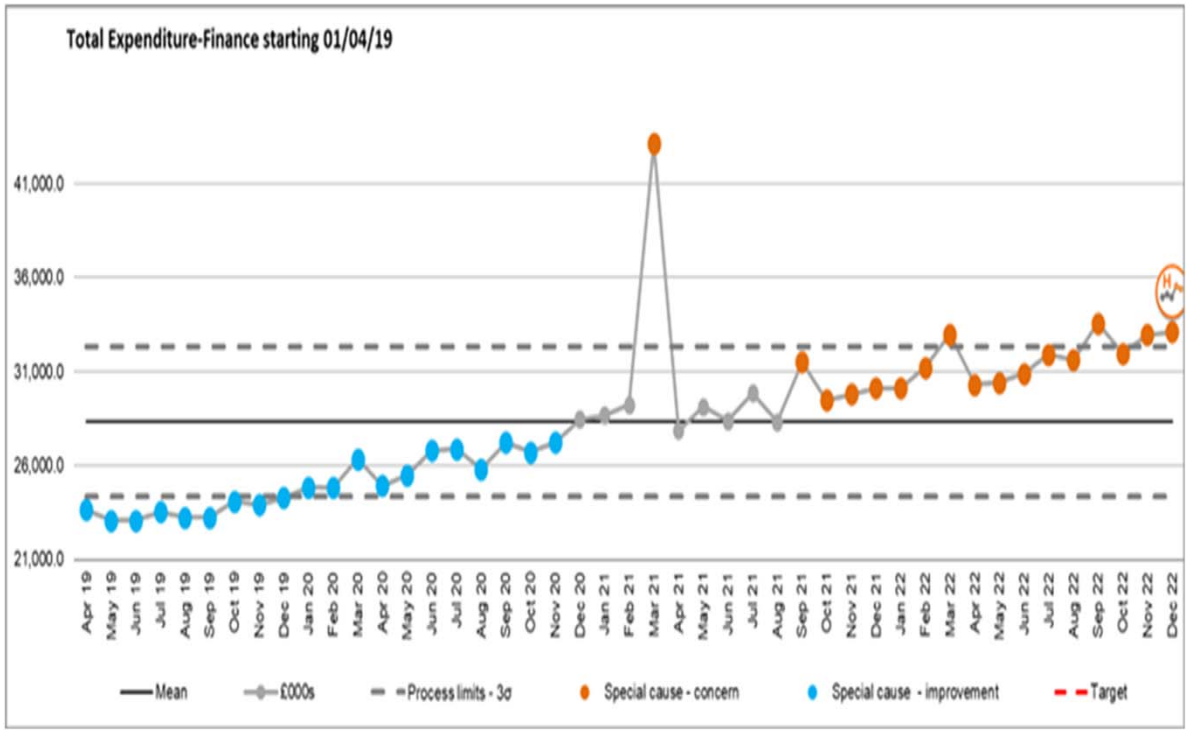
- The Trust continues to have a strong cash position which is sufficient to support a planned revenue deficit plan and the programmed capital expenditure

## Efficiency attainment

- The Trust has an annual efficiency target of £6.3m, against which a plan of £5.85m (of which some schemes are rated as red) has been identified, leaving a planning gap of £0.45m.
- YTD performance has been £3.6m against a plan of £3.4m which reflects the plan phasing, if delivered equally through the year the target to date would have been £4.7m.

# 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** | 20th January 2023 |
| **Chair of Committee/Group:** | Dr Julian Parkes |
| **Date of Report:** | 20th January 2023 |

| | |
|---|---|
| **ALERT**<br>**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. Breast Care Practitioner now offering capacity and as of 11th January bookings now at day 14.<br>• The 18-week RTT performance has been adversely impacted by reduced uptake of theatre lists due to reduced anaesthetic cover. This is now resolved and all elective lists are running again (55.95% of patients wait less than 18 weeks). The Trust is at risk of not delivering zero patients waiting over 78 weeks by the end of March 2023<br>• The national shortage of Health Visitors continues to be reflected locally with a 50% vacancy rate and this is affecting service provision<br>• Demand for support for Medically Stable for Discharge patients with complex needs has increased resulting in greater pressure for funding of out of hospital domiciliary and care home facilities<br>• VTE Compliance remains below target at 87.82 %<br>• Level 3 children's and adult's safeguarding remains below target. Additional training is being provided<br>• Cases of Clostridium Difficile have already exceeded the target for the year. 3 cases have the same ribotyping<br>• There has been 1 case of MRSA bacteraemia at the end of quarter 3<br>• Duty of Candour stage 1 compliance is 77% for WCCSS, 93% for Medicine and 34% for surgery |
| **ADVISE**<br>**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. MRI waiting times expected to recover by February 2023. Business case for expansion of endoscopy capacity by end of January<br>• One hour antibiotic times for sepsis were achieved in 71.37% in ED and 72.67% inpatients in December.<br>• There are currently 181 overdue incident actions<br>• The prevalence of timely observations was 79.71 in December. Excluding ED, the performance was 84.75%. 11 clinical areas are now achieving the 90% target<br>• Stage 2 Mental Capacity Act compliance shows an improvement to 70.00% in December. Work continues in this area<br>• The Trust have responded within timescale to the section 29A notice and work continues to improve training of staff and to undertake audits |

| | |
|---|---|
| **ASSURE**<br>**Positive assurances & highlights of note for the Board/Committee** | • Ambulance hand over times continue to be the best in the West Midlands<br>• In December 2022, 68.9% of patients were managed within 4 hrs in ED, making it 24th out of 109 reporting Trusts in the West Midlands. However, the urgent and emergency care pathway nationally remains under unprecedented strain<br>• 66.4% of patients are seen within the 62 day performance target for cancer, which is better than both West Midlands and national performance<br>• Despite increased levels of activity, 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 wards are being utilised<br>• Falls per 1000 bed days was 3.07 in December<br>• Vacancy rates for nurses and midwives is now less that 4%<br>• The most recent SHMI for the 12 months to June 2022 in 0.995 (rate as expected) |
| **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**<br>**Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)** | • |
| **ACTIVITY SUMMARY**<br>**Presentations/Reports of note received including those Approved** | Presentations received included<br>• Constitutional Standards and Acute Services Restoration and Recovery<br>• Community Services Report<br>• Safe High Quality Care Oversight report<br>• Maternity Services update<br>• Serious Incident Update<br>• Safeguarding update<br>• VTE Audit Report<br>• 104 day harm update<br>• CQUINs 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 | Dec-22 | 5 | 3 | 27 | ? | |
| No. | MRSA - No. of Cases | Dec-22 | 1 | 0 | 0 | ? | L |
| % | VTE Risk Assessment | Dec-22 | 87.82% | | 95.00% | ? | |
| % | Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Adults | Dec-22 | 75.00% | | 90.00% | F | H |
| % | Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Paeds | Dec-22 | 28.21% | | 90.00% | F | |
| No. | Falls - No. of falls resulting in severe injury or death | Dec-22 | 0 | 0 | 0 | ? | |
| Rate | Falls - Rate per 1000 Beddays | Dec-22 | 3.07 | 6.10 | 6.10 | ? | |
| No. | National Never Events | Dec-22 | 0 | 0 | 0 | ? | H |
| No. | Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired | Dec-22 | 6 | | | | |
| No. | Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired | Dec-22 | 0 | | | | |
| Rate | Midwife to Birth Ratio | Dec-22 | 33.9 | 28 | 28 | ? | |
| No. | Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital | Dec-22 | 17 | | | | |
| No. | Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community | Dec-22 | 9 | | | | |

**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 | 4 | 2 |
| Dec | 5 | 3 |
| Jan | | 3 |
| Feb | | 2 |
| Mar | | 3 |

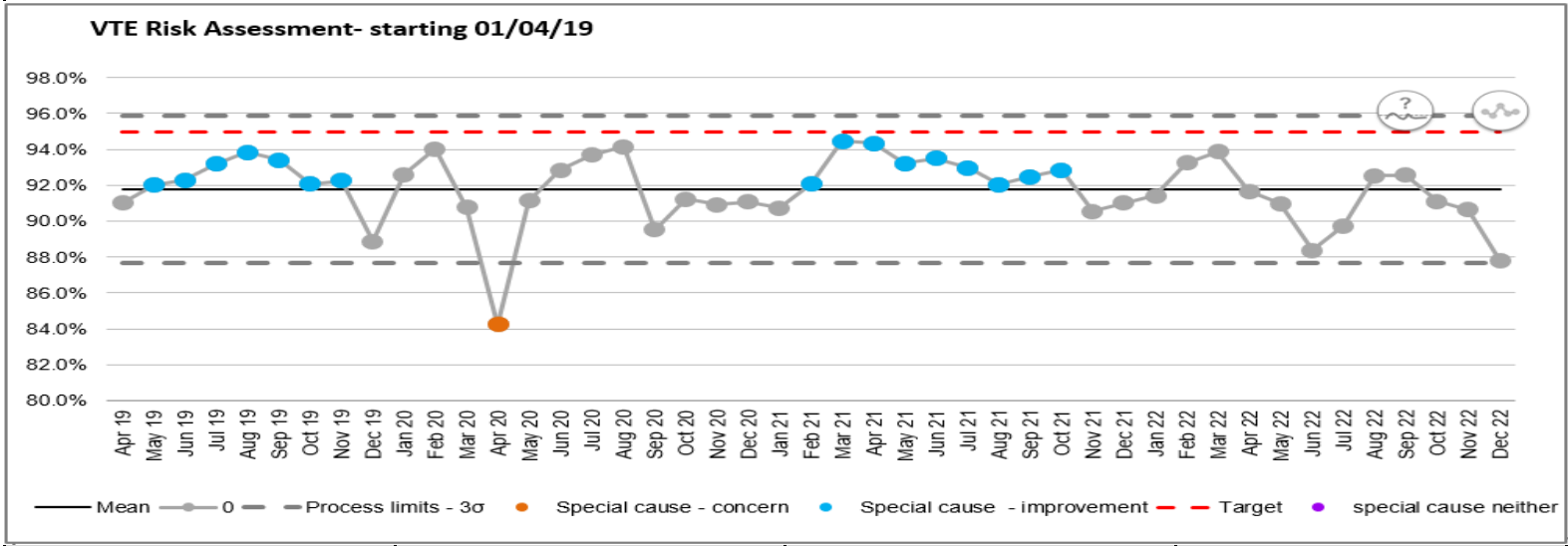
CUMULATIVE

| | Actual | Traj. |
|---|---|---|
| Apr | 0 | 2 |
| May | 1 | 4 |
| Jun | 5 | 6 |
| Jul | 6 | 8 |
| Aug | 8 | 10 |
| Sep | 14 | 12 |
| Oct | 21 | 14 |
| Nov | 25 | 16 |
| Dec | 30 | 18 |
| Jan | | 21 |
| Feb | | 24 |
| Mar | | 27 |

| Month |
|---|
| Dec-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<br><br>The Trust target for 2022/23 has been set by commissioners as 27. | There were 5 cases reported in December taking the year to date to 30, this is over the trajectory of 18. | 5 cases of Clostridium Difficile toxin were reported in Deecmber 2022. | Learning identified from PII meeting including ensuring stool samples are obtained from first episode of diarrhoea symptoms and prescribing improvements required for antibiotics. New nurse associate has joined the IPC team with a focus on C.Difficle, sample collection and antibiotic management. | N/A |

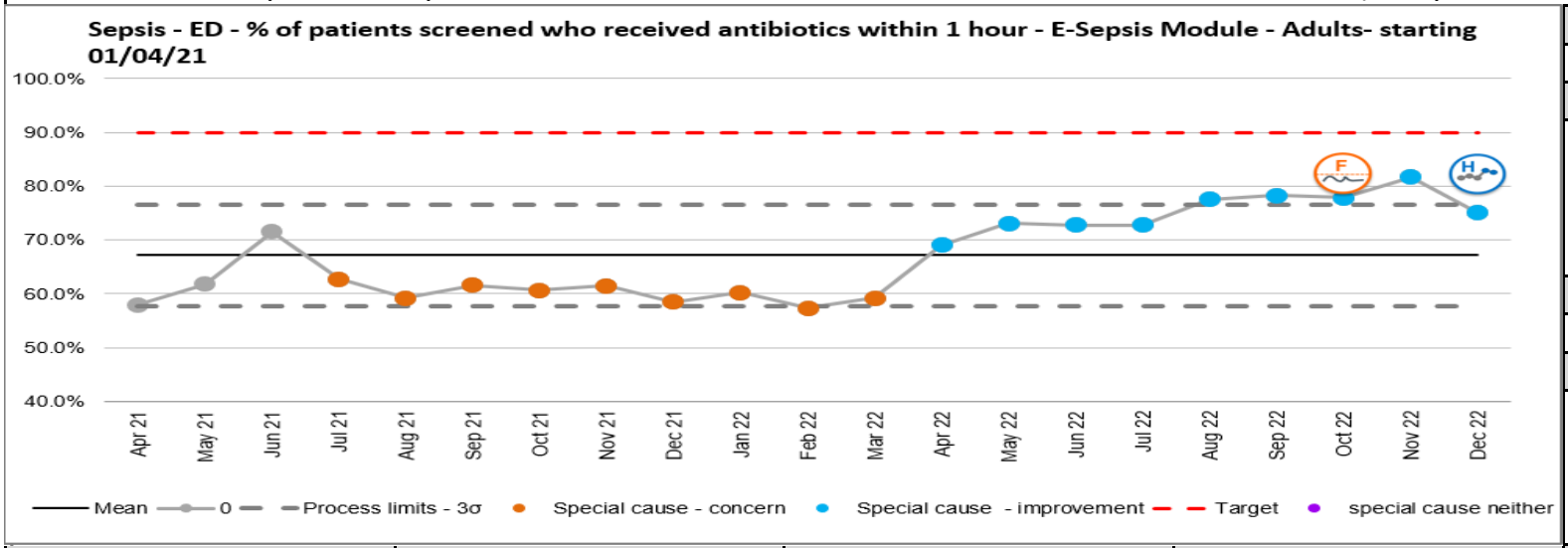
**Metric Name:** VTE Risk Assessment




| Month |
|---|
| Dec-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 admitted patients aged 16 or over undergoing risk assessment for VTE (agreed cohorts applied) | Performance remains below the target of 95%, within normal variation. December reported 87.82% and remains 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 |
|---|
| Dec-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 December 2022 was 75.00% . The data shows improving statistical variation and has been above the mean for the last 9 months. | The previously reported concerns regarding the accuracy of the E-sepsis data have been resolved with validation of data from the Sepsis team.<br>Focus on staff training continues. | The PBI report has been refreshed to focus on the Antibiotics within the hour.<br>Training on vitals to be refreshed.<br>Sepsis performance is now reviewed via the newly formed deteriorating patient group and reported via patient safety group. | The sepsis team reviews all open sepsis assessments on vital pac ensuring they are closed down when appropriate. They are also responding to sepsis alerted patients. Results are comparable with high perfoming trusts. |

# 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 19th December 2022 and Monday 30th January 2023 |
| **Chair of Committee/Group:** | Junior Hemans |
| **Date of Report:** | 30th January 2023 |

| | |
|---|---|
| **ALERT**<br>**Matter of concerns, gaps in assurance or key risks to escalate to the Board/Committee** | • Trust-level Retention (24 months) whilst stabilised at 80% shows an Adverse trend against target (85%). Whilst medical colleague retention is at a rate of 88%; an 8% improvement since April 22.<br><br>• Turnover amongst qualified nursing & midwifery colleagues is a concern, with the 12-month key performance indicator (KPI) ranging between 13-14% since September 2021. The risk is mitigated by partnership work with the Royal Wolverhampton NHS Trust, and the Clinical Fellowship Program.<br><br>• The most common reason for voluntary resignation amongst nursing &midwifery colleagues during 2022 remains work-life balance concerns; mirroring a trend across the wider workforce, correlated to sustained high levels of stress/anxiety-related absence amongst clinical colleagues.<br><br>• There are recruitment events planned throughout April, July and November 2023, which in addition to community initiatives advertising traditional vacancies, will also seek to grow a cohort of Legacy Mentors. This targets experienced nurses who will join the Trust with a remit for supporting new starters, and championing best practices amongst the wider workforce, following a pastoral approach to retaining talent.<br><br>• Sickness absence spiked to a 24-month high of 7% during December 2023; driven by a month-on-month doubling of days lost to winter illnesses (cold/flu), and a rise above 2300 full-time equivalent (FTE) days lost to stress/anxiety-related illness for the first time since December 2021.<br><br>• Annual appraisal compliance has begun to consolidate above the 80% average. |

| | |
|---|---|
| **ADVISE**<br>**Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought** | • The People and Organisation Development Committee heard from members of the BAME Council staff network on success stories, achievements, challenges and recognition. The committee noted that there would be a newly developed survey due to be distributed to all areas to allow staff to provide feedback on their own experiences in the workplace. The committee resolved to receive the survey results in due course and noted the shared governance model continues to be developed. The Committee Chair suggested discussing achievements with the communications team to share success stories and expertise for wider learning.<br><br>• The committee received a report detailing employment relations activity within the Trust, including employment tribunal activity. The report title is 'Colleagues in Difficulty' and the data will be presented to the committee every six months, and any matters for escalation to Board will be highlighted. For this reporting period, there are no matters for escalation to Trust Board and assurance on the management of current employment tribunals was received.<br><br>• The committee noted the report from the LGBTQ+ staff network group and were pleased to note the progress on the Rainbow Badge accreditation scheme and for the improvements achieved by the network. The committee resolved to receive a further update from the network Chair and in the meantime to commend progress in this area to the Trust Board. In addition, the committee reviewed data collated from the survey and resolved to receive a further report in February 2020 following discussions with the LGBTQ+ Inclusion Centre. . |

| | |
|---|---|
| **ASSURE**<br>**Positive assurances & highlights of note for the Board/Committee** | • The total response rate for the Staff Survey for 2022 is 49.6% and the committee received an initial report on areas of improvement, however results are currently embargoed until the National Staff Survey report has been released later quarter, provisionally in March 2023. The committee chair noted that it is positive that so many people had come forward to voice their opinions, noting an increase in response rates from Black and Minority Ethnic colleagues. The committee noted the contents of the report.<br><br>• The Committee received a verbal update on the Integrated Care Board work, noting that all workstreams are on track for delivery as planned. The Growing for the Future workstream is working across health and social care and the system signed the Care Leaver Covenant in January 2023. The committee noted there would be a written update on outcomes for March committee.<br><br>• The Committee noted and received the safer staffing report commending the ongoing work to reduce agency use across the trust. There is now a total of 262 Clinical Fellows nurses employed by the Trust.<br><br>• The committee noted that a total of nineteen areas are reported to not use agency staffing, however, off-framework figures had increased during November 2022 and will be sustained during December due to capacity issues. |
| **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**<br>**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<br>• Program of staff voice (board to ward) to be scheduled to year end.<br>• Report on Retention and spotlight report to be scheduled for PODC in March 2023. |
| **ACTIVITY SUMMARY**<br>**Presentations/Reports of note received including those Approved** | • National Staff Survey Report to come to PODC in March 2023<br>• Update on the Healthy Attendance Project (HAP) – assurance action plan approved PODC to be considered in March 2023 |

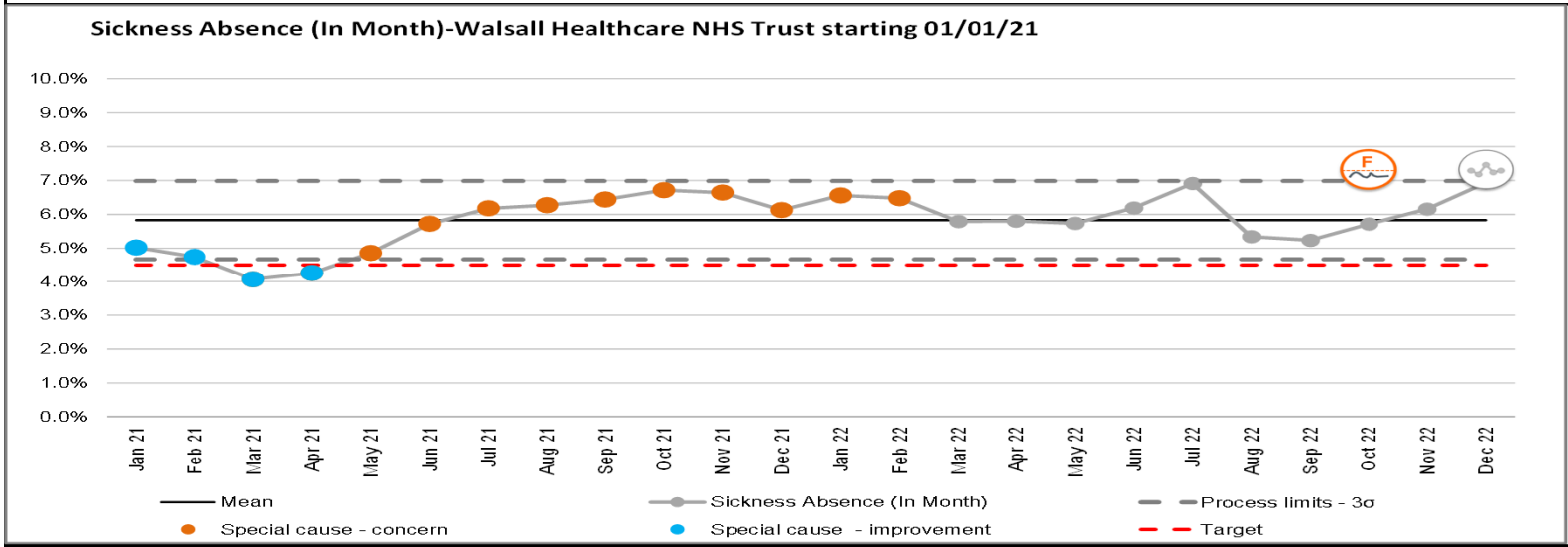
| | |
|---|---|
| **ACTIVITY SUMMARY Major agenda items discussed including those Approved** | The committee resolved the following items be referred to the Trust Board for further discussion and information.<br><br>1.Trust Workforce Metrics and escalation of exception reports specifically continued staff turnover and retention concerns.<br>2. Update on staff survey report following lifting of embargo in March 2023.<br>3. Annual Equalities, Diversity, and Inclusion Progress Report WRES and WDES data once available March 2023. |
| **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:<br><br>• Health and Wellbeing Group.<br>• Joint Negotiating and Consultative Committee.<br>• Local Negotiating Committee (report to follow).<br>• Education Steering Group.<br>• Equality, Diversity, and Inclusion Group<br>• Local Negotiating Committee<br>• WRES 2022 Indicators |
| **Self-evaluation/ Terms of Reference/ Future Work Plan** | • Terms of reference and future work plan are in place.<br>• 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 | Dec-22 | 6.93% | | 4.50% | ? | |
| % | PDRs | Dec-22 | 83.51% | | 90.00% | F | |
| % | Mandatory Training Compliance | Dec-22 | 88.34% | | 90.00% | ? | H |
| % | % of RN staffing Vacancies | Nov-22 | 3.53% | | | | |
| % | Turnover (Normalised) | Dec-22 | 12.16% | | 10.00% | ? | H |
| % | Retention Rates (24 Months) | Dec-22 | 80.32% | | 85.00% | F | L |
| % | Bank & Locum expenditure as % of Paybill | Nov-22 | 10.33% | | | F | |
| % | Agency expenditure as % of Paybill | Nov-22 | 5.92% | | | F | |

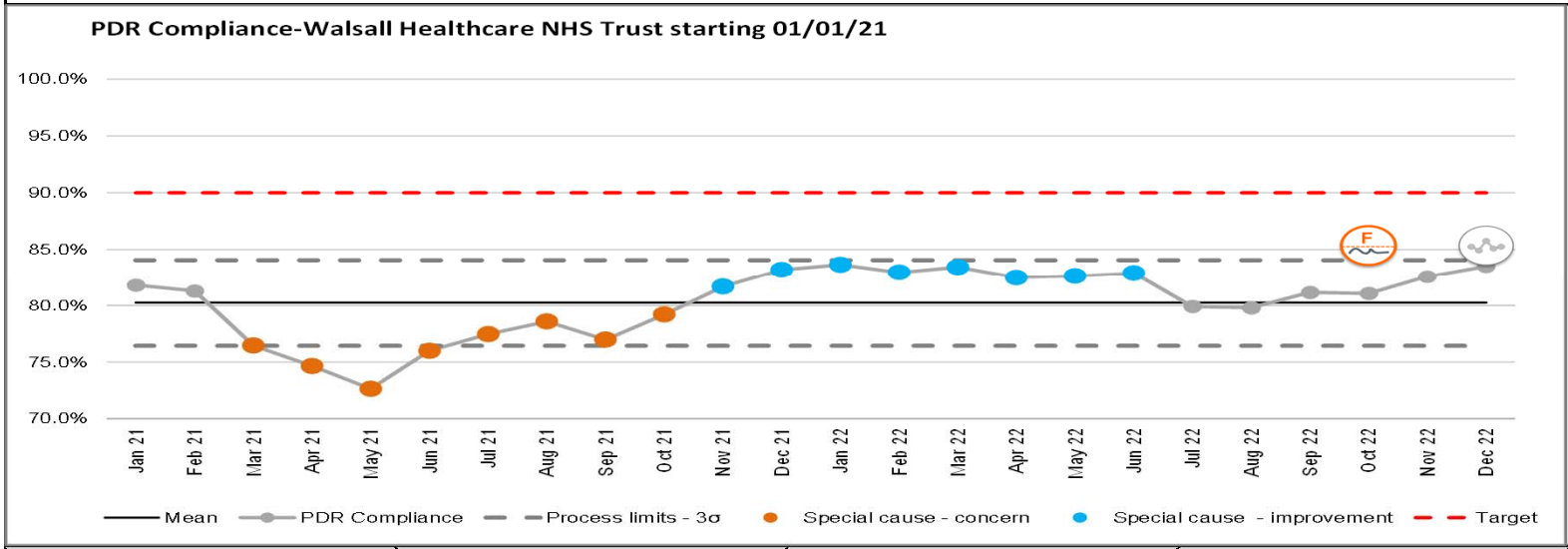
**Metric Name:** Sickness Absence




| Month |
|---|
| Dec-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 spiked to the upper limits of the trend range, reflecting an escalation in days lost to traditional winter illness (Cold/Influenza). | Reductions in long-term musculoskeletal illness, due to recovery plan interventions, are being offset by rising stress/anxiety-related absence. | Realising the procedural improvements and colleague lifestyle benefits identified within the recently drafted Health & Well-Being strategy will represent a significant catalyst towards restoration of pre-pandemic absence levels. | Monitoring of sickness absence includes Executive oversight at the monthly Divisional review meetings. Fast track referrals by the Occupational Health Team to Physiotherapy Services will ensure that injured colleagues receive early recovery interventions. |

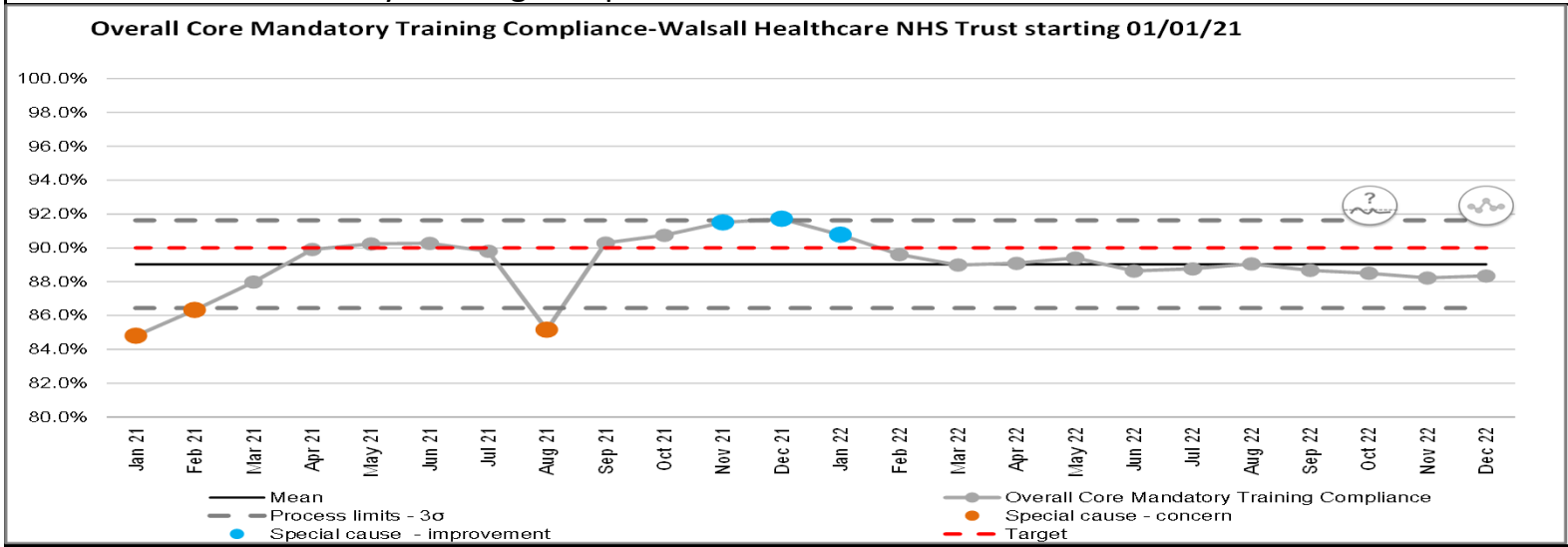
**Metric Name:** PDRs




| Month |
|---|
| Dec-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. | Annual appraisal compliance continues to improve and is currently 83.5%. | Compliance remains highest amongst Medical and Dental colleagues (89%), although evidence of increased appraisal sessions across all staff groups is present. | 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 |
|---|
| Dec-22 |
| **Variance Type** |
| Common Cause - No Significant Change |
| **Target** |
| 90.00% |
| **Target Achievement** |
| Variation Indicates Inconsistently Passing and Falling Short of the Target |

| Background | What the chart tells us | Issues | Actions | Mitigations |
|---|---|---|---|---|
| Training compliance is calculated using exclusion lists. | Training compliance remains high at 88%, with most individual competencies now at or above the 90% target. | Safeguarding Adults Level 3 (80%) and Adult Basic Life Support (67%) remain outliners. | 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

## December 2022

Caring for Walsall together

# How to Interpret SPC (Statistical Process Control) charts

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

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

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

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

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 |
| 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 |

| Performing against Trajectory | SPC Assurance | SPC Variation | Rationale | Ragging Applied |
|---|---|---|---|---|
| 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 |
| 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 |

# EXECUTIVE SUMMARY

| QUALITY | PERFORMANCE |
|---|---|
| •Trust wide CQC action plan with responsible executive directors and identified leads has been established.<br>•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.<br>•VTE compliance for December 2022 was 87.82% which shows a slight decline from November 2022 (90.65.%) and continues to be below the 95% target. Divisional teams continue to report on their performance and improvement plans into Patient Safety Group (PSG).<br>•The prevalence of timely observations for December 2022 was 79.71% compared to 82.18% in November 2022. Excluding the ED performance was 84.75%. Significant improvements have been made in MLTC and trust wide 11 clinical areas achieved the 90% target.<br>•Falls per 1000 bed days was 3.07 in December 2022 and in line with the previous consistent performance.<br>•The Trust target for Clostridium difficile 2022/23 has been set at 27 cases with 5 cases of reported in December 2022. Overall performance year to date is above trajectory.<br>•The percentage of patients screened who received antibiotics within 1 hour within the Emergency Department was 76.77% by E-sepsis in December 2022.<br>•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. | •The Trust continues to deliver the best Ambulance Handover times (<30 mins) in the West Midlands, being the top performing organisation for 15 months. This has been achieved despite continuing to support neighbouring Trusts with record 230 out of borough ambulances intelligently conveyed to Walsall.<br>•4-hour Emergency Access Standard performance in December was 69.8% of patients managed within 4 hours of arrival. WHT's national ranking was 24th best out of 110 Trusts.<br>•In November 2022, for 62-day GP RTT Cancer performance the Trust treated 66.4% within 62 days, this is materially better than the West Midlands average (47%) and national average (61%). National ranking position is 48th out of 121 Trusts.<br>•The Trust's 6 Week Wait (DM01) Diagnostics performance is 44th (November 2022 reporting), out of 120 reporting Trusts. Temporary challenges in MRI (one scanner lost capacity in December due to burst water-pipe) and Non-Obstetric Ultrasound with reduced elective capacity over the Festive Period has outweighed Cardiac Physiology progress. The Trust's performance in December 2022 was 25.23%.<br>•The Trust's 18-week RTT performance was 55.95% of patients waiting under 18 weeks at the end of December 2022, national ranking position 76th (out of 119 reporting Trusts) for November 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 December.<br>Board should note the following risks:<br>•Patients referred by their GP on 2 week wait suspected cancer and Breast symptomatic pathways are experiencing longer waiting times. As part of the expansion in medical Oncology recruitment of Oncology ACP and CNS has been successful with staff commencing in December and January.<br>•18-week RTT revised forecast indicates 109 patients at risk of remaining over 78-weeks at 31st March 2023. |
| **WORKFORCE** | **FINANCE** |
| •Sickness absence spiked to the upper limits of the trend range, reflecting an escalation in days lost to traditional winter illness (Cold/Influenza).<br>Reductions in long-term musculoskeletal illness, due to recovery plan interventions, are being offset by rising stress/anxiety-related absence.<br><br>•Annual appraisal compliance continues to improve and is currently 83.5%. Compliance remains highest amongst Medical and Dental colleagues (89%), although evidence of increased appraisal sessions across all staff groups is present.<br><br>•Training compliance remains high at 88%, with most individual competencies now at or above the 90% target. Safeguarding Adults Level 3 (80%) and Adult Basic Life Support (67%) remain outliers. | •The Trust entered 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<br><br>•The ICB reported position is a £29.5m deficit at month 9, £28.5m adverse to plan.<br><br>•The Month 9 Year to Date deficit is £4.801m, which is adverse to the financial plan by £7.288m. 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. The Trust is still forecasting a breakeven revenue position for 22/23<br><br>•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 and additional funding being awarded during year, the current capital programme is forecast to be £41.661m. |

Walsall Healthcare NHS
NHS Trust

| MEETING OF THE PUBLIC TRUST BOARD<br><br>WEDNESDAY 8TH FEBRUARY 2023 | | | |
|---|---|---|---|
| **Director of Nursing Report** | | | |
| **Report Author and Job Title:** | Lisa Carroll<br>Director of Nursing<br>Caroline Whyte Deputy Director of Nursing | **Responsible Director:** | Lisa Carroll<br>Director of Nursing |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☐ Discuss ☐ Inform ☒ Assure ☒ | | |
| **Assure** | • Safeguarding adults and children's training is achieving the Trust target for all level 1 and level 2 training.<br>• Vacancy rate for registered nurses and midwives is now below 4%, recruitment continues at pace.<br>• Falls per 1000 bed days was 3.08 in November 2022 and 3.07 in December 2022 (3.30 in October 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 and 53% of clinical staff have completed the training<br>• The total number of Trust acquired pressure ulcers reported in November 2022 increased slightly from October's performance, but this reduced again in December 2022.<br>• Within the ED department, 76.77% of patients received antibiotics within the first hour in November 2022; this figure declined for December 2022 to 71.37%. For inpatients, 66.67% of patients received antibiotics within the first hour in November 2022, this figure improved for December 2022 to 72.67%.<br>• The prevalence of timely observations for November 2022 was 82.18% and 79.71% in December 2022. Excluding the Emergency Department 2022, performance was 86.16% in November and 84.75% in December 2022. 11 clinical areas are now achieving the 90% target.<br>• MCA compliance for November was 72.41% and for December 70.00%, this was a significant increase from the October 2022 performance of 30.95% | | |
| **Alert** | • Cases of Clostridium Difficile toxin reported in November and December 2022 were 4 and 5 respectively. Overall performance year to date is now above trajectory and a 'Period of Increased Incidence' (PII) was identified within MLTC division, with 3 cases having the same ribotyping.<br>• Safeguarding level 3 adults and children's training remains consistently below Trust target. | | |

| | | |
|---|---|---|
| | • VTE compliance for November 2022 was 90.65% and December 2022 87.82% which is a decline from October's performance of 91.1% and continues to be below the 95% target. | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Safe High Quality Care BAF<br>IPC BAF<br>**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).<br>**2066** – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15)<br>**2245** - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20).<br>**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).<br>**2430** – Risk of harm to children due to fragmented record storage (Risk Score 8).<br>**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).<br>**2540** - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems (Risk Score 12).<br>**2581** – Internal risk for patients awaiting Tier 4 hospital admission (reduced in month to Risk Score 16).<br>**2587** - Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks (Risk Score 9).<br>**2601** - Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6 (Risk Score 12).<br>**2917** - Inappropriate use of SCALE2 within NEWS2 (reduced in month to Risk Score 16). | |
| **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 – February 2023**

**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***

A Trust wide corporate action plan from previous CQC inspections is in place and monitored through the Divisional Governance process and assurance meeting with members of the executive team.

On the 18 October 2022 the Trust received a Section 29a warning notice pertaining to the management of medicines. The Trust provided a response to the CQC detailing the immediate and ongoing actions and further evidence of the improvements made and compliance with the regulations/legislation will be submitted over the next few weeks.

A medicines management action plan is in place to ensure the immediate actions taken on receipt of the notice and the ongoing actions identified are taken. A weekly executive led oversight meeting is in place.

***Falls***

The number of Trust falls recorded for November 2022 is 51 and 55 in December 2022

Hospital falls were reported as 49 in November and 51 in December 2022.

Community falls were reported as 2 in November 2022 and 4 in December 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.

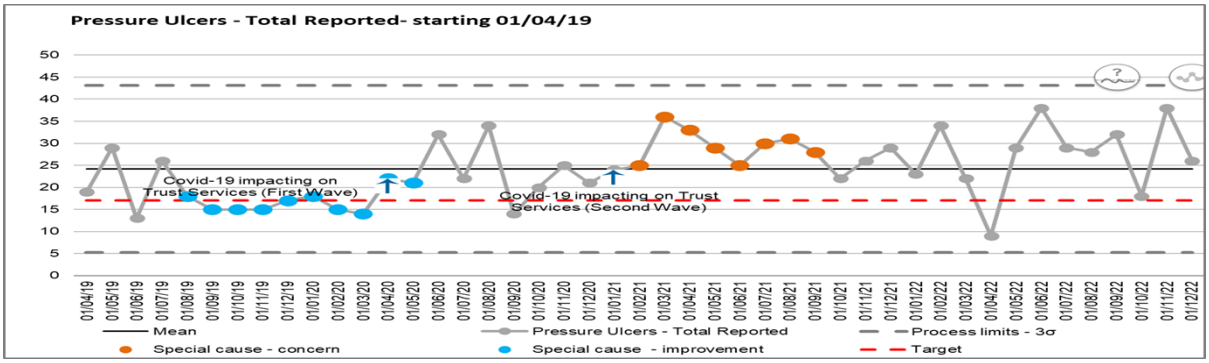
Falls per 1000 bed days was 3.08 in November 2022 and 3.07 in December 2022

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 38 November and 26 in December 2022. Lessons continue to be learnt using the RCA process.

The hybrid mattresses were to be delivered week commencing 30.01.23. This has been slightly delayed whilst a suitable area for storage and decontamination of beds is made available.



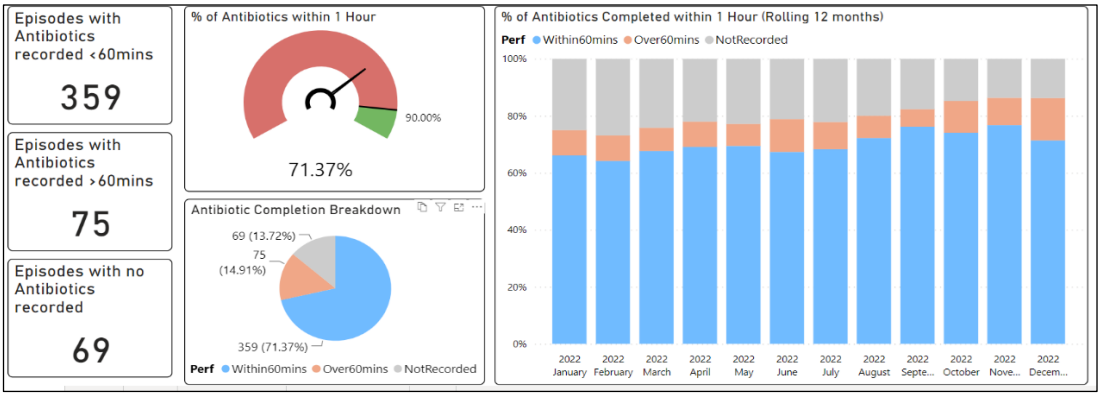

***Venous Thromboembolism (VTE)***

VTE compliance for November 2022 was 90.65% and December 2022 was 87.82%. This continues to be below the 95% target for compliance.

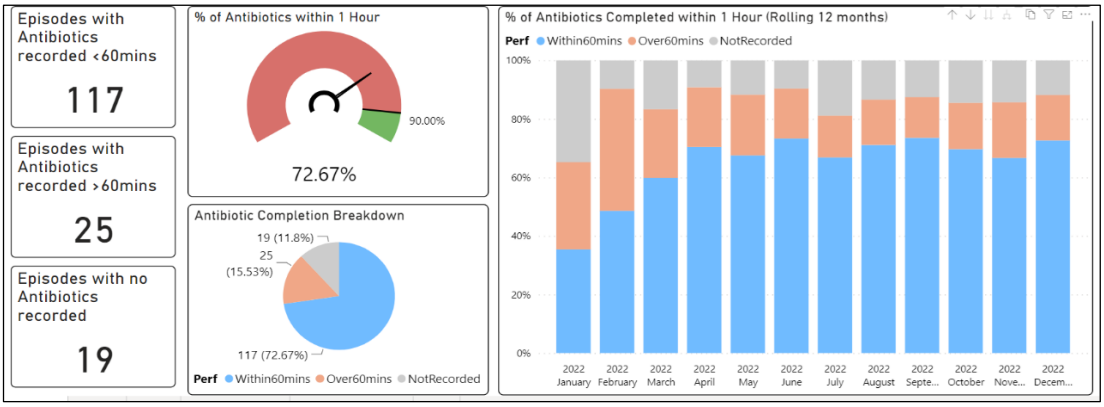
***Sepsis***

Within the Emergency Department (ED), 76.77% of patients received antibiotics within the first hour in November 2022, this figure declined for December 2022 to 71.37%.
For inpatients, 66.67% of patients received antibiotics within the first hour in November 2022, this figure improved for December 2022 to 72.67%.

*ED sepsis performance*




*Inpatient sepsis performance*



**Medicines Management**

Weekly medicines management audits are in place covering medication storage, prescribing and administration practice and CD management. There is an improvement plan to address the gaps in this audit. A new drug chart has been developed which will support best practice such as space for name stamps and has been piloted with a plan to roll out this month.

Weekly medicines management results – Trust wide

| | Overall score | Medicine room | Does patient have a wrist band insitu with appropriate allergy status | Patient prescription charts have details of patient name, date of birth and hospital number or NHS number? | Is allergy status documented on the prescription chart? | Is the nature of the allergy documented on the prescription chart? | If there has been an omission of a medication, has a code been used? | Is there evidence that action has been taken to address the omission, unless there is a valid clinical reason for the omission? | Is the patient's weight documented on the prescription chart? | Are all the medication names on the prescription chart written in block capitals? | Are all the medications prescribed on the prescription chart signed? | Are all the medications prescribed on the prescription chart signed with name printed in block capitals / or stamp used? | Are all the medications within their expiry date? (5 random medications checked) | Controlled drugs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31/10/2022 | 81.80 | 91.40 | 89.50 | 93.38 | 98.20 | 58.60 | 91.80 | 72.75 | 26.97 | 46.80 | 98.40 | 39.49 | 97.70 | |
| 04/11/2022 | 79.63 | 82.40 | 81.60 | 88.00 | 88.55 | 59.23 | 90.00 | 68.33 | 60.41 | 58.84 | 89.70 | 50.37 | 90.00 | 78.90 |
| 14/11/2022 | 84.00 | 87.55 | 91.90 | 100.00 | 97.80 | 72.02 | 92.59 | 82.80 | 61.57 | 56.94 | 97.96 | 51.90 | 100.00 | 90.79 |
| 21/11/2022 | 88.92 | 92.72 | 97.66 | 97.41 | 96.50 | 62.31 | 92.80 | 88.60 | 71.90 | 62.66 | 97.89 | 53.77 | 100.00 | 91.67 |
| 28/11/2022 | 89.38 | 92.61 | 93.64 | 99.13 | 97.25 | 74.02 | 99.21 | 87.79 | 70.45 | 69.52 | 99.02 | 68.39 | 100.00 | 86.75 |

***Surgical Site Infections (SSIs)***

In November 2022 eleven surgical site infections were reviewed. Five cases occurred in breast surgery and six in trauma and orthopaedics.

The table below details the current grade and review status of each case.

| Type of surgery | Total cases reviewed | Superficial SSI | Deep SSI | Does not meet SSI criteria | Under review |
|---|---|---|---|---|---|
| **Breast** | 5 | 1 | 0 | 1 | 3 |
| **T&O** | 6 | 0 | 1 | 1 | 4 |
| **Total** | 11 | 1 | 1 | 2 | 7 |

6 surgical site infections were identified in December 2022 all relating to trauma and orthopaedics on wards 10 and 11.

The table below details the current grade and review status of each case.

| Type of surgery | Total cases reviewed | Superficial SSI | Deep SSI | Does not meet SSI criteria | Under review |
|---|---|---|---|---|---|
| Left femur IM Nail | 1 | | | 1 | 0 |
| Right gamma nail | 1 | | | 1 | 0 |
| THR | 1 | Case identified as not related to care at WHT | | | |
| NOF | 3 | | | 1 | 2 |
| **Total** | 6 | | | 3 | 2 |

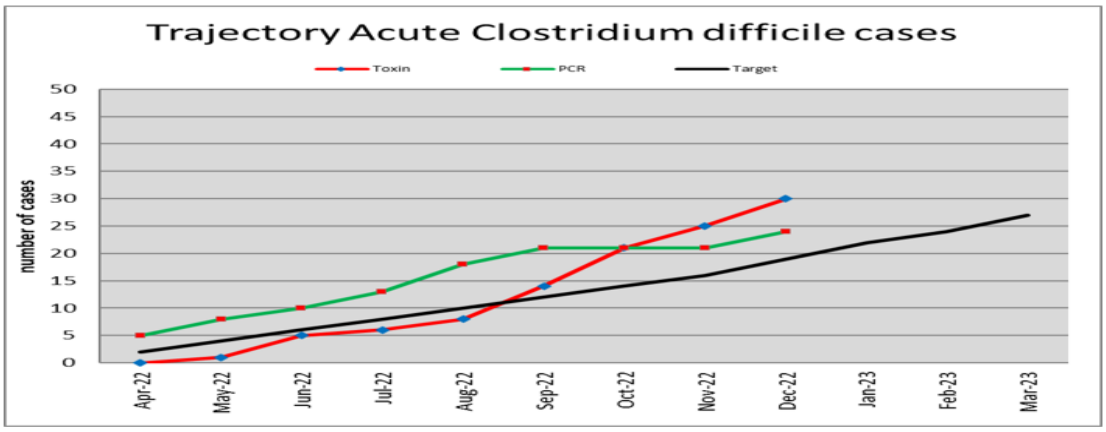
***Clostridiodes difficile (C. diff)***

The Trust has a target set for no more than 27 acute acquired cases of C.difficile. The Trust is now over trajectory following a continued increasing trend in C.difficile cases since September 2022.

A Period of Increased Incidence (PII) has been identified within MLTC division, with 3 cases with the same ribotyping (002).

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 | 4 | 5 | | | |
| 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 | 25 | 30 | | | |

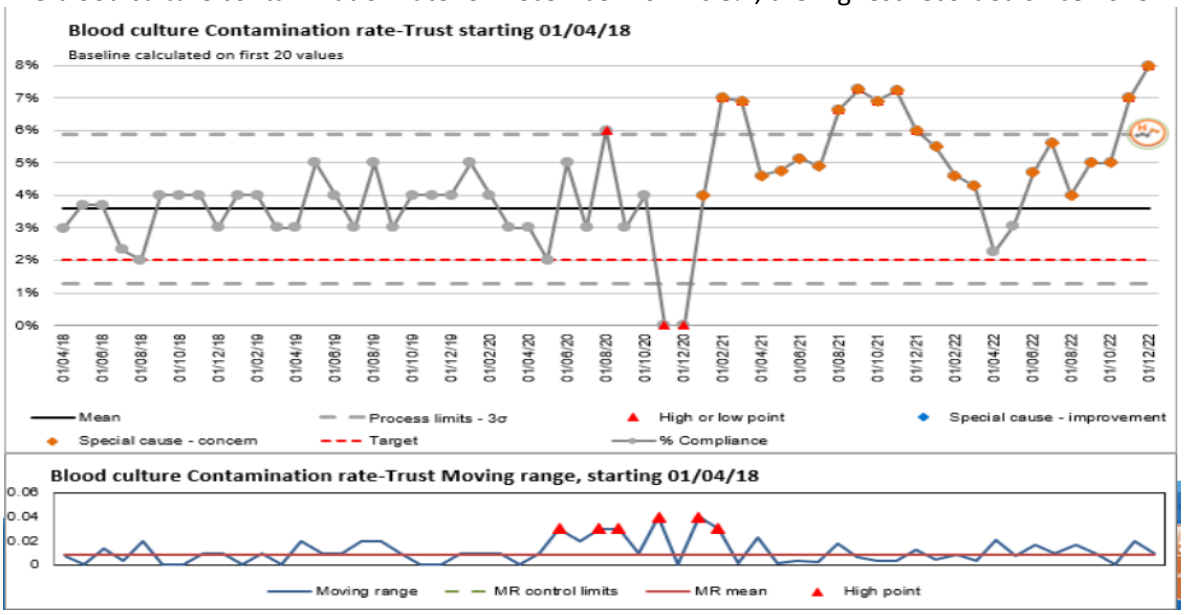



***MRSA Bacteraemia***

An MRSA bacteraemia was reported on ward 25 in December 2022 from a patient who had blood cultures taken two days after admission. The patient had been discharged home and was clinically well at the time of the positive result and had to be recalled to receive further antibiotics. Following a review of the case this was deemed to be a blood culture contaminant. This resulted in the patient receiving antibiotics that they did not require.

***Blood culture contaminants***

The blood culture contamination rate for December 2022 is 8%, the highest recorded since 2018.



50% of the reported cases are from the Emergency Department. A task and finish group is being established to focus on improving practice.

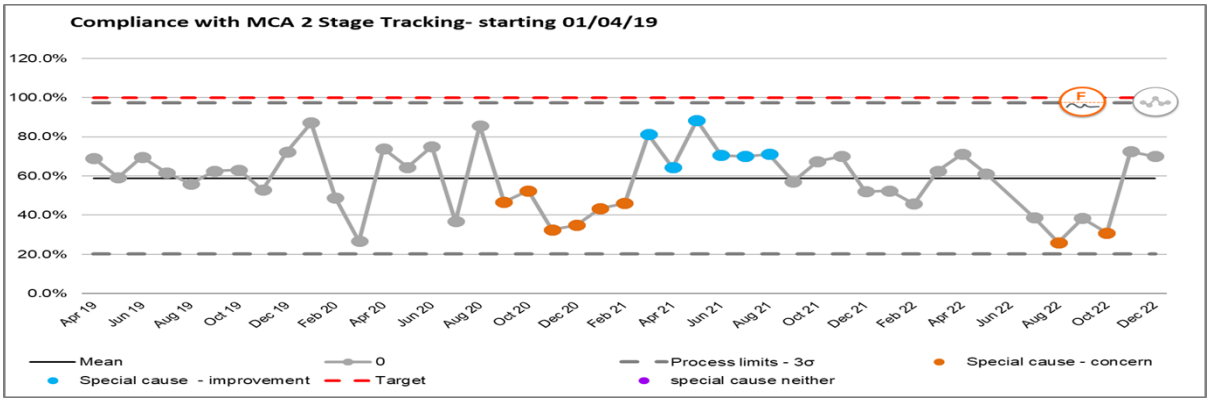
***Percentage of observations undertaken within timeframe***

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%.

The prevalence of timely observations for November 2022 was 82.18% including ED and 86.16% excluding ED, December 2022 results were 79.71% including ED and 84.75% excluding ED.

***Mental Capacity Assessment (MCA)***

MCA compliance for November was 72.41% and for December 70.00%, this was a significant increase from the October 2022 performance of 30.95%.




***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 although level 3 children's training has seen an increase of 2% in month. Additional training oppotunities are being provided to complete this training and an e-learning safeguarding level 3 training module is being explored as an alternative to the current teams training.

**Nurse Sensitive Indicator Audits**

New nursing documentation was launched in all inpatient areas in 2022. A review of all the audit questions has been completed and is going through approval processes.

Audit review meetings were re-established in November 2022 with a new quality dashboard collecting all quality audit information. Divisions attend confirm, challenge and support meetings where results are discussed and action plans to improve results developed and successes celebrated.

Audit results

| | CARE OF THE DYING | CATHETER AUDIT | CONTINENCE | DETERIORATING PATIENT & SEPSIS | DOCUMENTATION | ENVIRONMENT | FALLS & DECONDITIONING | IPC | MEDICINES MANAGEMENT | NUTRICIAN & HYDRATION | ORAL CARE | PAIN MANAGEMENT | PATIENT EXPERIENCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| JANUARY | N/D | N/D | 47.0% | 100.0% | 97.4% | 95.0% | 86.0% | 97.3% | 93.9% | 79.0% | 87.8% | 90.1% | 89.5% |
| FEBRUARY | 96.3% | 74.3% | 73.8% | 89.1% | 90.2% | 94.6% | 88.0% | 97.9% | 92.5% | 81.6% | 85.1% | 90.9% | 95.0% |
| MARCH | 92.3% | 52.9% | 87.5% | 88.4% | 90.0% | 90.8% | 88.5% | 95.9% | 92.9% | 89.9% | 89.9% | 98.7% | 90.4% |
| APRIL | 88.1% | 58.6% | 86.0% | 67.4% | 91.0% | 92.0% | 76.0% | 96.8% | 90.6% | 80.1% | 95.9% | 96.8% | 92.5% |
| MAY | 97.8% | 54.4% | 90.2% | 59.8% | 92.1% | 95.3% | 84.5% | 95.9% | 90.5% | 86.3% | 87.8% | 84.2% | 91.4% |
| JUNE | 95.4% | 55.9% | 76.9% | 56.5% | 90.3% | 92.8% | 93.8% | 94.6% | 85.2% | 86.8% | 87.9% | 95.5% | 94.0% |
| JULY | 96.3% | 63.8% | 71.4% | 60.7% | 95.8% | 55.8% | 79.0% | 94.5% | 86.1% | 85.4% | 84.7% | 88.0% | 94.1% |
| AUGUST | 87.0% | 80.1% | 79.4% | 66.7% | 92.3% | 89.3% | 83.0% | 95.1% | 89.8% | 87.6% | 86.5% | 87.3% | 93.9% |
| SEPTEMBER | 83.3% | 57.5% | 92.1% | 67.9% | 93.8% | 92.1% | 88.2% | 96.0% | 88.0% | 83.3% | 75.9% | 86.4% | 61.4% |
| OCTOBER | 100.0% | 90.5% | 92.1% | 100.0% | 92.3% | 94.3% | 82.0% | 96.1% | 90.0% | 90.1% | 86.9% | 95.0% | 96.1% |
| NOVEMBER | 96.0% | 66.1% | 84.3% | 41.0% | 91.7% | 91.8% | 88.0% | 93.6% | 93.2% | 89.3% | 89.2% | 96.2% | 94.9% |
| DECEMBER | 92.1% | 86.6% | 86.7% | 97.7% | 91.6% | 93.2% | 82.4% | 94.6% | 95.6% | 90.0% | 90.1% | 98.8% | 96.7% |

***Safe Staffing***

***Vacancy position***

The RN and Midwifery vacancy rate for September 2022 has reduced to less than 4%.

***Recruitment***

29 Clinical Fellowship Nurses arrived in the Trust in December 2022 and a further 10 are expected in January 2023.

Pastoral care is being delivered by the CFP team and FORCE with allocated senior nurse support in place.

NHSE have launched a Pastoral Care Award and all Trusts are expected to gain this by July 2023 in order to secure future funding for international recruitment. The Trust is developing an action plan to support attainment.

In December 2022 21 CSWs were offered bank positions.

The Trust has previously reported a 50% vacancy rate in the Health Visiting service and a prioritisation plan is in place and agreed with the ICB and Local Authority.

There has been successful recruitment and over the 8 weeks the following will be commencing in post:

- 2 Band 5 RNs into Health Visiting team
- 2 Band 6 RNs into Health Visiting team
- 1 Health Visitor for children with additional needs/disabilities
- 1 Public Health Nurse
- 1 RN into School Nursing team
- 1 Senior Assistant Practitioner into the Single Point of Access team

Following midwifery recruitment of Clinical Fellowship Midwives and newly qualified Midwives the midwifery vacancy rate has significantly reduced to 5 WTE

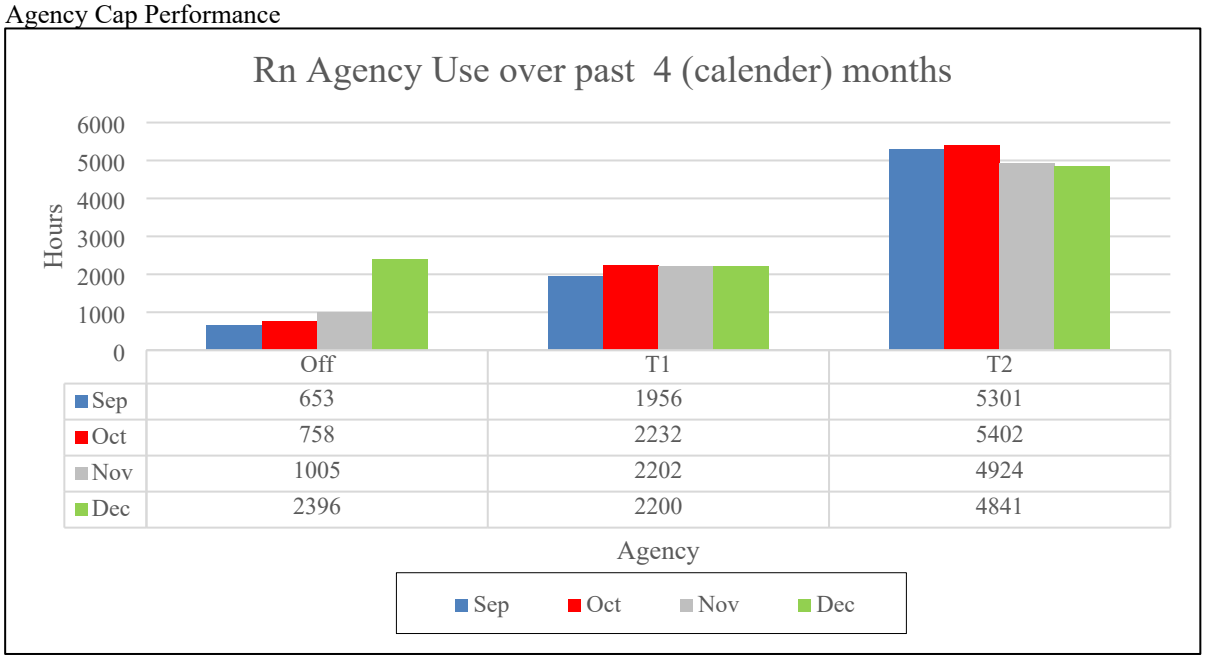
***Temporary staffing***

A total of 2396.25 hours of off-framework was used in December 2022 compared to 1005 hours used in November 2022. The increase in off-framework use is driven by the activity within the Trust resulting in

patients being held in ED for prolonged periods and corridor nursing, additional capacity in addition to the planned winter wards being open and increased staff sickness and absence reflective of the covid and flu prevalence within the community.

The highest use areas for off framework agency staff are ED using 491.5 hours, ICU using 457 hours and Ward 21 using 638 hours.

Agency Cap Performance




| | Off | T1 | T2 |
|---|---|---|---|
| Sep | 653 | 1956 | 5301 |
| Oct | 758 | 2232 | 5402 |
| Nov | 1005 | 2202 | 4924 |
| Dec | 2396 | 2200 | 4841 |

***Agency Cessation***

The Trust continues to focus on ceasing agency use by the end of March 2023.

As of the end of December 2022 there are 20 departments where agency is no longer in use at any Tier, unless authorised in extreme circumstances.

***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 1450 hours of RN and 911 hours of CSW were re-deployed across the Trust during December 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 November 2022 there were 162 open red flags open and 182 in December 2022 compared to 229 in October 2022.

77% of Red Flags are reported during the day, 23% at night (November 2022 data).

The 3 Red Flags with the highest number of reports continue to be:

- Patients require 1-1 needs not met
- Increase in patient Acuity impacting ability to care
- Delay (over 30 minute) personal care

A review was undertaken to examine if there were falls recorded on wards and dates that had a Red Flag raised for a 1:1 not being available. Based upon December 2022 activity there were no incidents reported of a fall with harm however a total of 6 incidents were reported 2 as low harm and 4 no harm.

**Acute Medical Unit (AMU) Board Update**

- All but Renal job plans are complete. Renal will take another 3 months due some shift pattern issues.
- Managers framework is progressing.
- AMU get together to be planned in March 2023 (to review the last 12 months).
- Dr Asif has joined as new CD and Ruchi will hand over the AMU improvement.
- New Medical Staffing lead appointed.
- New ESR system link working well and trials nearly complete.
- Vindu Raka a national medical director for the transformation NHSE is visiting in January 2023. The CMO will highlight the work that has been achieved by the group.
- Band 6 nursing interviews imminent to fill gaps.
- Discharge audit in progress

**End of Report**

| MEETING OF THE TRUST BOARD - WEDNESDAY 8TH FEBRUARY | | | |
|---|---|---|---|
| Hospital Mortality Report (November - December 2022) | | | |
| **Report Author and Job Title:** | Mr Salman Mirza, Deputy Chief Medical Officer<br>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:<br>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). Please note - up to date data not available at the time of writing the report. | | |
| **Advise** | • The medical examiner team reviewed 100% of the total eligible inpatient deaths for the months November and December.<br>• Community ME is now being rolled out to all Walsall GP Practices.<br>• 6 LeDeR deaths were reported during this period. | | |
| **Alert** | • There are currently 21 SJRs outstanding, however good progress is being made within specialties to clear this. The number of SJRs requested by ME service has increased which has resulted in a higher number of outstanding SJRs in this report. | | |
| **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<br>• Performance against SHMI is recorded on the trust risk register<br>• 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.<br>• 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 |
|---|---|---|---|---|
| **Sept-22** | 7796 | 97 | 7805 | 9 |
| **Oct-22** | 7882 | 110 | 7830 | 25 |
| **Nov-22** | 9425 | 109 | 8145 | 11 |
| **Dec-22** | 8228 | 164 | 7363 | 14 |

1.2 SHMI (Inpatient deaths plus 30 days post discharge - please note data not updated at the time of writing)
The most recent published SHMI value for the 12-month rolling period (published 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).

An SPC chart relating to SHMI is currently being developed and will be included in the next report.

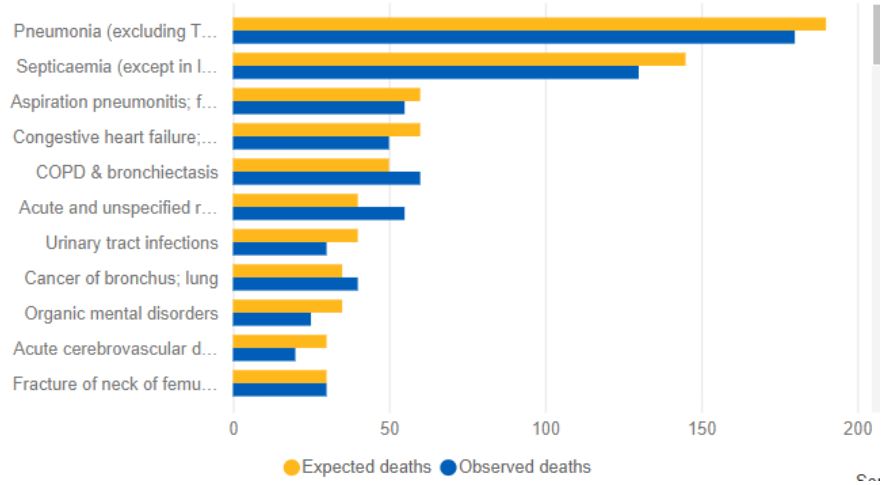
SHMI in comparison with neighbouring Trusts (*NHS Digital)

| 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:

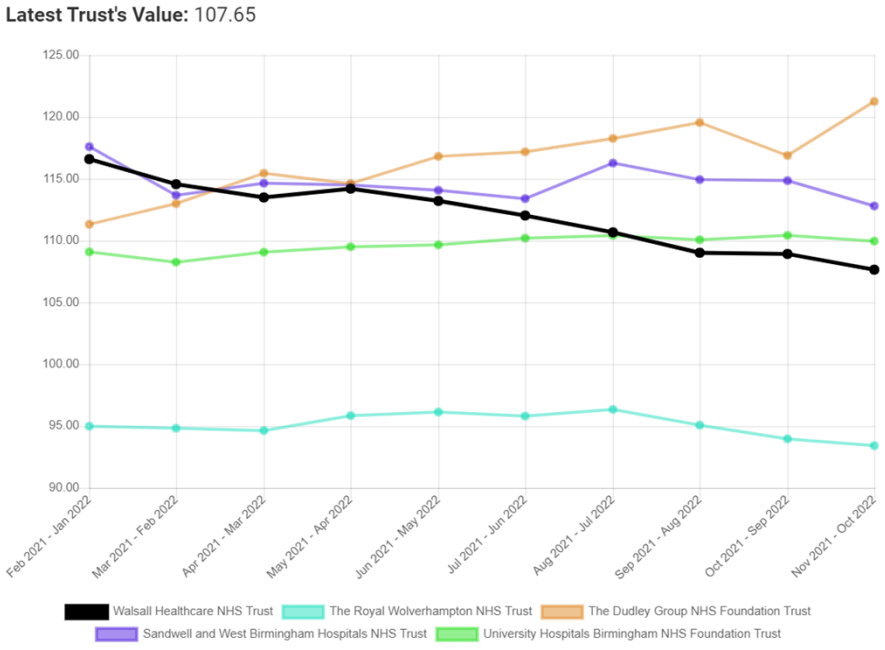



It can be seen from the above that there are three areas where observed deaths are higher than expected deaths: COPD and bronchiectasis; acute and unspecified renal failure; and cancer of bronchus. Patient level data has been provided to the relevant specialty and will subsequently be reported at the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

## 2. HMSR

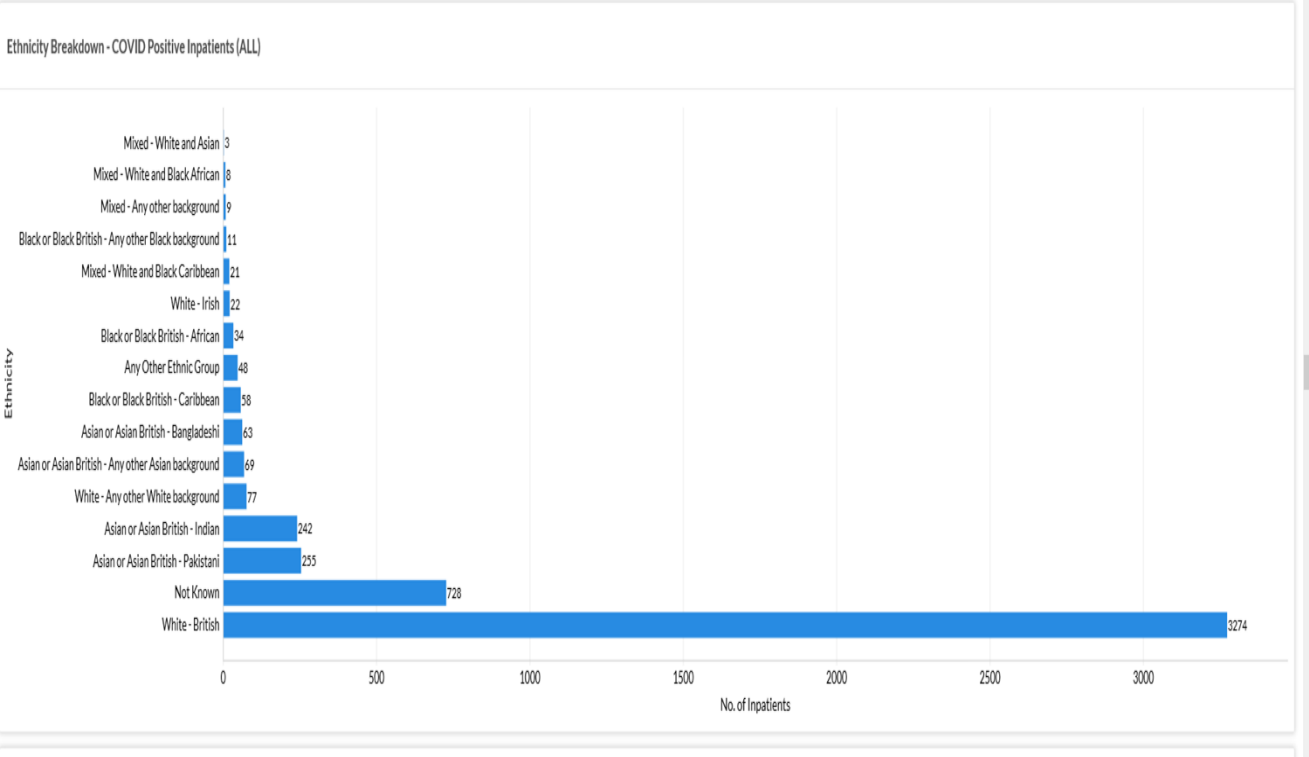
The chart below is taken from available data within HED and illustrates the Trust's performance in relation to peer group. Although HMSR remains higher than the national average (99.78) there is a steady reduction in HMSR.

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

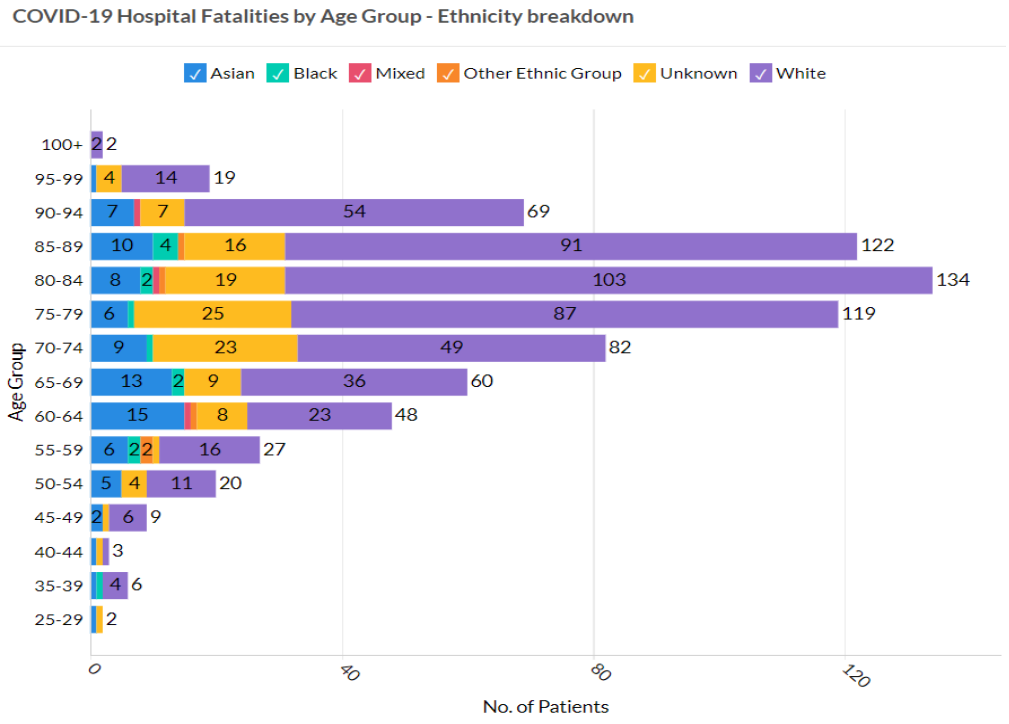


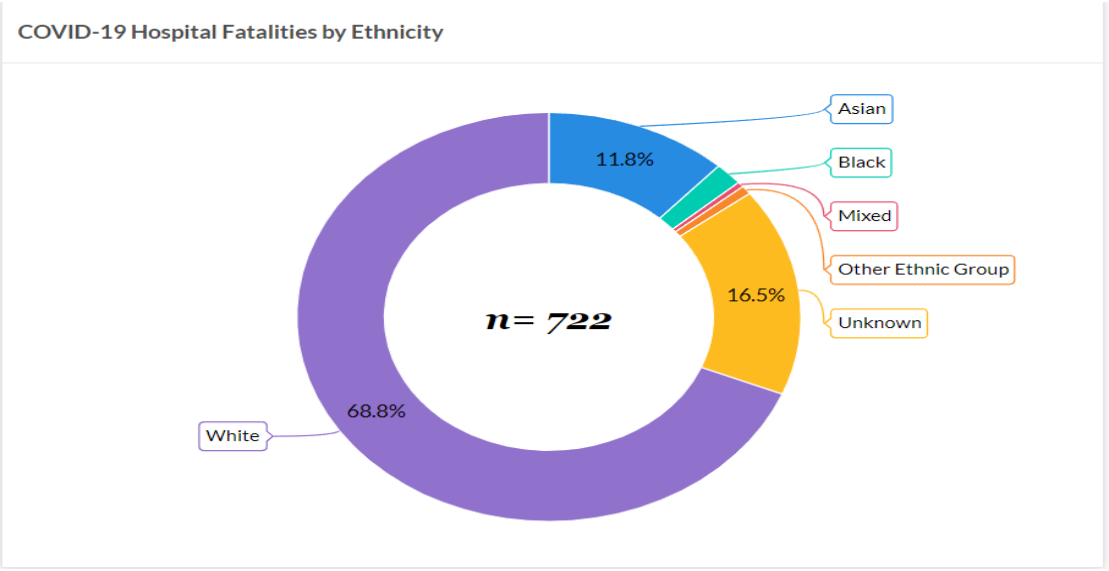
## 3. Covid 19 inpatient/ethnicity

The graph below shows ethnicities for all covid positive inpatients.




The graphs below show ethnicities for all covid positive deaths.






**Alerts**

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

| Alert | Alert Period | CCS Diagnostic Group | Score | Alert Level |
|---|---|---|---|---|
| SHMI | Oct 2021 - Sep 2022 | 24 - Cancer of breast | 325.81 | Red |
| | Oct 2021 - Sep 2022 | 59 - Deficiency and other anemia | 212.12 | Red |
| | Oct 2021 - Sep 2022 | 55 - Fluid and electrolyte disorders | 169.24 | Red |
| | Oct 2021 - Sep 2022 | 19 - Cancer of bronchus; lung | 145.8 | Red |
| | Oct 2021 - Sep 2022 | 157 - Acute and unspecified renal failure | 145.62 | Red |

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

There were no HSMI alerts for the Trust during this period.

## 4. Specialty Learning / Feedback

The following specialties presented at the Mortality Surveillance Group.

### Child Death Review

For the year 2022 – 2023 to date there have been a total of 17 deaths:

- Neonatal - 5
- Older - 12

3 reviews have been completed.

Overall, there are 22 child death reviews outstanding

- 1 awaiting police investigations

- 10 awaiting coroners outcomes
- 5 awaiting PMRT from elsewhere
- 2 awaiting PMRT from here
- 2 awaiting CDRM from BCH
- 2 ongoing

Two individual cases were discussed which outlined the following areas of good practice:

- APLS and SUDIC protocols followed
- Parents fully supported throughout
- Bereavement support was highlighted:
    - Including whole family in discussions
    - Memory box, memorial garden

There were also areas for improvement highlighted:

- Staff should have a good understanding of the case before making telephone calls
- Ideally a joint home visit should be carried out (to include police etc)

**Cardiology**

The report covered the period June 2022 – Sept 2022.

During that period there were:

- Total deaths = 15 (7 males & 8 females)
- Age range = 65-93 years
- Average age = 78 years
- Number of deaths reviewed = 13
- Number of SJRs required = 0

The top 5 diagnosis on death certificate were:

- End stage Heart failure (IHD/AS)
- IHD (ischaemic heart disease)
- Sepsis
- Heart failure

The following areas of good practice were identified:

- MDT approach.
- Good communication (Patient/family involvement in decision making).
- Good documentation.
- Early involvement of Palliative team.
- Early recognition of dying/end of life patient.

**Intensive Care**

5 cases were discussed which were all the subject of SRJ.

There were a number of learning points that arose from discussion and from review of the cases although it was agreed that these would not have changed outcome due to background history

- Discussion with Microbiologist for persistence temperature could have given another point of view, although understandably there was no major rise in infection markers and cultures were negative.
- Could not find any family discussion or updates given by ITU doctors. All daily updates were by nurses, the family didn't ask for medical team and they were happy with updates. ITU team should have updated family frequently. Information cascaded at the Audit meeting and planned that every patient should be updated by ITU team every 48 hours but any major change in patient clinical condition to be updated by Registrar or Consultant.
- A dose of antibiotics was missed because of no IV access – IV access was delayed – this should have been dealt with more urgently.

There were areas identified for improvement:

- Missing or incomplete documentation:
  Action: Presentation of these cases in monthly Audit meeting and giving feedback to the concerned ITU doctors and staff involved
- Family Update and involvement:
  Action: ITU team to update every 48 hours or when any manor change in patient clinical condition to be updated by Registrar or Consultant. Cascaded this through audit meetings and emails. Review by audit. Communication workshop.
- Emphasis of CVC days to bring down unit acquired infections:
  Action: Recent audits showed positive response.
- Missing or incomplete LocSSIP:
  Action: Merging LocSSIP into the ICU booklet

**Mortality Reviews - Structured Judgement Reviews (SJRs)**

5.1 There are currently 21 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 and a total of 12 SJRs were completed in November and December.

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

5.3 1 LeDeR review was identified in November and 5 in December.

5.4 The issue around missing notes/loose filing remains an issue. The Learning from Deaths Administrator is working closely with the Coding Team to develop a process to mitigate as far as within their gift to do so.

**SJR outcomes (total deaths reviewed categorised by outcomes)***

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

| Score 2 Strong evidence of avoidability | | |
|---|---|---|
| This Month | 0 | 0.0% |
| This Quarter (QTD) | 2 | 10.5% |
| This Year (YTD) | 3 | 6.9% |

| Score 3a Probably avoidable (more than 50:50) | | |
|---|---|---|
| This Month | 1 | 14.3% |
| This Quarter (QTD) | 1 | 5.3% |
| This Year (YTD) | 4 | 9.1% |

| Score 3b Probably not avoidable (less than 50/50) | | |
|---|---|---|
| This Month | 3 | 42.80% |
| This Quarter (QTD) | 3 | 15.8% |
| This Year (YTD) | 8 | 18.2% |

| Score 4 Probably not avoidable | | |
|---|---|---|
| This Month | 4 | 57.1% |
| This Quarter (QTD) | 9 | 47.4% |
| This Year (YTD) | 27 | 61.3% |

| Score 5 Slight evidence or definitely not avoidable | | |
|---|---|---|
| This Month | 0 | 0.0% |
| This Quarter (QTD | 1 | 5.3% |
| This Year (YTD) | 2 | 4.5% |

## 5. Medical Examiner

The medical examiners reviewed 100% of deaths in September and October. This included 8 community deaths in November and 11 in December.

The community ME programme is being rolled out to all Walsall GPs. The Lead ME presented to the LMC in November and in order to progress the roll out the LMC and ME office have sent a joint letter to the GP practices informing them of the programme which should lead to increased uptake from GPs.

Funding for EMIS access has been agreed by the Chief Medical Officer and discussions with EMIS are underway.

## 6. Matters for escalation to QPES from Mortality Surveillance Group

There were no matters for escalation to QPES during November and December

| | | | |
|---|---|---|---|
| **MEETING OF PUBLIC TRUST BOARD**<br>**Wednesday 8th February 2023** | | | |
| Patient Voice Report<br>Quarter 3 –October 2022 – December 2022 | | | |
| **Report Author and Job Title:** | Garry Perry<br>Associate Director<br>Patient Relations and Experience | **Responsible Director:** | Lisa Carroll<br>Director of Nursing |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☒ Discuss ☐ Inform ☐ Assure ☐ | | |
| **Assure** | The Patient Experience and Relations team are compliant with regulatory obligations in relations to complaints and FFT. | | |
| **Advise** | Compared to Q2, the Trust has retained a similar (no less than -1% change), or improved average recommendation score across all areas The Trust average compliance rate for complaints (response timeframes) for Quarter 3 remains at 78%. This is equivalent to the previous quarter. | | |
| **Alert** | Nil for this quarter | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | There are no risk implications associated with this report. | | |
| **Resource implications** | There are no resource implications associated with this report. | | |
| **Legal and/or Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | | |
| **Strategic Objectives** | Safe, high-quality care ☒ | Care at home ☐ | |
| | Partners ☒ | Value colleagues ☒ | |
| | Resources ☐ | | |

# Quarterly Patient Voice Report (October-December 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 October - December 2022. The report also provides detail on learning taken and a summary of activity to support an enhanced positive Patient Experience including updates on National Surveys, volunteering, and spiritual, pastoral, and religious care.

## 2. Background

A report on patient and carer experiences is 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 with a and engaged in shaping service developments. The Patient Voice provides an opportunity for trends to be identified and for improvement and learning arising from outcomes.

## 3. Details

### 3.1 Feedback data

The Trust received a total of **15,187** feedback contacts between October and December 2022.This includes all Patient Relations related contacts, along with Friends and Family Test and Mystery Patient responses.

| | |
|---|---|
| Complaints (including MP letters) | 88 |
| Concerns | 572 |
| Compliments | 87 |
| Friends and Family Test | 14362 |
| Mystery Patient (QR code) | 78 |

**Table 1. Patient Feedback by contact type**

### 3.2 Complaints and Concerns

The top 3 trends for complaints, concerns and queries in Quarter 3 relate to Appointments (306), Clinical Care, Assessment and Treatment (219) and Attitude (32). Appointments remains the highest category for contacts as in Quarter 2, however, there has been a noted increase in contacts (267 previous quarter).

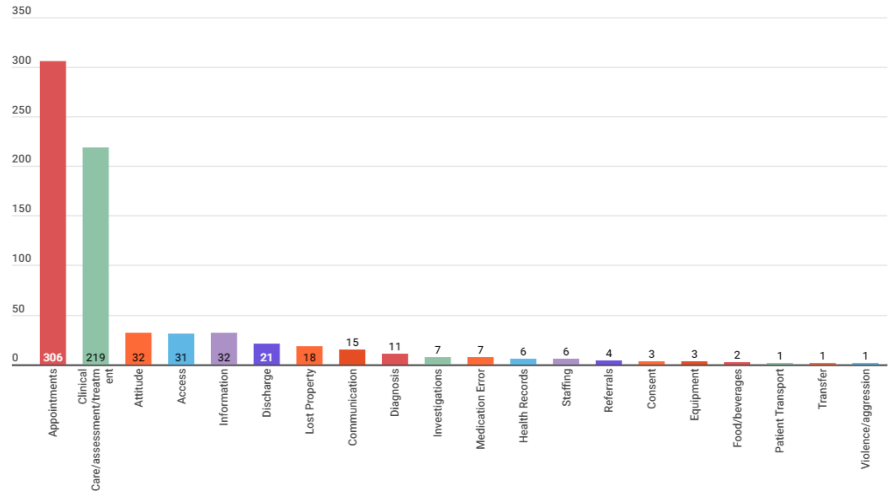



**Table 2. Patient Feedback by category type**

### 3.3 Complaint response times

The Trust average compliance rate for complaints (response timeframes) for Quarter 3 was 78%. This is equal to that of the previous quarter. 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.

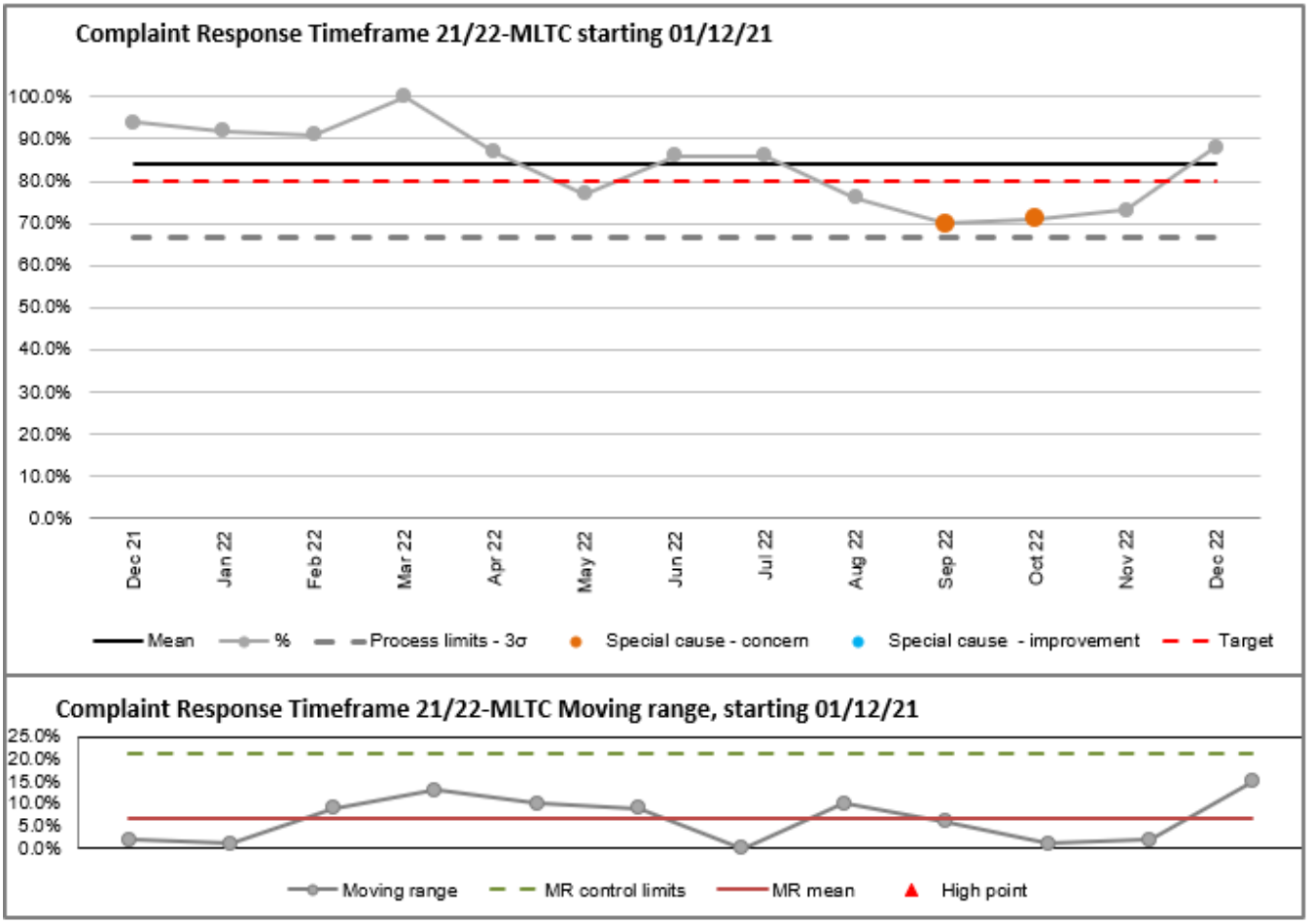



**Table 3. Complaint response times**

### 3.4 Implementing the new Parliamentary Health Service Ombudsman Complaint Standards

We continue to be engaged attending the PHSO complaints handling seminars where we are an early adopter pilot of the new national complaint standards. Public evaluation is now taking place to consider all the feedback received from the pilot sites and early adopters. It has already been indicated that there are no significant changes being made to the original model complaints handling procedure which we have adopted.

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
- 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 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 Q2, the Trust has retained a similar (no less than -1% change), or improved average recommendation score across all areas other than postnatal community which has shown a 22% decrease over the quarter and ED which has shown a 2% decrease. When compared nationally, the Trust returned a higher average recommendation score for Community (4%) and an equal score in ED. When compared regionally the Trust returned a higher average recommendation score for ED (5%), Community (6%) and Postnatal Ward (3%), and an equal score for Outpatients. When compared to the 3 local organisations, the Trust returned a higher average recommendation score for ED (5%), Community (6%), Antenatal (2%) and Postnatal Ward (2%). Throughout Q3, Outpatients, ED and Community have maintained a consistent recommendation score.

| FFT Recommendation Score | Inpatients | Outpatients | ED | Community |
|---|---|---|---|---|
| Trust Q3 Average | 86 | 91 | 76 | 99 |
| Oct-22 | 85 | 91 | 72 | 96 |
| Nov-22 | 87 | 91 | 77 | 99 |
| Dec-22 | 84 | 91 | 73 | 99 |
| Royal Wolverhampton (Oct 22) | 91 | 93 | 68 | 92 |
| The Dudley Group (Oct 22) | 91 | 88 | 69 | 91 |
| Sandwell and West Birmingham (Oct 22) | 86 | 90 | 63 | * |
| National Average (Oct 22) | 94 | 93 | 74 | 94 |
| Black Country ICB (Oct 22) | 89 | 91 | 69 | 92 |

**Table 4 Friends and Family recommendation score**

| FFT Recommendation Score | Antenatal | Birth | Postnatal Ward | Postnatal Community |
|---|---|---|---|---|
| Trust Q3 Average | 81 | 80 | 83 | 88 |
| Oct-22 | 93 | 81 | 74 | 67 |
| Nov-22 | 85 | 84 | 81 | 54 |
| Dec-22 | 85 | 80 | 90 | 77 |
| Royal Wolverhampton (Oct 22) | 82 | 88 | 81 | 86 |
| The Dudley Group (Oct 22) | 96 | 93 | 78 | * |
| Sandwell and West Birmingham (Oct 22) | 80 | 78 | * | * |
| National Average (Oct 22) | 90 | 93 | 92 | 90 |
| Black Country ICB (Oct 22) | 91 | 87 | 79 | 83 |

**Table 5 Friends and Family recommendation score**

### 4.2 Response Rate

The below tables illustrate the Trusts Friends and Family Test response rate as compared internally, nationally, regionally, and locally (Please note, comparable national, regional, and local data has a 2-month reporting delay). Compared to Q2, the Trust has retained a similar average response rate for Inpatients, Outpatients, Antenatal and Birth, and an improved response rate for ED. A decreased response rate has been returned for Community (2%), Postnatal Ward (1%) and Postnatal Community (3%). When compared nationally, the trust returned a higher response rate for Inpatients (5%), Outpatients (13%), ED (11%) and Birth (6%). When compared regionally, the Trust has returned a higher response rate for Outpatients (13%). When compared to the 3 local organisations the Trust returned a higher response rate for Outpatients (14%) and Birth (4%). Throughout Q3, Inpatients, Outpatients and ED maintained a consistent response rate.

| FFT Response Rate | Inpatients | Outpatients | ED | Community |
|---|---|---|---|---|
| Trust Q3 Average | 25.0 | 20.2 | 18.8 | 4.9 |
| Oct-22 | 26.1 | 20.6 | 20.7 | 2.8 |
| Nov-22 | 25.1 | 20.1 | 20.4 | 5.2 |
| Dec-22 | 23.9 | 20.2 | 20.7 | 1.7 |
| Royal Wolverhampton (Oct 22) | 28.3 | 4.6 | 20.7 | 6.2 |
| The Dudley Group (Oct 22) | 37.3 | 6.4 | 32.4 | 6.1 |
| Sandwell and West Birmingham (Oct 22) | 15.9 | 8.3 | 11.5 | |
| National Average (Oct 22) | 19.6 | 7.6 | 9.9 | 3.6 |
| Black Country ICB (Oct 22) | 30.7 | 6.9 | 23 | 4.2 |

**Table 6 response rate**

| FFT Response Rate | Antenatal | Birth | Postnatal Ward | Postnatal Community |
|---|---|---|---|---|
| Trust Q3 Average | 12.3 | 17.9 | 10.8 | 10.0 |
| Oct-22 | 13.5 | 18.6 | 11.8 | 6.7 |
| Nov-22 | 11.4 | 21 | 11.2 | 7.2 |
| Dec-22 | 10 | 15 | 8.2 | 8 |
| Royal Wolverhampton (Oct 22) | | 25.2 | | |
| The Dudley Group (Oct 22) | | 9.1 | | |
| Sandwell and West Birmingham (Oct 22) | | 9 | | |
| National Average (Oct 22) | | 12.6 | | |
| Black Country ICB (Oct 22) | | 18.6 | | |

**Table 7 response rate**

### 4.3. Mystery Patient feedback

The below tables illustrate the Mystery Patient feedback received during Q3. The scored questions have fluctuated throughout the quarter. Courtesy of staff, environment, and involvement have all showed a decline in November from October however early signs of improvement can be seen in December. Respect and Dignity has improved month on month throughout the quarter.

Compared to Q2, the average score has improved slightly for Courtesy, environment, and respect and dignity, however, has declined for involvement in decisions about your care and treatment by 1.5. A total of 78 Mystery Patients were returned in Q3, a reduction of 36% on Q2.

| Scored Questions | Oct | Nov | Dec |
|---|---|---|---|
| Courtesy of the staff rating | 8.2 | 7.1 | 7.9 |
| Environment and hospital facilities rating | 8.0 | 6.8 | 7.7 |
| Treated with respect and dignity | 8.3 | 8.4 | 9.0 |
| Involvement in decisions about your care and treatment | 7.5 | 6.4 | 6.8 |

**Table 8 scored questions mystery patient scheme**

| Responses | Q2 Monthly Average | October | November | December | Q3 Total |
|---|---|---|---|---|---|
| Community | 7 | 5 | 2 | 0 | 7 |
| Emergency Department | 2 | 0 | 1 | 0 | 1 |
| Inpatients | 19 | 5 | 21 | 14 | 40 |
| Maternity | 5 | 4 | 4 | 1 | 9 |
| Outpatients | 8 | 5 | 8 | 6 | 19 |
| Unknown | N/A | 2 | 0 | 0 | 2 |

**Table 9 responses in number's mystery patient's scheme**

## 5.0 National Survey updates:

**5.1** The published findings for the **Adult 2021 survey** have been received and the action plan has been adjusted. The results have been shared with senior leaders and discussed with the Patient Feedback Oversight Group, Patient Experience Group, Matrons Forum, and the Junior Doctor Grand Round.

### Areas of Focus

- 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

### Action Update

✓ Sleep packs to accompany a re-launch of the noise at night protocol have been distributed to all in-patient areas

- ✓ 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. This piece of work will be supported by a Surgical Matron who will lead on development.
- ✓ Healthwatch Walsall have provided some early insight from their discharge survey. However, much is in place focussing on the Walsall Together collaboration response to the National Discharge Taskforce. The discharge lounge produced and shared guidance on planning for an effective discharge 'Get AKTING, Think HOME'.


- ✓ 'Sorry to disturb you' card in design for patients who must be moved at night – reinforcing need to explain and apologise where this happens
- ✓ Ward welcome boards installed – QR code links to Health and Social Care access

### 5.2 Maternity

The 2022 draft survey findings were shared with us and disseminated internally in September 2022.

Full publication of results is now available. Action planning is in progress to align the ongoing improvement initiatives in Maternity with the benchmarked outcomes when published against the national comparators. At the time of writing this report, we have carried out internal scrutiny of the preliminary results against the set from 2021.

The results demonstrate encouraging signs of improvement overall however they still fall below the 10% or greater threshold to move us statistically higher in terms of national comparators but are a useful benchmark and should be noted. It is worth acknowledging that within the final data set and with the national weighting applied – our response rate was 15% lower than the average and this will have also affected comparisons.

### 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 Children and Young Peoples Survey 2020

2-year action plan due to be completed in March 2023 and outcomes presented to the Patient Feedback Oversight Group. The next survey (sample month is Nov/Dec 22) is due for headline reporting in June with full publication expected later in the year.

### 5.5 National Cancer Survey 2021

Tumour group action plans are currently being pulled together by lead Cancer Nurse Specialists. The trust has 3 questions below the expected range as a focus for improvement, and 6 questions reported above the expected range. Deadlines for actions are being set for April 2023 in preparation for the 2022 results and will be mapped to together as a continued action plan.

## 6. Spiritual, Pastoral and Religious Care (SPaRC) October-December 2022

In the last quarter **1523** encounters were undertaken by the team here at Walsall. With **2882** types of support provided covering pastoral, spiritual and religious care. **1293** of these encounters were specific to a faith group.

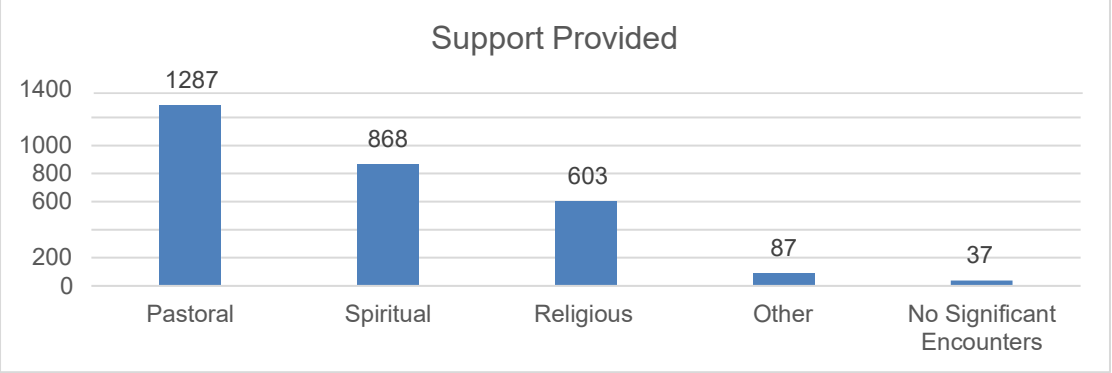



**Table 10 support by type**

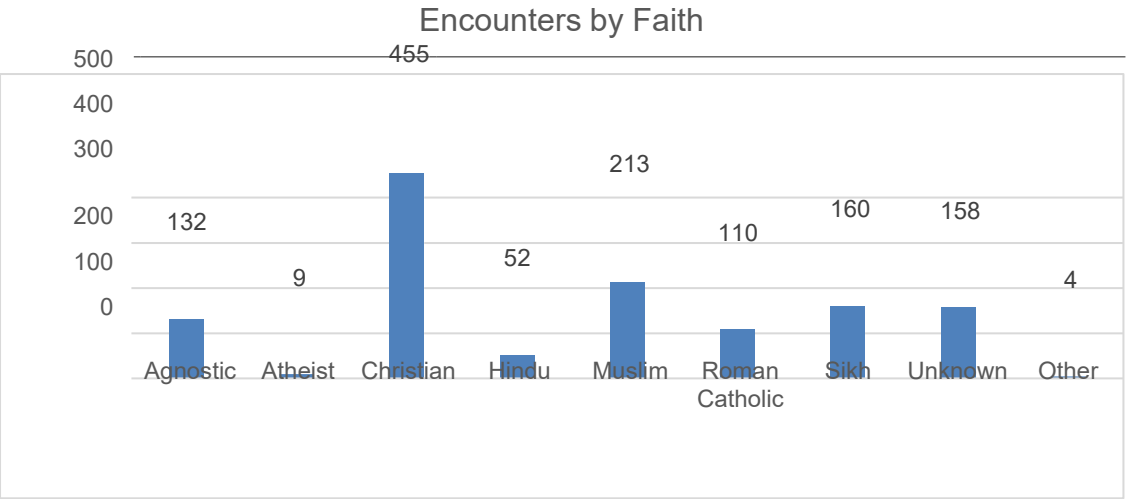



**Table 11 support by encounter**

### 6.1 Working in partnership

The SPaRC team led by Linford Davis as Head of SPaRC - a joint appointment with our partners at the Royal Wolverhampton NHS Trust has re-shaped the way in which the team operates across both Trust sites. Our Chaplaincy Team Lead's Joe Fielder and Edd Stock have swapped Trusts and the teams have been strengthened further following appointments to vacant roles at RWT and Bank Chaplains here at Walsall who will also work cross site.

### 6.2 Faith in Action Summit


Actions to combat the cost-of-living crisis, health inequalities and homelessness were top of the agenda when dozens of faith and community leaders gathered with public sector officials at a key summit held in November.

Around 200 people attended the 2022 Faith in Action Summit at the Banks' Stadium organised by the West Midlands Regional Mayor, Andy Street to help drive forward new ideas and projects aimed at tackling some of the most critical issues currently facing communities across the West Midlands.


The Summit aimed to build on the close relationships that were forged during the height of the Covid pandemic when the public sector worked closely with faith and community groups to communicate vital health messages, dispel misinformation, and fake news, and even turn places of worship into vaccination centres. Our Associate Director, Garry Perry was invited as a panellist speaking on the value of radical kindness and the faith community response to covid-19.

### 6.3 Baby Loss Awareness

Special light displays, and a memorial service took place to observe Baby Loss Awareness Week. Taking place from 9-15 October every year, Baby Loss Awareness Week raises awareness of pregnancy and baby loss in the UK. Throughout the week, bereaved parents, and their families and friends, unite with others across the world to commemorate the lives of babies who died during pregnancy, at, or soon after, birth, and in infancy. The baby memorial service was led by the Trust's Chaplaincy and Spiritual Care Team and Bereavement Team on Sunday 9 October. All parents and families who suffered the loss of a baby regardless of gestation were invited to attend the service, which took place in the Chapel at Walsall Manor Hospital. More than 60 people attended, showing how important and significant the occasion was.

### 6.4 Celebrating Religious Festivals

The Team led events for patients and staff celebrating the recent religious festivals of Diwali and Christmas, which included the handing out of samosas (donated by the Hindu Temple and two Walsall Gurdwaras) Dhol drumming and prayers.

Christmas involved the light switch on event, department and ward-based carol singing and an online Christmas message from staff – 'what Christmas means'.

### 7.0 Patient involvement Partners (PiP's)

The Patient Partners received a presentation on Duty of Candour explaining that the template followed is considered to not be user friendly. The partners have agreed to attend a Duty of Candour workshop to co-design changes to the current process, to improve documentation and actively monitor the improvements from 1st April 2023.

The PIP's requested further detail on actions associated with mystery patient feedback and suggested that the Trust website publicises an estimation of referral to treatment times and a request has been made for involvement in the re-design of the planned work on the Trust website.

Two volunteer patient assessors supported the facilities team in carrying out a PLACE (Patient-Led Assessment of the Care Environment) audit.

## 8.0 Voluntary Services

### 8.1 Volunteer Summary

| | |
|---|---|
| 60<br>Applied to volunteer in Q3<br>Down 14% on Q2 | Volunteers supporting the hospital in Q3<br>89 |
| Total Hours Logged in Q3<br>3198 | **Top hours for Q2**<br>1ST 143 2ND 117 3RD 84 |

**Table 12 Volunteer summary**

### 8.2 Chaplaincy Volunteers

| Support Provided | Oct-22 | Nov-22 | Dec-22 | Total |
|---|---|---|---|---|
| Pastoral | 61 | 103 | 65 | **229** |
| Spiritual | 22 | 7 | 9 | **38** |
| Religious | 12 | 2 | 5 | **19** |
| **Total** | **95** | **112** | **79** | **286** |

| Encounters by faith | Oct-22 | Nov-22 | Dec-22 | Total |
|---|---|---|---|---|
| Agnostic | 2 | 1 | 1 | **4** |
| Buddhist | 0 | 1 | 0 | **1** |
| Christian | 23 | 23 | 10 | **56** |
| Hindu | 1 | 0 | 1 | **2** |
| Jain | 0 | 0 | 1 | **1** |
| Muslim | 2 | 7 | 3 | **12** |
| Roman Catholic | 1 | 6 | 11 | **18** |
| Sikh | 3 | 2 | 1 | **6** |
| Unknown / Not disclosed | 37 | 66 | 44 | **147** |
| **Total** | **69** | **106** | **72** | **247** |

**Table 12 Chaplaincy Volunteers**

### 8.3 Volunteer Annual Awards.

VOLUNTEER AWARDS
Celebrating our volunteer heroes

October 2022 saw the long-awaited return of the annual volunteer awards and celebration. Due to the pandemic these have not been held since 2019, a key date in the annual volunteer calendar. Held at Calderfields Golf and Country Club and attended by Mayor of Walsall, Councillor Rose Martin, the evening was a great success awarding our unsung volunteer heroes. With more than 100 volunteers and staff in attendance, accolades were presented in the following categories.

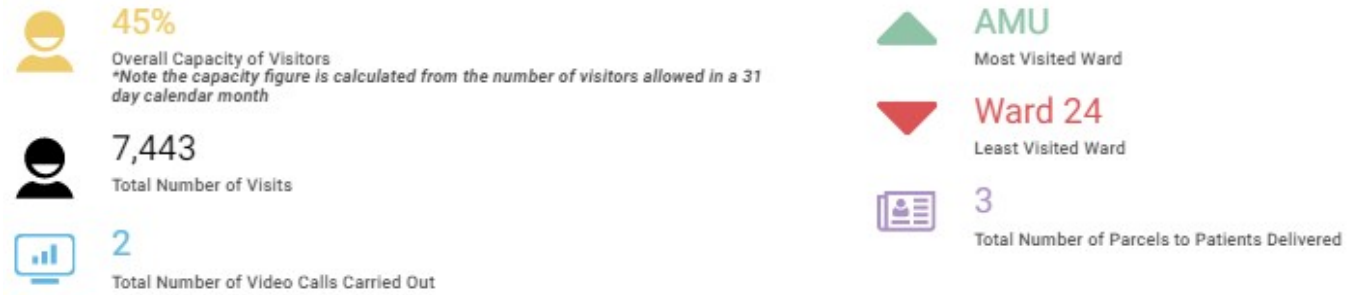

- Bronze award for one year of service
- Silver award for five years of service
- Gold award for 10 years of service
- Special recognition for 15 years of service or more
- Volunteer of the year – Community
- Volunteer of the year – Young Person
- Volunteer of the year – Hospital
- Bronze, Silver, and Gold Contribution award

The Trust look forward to the 2023 awards with planning already underway for them to be held in the summer.

### 8.4 Volunteer Christmas Celebration

To mark the end of a brilliant year for Voluntary Services, volunteers attended a Christmas celebration and quiz held at the Trust. To mark the volunteers hard work over the year, and to celebrate Christmas and the New Year, volunteers enjoyed a fun filled afternoon with drinks, mince pies and a Christmas Quiz. Great fun was had by all as the year was ended.

### 8.5 Visiting – Welcome Hub




## 9.0 Engagement

### 9.1 'It's OK to ask'


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

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


Each patient accessing Trust services were offered a bookmark telling them 'It's OK to ask' and explaining why it's so important they understand their care and are involved in the process.

We asked **patients** and **staff** about the campaign and our initial findings demonstrate:

- **93%** of patients believed it important to know what their main problem was when in hospital
- **88%** of patients believed it important to know what they need to do and why
- **100%** of staff believe it important for patients to understand what they need to do and why it is important

When staff were asked '**What support do they need to better communicate to patients their main problem, what they need to do and why it is important.'**

**Staff responded that:**

- having literature with simple steps that patients can do whilst in hospital and then at home to improve their condition would be helpful
- involve MDT and family or Carer when patient has no capacity due to illness or disability "

The campaign will continue to be promoted and additional staff groups engaged in the reason for doing this and how they can make small changes to ensure implementation at every level.

**9.2 World AIDS day – December 1, 2022**


In December we supported the promotion of World AIDS Day alongside the Trust Sexual Health team.

World AIDS Day takes place on 1 December each year. It's an opportunity for people worldwide to unite in the fight against HIV, to show support for people living with HIV, and to commemorate those who have died from an AIDS-related illness. Founded in 1988, World AIDS Day was the first ever global health day.

**9.3 Carers' Rights Day**

Our newly appointed Family and Carers Support Officer attended Carers' Rights Day in partnership with Walsall Council, where a drop-in session was held on 24 November at Walsall Town Hall.


The session was held for unpaid carers to find out information to help them in their role and covered topics such as managing energy costs and legal rights. Supported by the wider Patient Experience Team is attending we spoke and secured feedback from people who have caring responsibilities to help with the planning as we launch formally our 'Family and Carers Support Service' within the Trust including our carers commitment.

**10.0 Recommendations**

Note the contents of the report and associated activity

| MEETING OF THE TRUST BOARD 08/02/23 | | | |
|---|---|---|---|
| **The Quality Improvement Team Update** | | | |
| **Report Author and Job Title:** | Kate Salmon<br>Deputy Chief Strategy Officer – Improvement and Collaboration<br>&<br>Joyce Bradley<br>Head of Quality Improvement | **Responsible Director:** | Simon Evans,<br>Group Chief Strategy Officer |
| **Recommendation & Action Required** | Members of the Committee are asked to:<br>Approve ☐ Discuss ☐ Inform ☒ Assure ☐ | | |
| **Assure** | • That capacity and capability building in a consistent QI Approach continues in appropriate format with social distancing<br>• Engagement of the QI Team by operational areas to provide QI Approach to making improvements<br>• Addressing the CQC requirements for organisations to develop a mature QI approach | | |
| **Advise** | • Working more widely with partners across the Black Country and beyond<br>• Closer collaboration with Wolverhampton and now one QI Team across the Trusts<br>• When comparing training figures provided by the national team, WHT is one of the largest QSIR training providers in England. | | |
| **Alert** | • Opportunities for training and support to areas using a QI approach to improvement are available despite small size of the team. | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | There are no risk implications associated with this report. | | |
| **Resource implications** | There are no resource implications as a result of this report. | | |
| **Legal and/or Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this report. | | |
| **Strategic Objectives** | Safe, high-quality care ☒ | Care at home ☐ | |
| | Partners ☐ | Value colleagues ☒ | |
| | Resources ☒ | | |

# QUARTERLY UPDATE FROM THE QUALITY IMPROVEMENT TEAM

## 1. PURPOSE OF REPORT

1.1 The purpose of the report is to inform the Committee of the progress with increasing the capacity and capability of colleagues in an agreed QI Approach, namely the Quality Service Improvement and Redesign (QSIR) programmes across the organisation and beyond through quarter 3 of financial year 2022/23.

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

## 2. BACKGROUND

2.1 The QI Team has been delivering the range of QSIR Programmes since January 2019. With the collaborative working across both RWT and WHT the two facets delivering QI training have become one 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 in the last quarter with 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 recruiting to the Divisional Clinical Lead roles, the establishment within the QI Team and when vacancies are likely to be filled.

3.3 This quarter saw the QI Board action plan, generated to address the recommendations in the report developed by the national Improvement Capability Building and Delivery (ICBD) Team at NHSE, being approved. The plan sets out the work and ambitions of the QI team for embedding quality improvement at all levels of the organisation and implementation of the actions has begun in earnest.

3.4 Other teams supported during the last quarter include the Paediatric Assessment Unit, working with the Quality team in Community and supporting the development of the 'Eat, Drink, Dress, Move to Improve' programme with the Associate Director for AHPs.

3.5 Training specifically for SAS Doctors was delivered as the first part of a development programme for this group of staff.

3.6 The report identifies the areas which will be the focus of work for the QI Team during Q4 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:-

- Reconciliation of data held on ESR for delegates who completed any of the trust's QI Training programmes.
- Patient Flow through Gynae and Antenatal Clinics – the clinics will be more efficient through the application of Health Care Systems Engineering (HCSE) principles.

3.8 Other pieces of work that will be undertaken and may be completed within the next quarter and include:-

- Establishment of a Community of Practice for Quality Improvement
- Reinvigoration of the QI Huddle Boards and roll out to areas requesting them.
- Engagement of clinical areas in opportunities for improving flow through the application of Health Care Systems Engineering.

## 4. RECOMMENDATIONS

The Committee is asked to **Note:**

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

4.2 the ongoing support by the QI 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 4, 2022/23

Quality Improvement Team

Walsall Healthcare NHS Trust

# Quality Improvement Team Update

## Quarter 3 – 2022/23

**Quality Improvement Team**
Joyce Bradley – Head of Quality Improvement

Caring for Walsall together

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

# Contents

# Executive Summary

The QI Team at Walsall has been busy through out Quarter 3 of 2022-23. Training that recommenced in the tail end of Q2 all completed prior to the Christmas break. There were some disruptions to delegates being able to attend their training session due to operational pressures and those who did not complete will be picked up during future cohorts.

All three QSIR Programmes were delivered as well as the full day flow workshop for Health Care Systems Engineering (HCSE). Ongoing projects were supported and the team was on-site consistently during this quarter.

The delivery plan to address the areas identified from the Board QI development sessions has been approved and work has commenced to move these actions forwards.

Work has been ongoing with developing communications information to be sent out to support colleagues in understanding the difference between QI, Clinical Audit and Research and members of the Qi team have started to attend the Clinical Effectiveness Group.

Additional resources have been identified to enable the organisation to have two Clinical Leads per division – one a medic and one a Nurse/midwife/AHP/Pharmacist depending on applicants. The team undertook interviews for some of these roles during Q3 with 3 new starters in January and further interviews planned during Q4

Quality Improvement Team

Walsall Healthcare NHS Trust

# Quality Improvement Team - WHT

The QI Team consists of:-

1 x Trust Clinical Lead (2 PA per week)  Dr Atul Garg – Intensivist (from 01/09/22)

8 x Divisional Clinical Leads

- Interviews held and Clinical Leads for Surgery, WCCSS and Community will start January 2023

1 x  Head of Quality Improvement – J Bradley

1 x Quality Improvement Programme Lead – T Johnson

1 x Quality Improvement Facilitator – C Hill

1 x Administrator/Junior Project Officer – K Ginday

1 x Medical QSIR Accredited trainer 0.9 PA per week – Dr Waterhouse

# Capacity & Capability

QI Training Delivery

Cohorts 12, 14 and 15 completed during this quarter although a number of delegates were pulled due to operational pressures and they will complete during Cohorts 16 or 17 which will commence in late January 2023.

Training numbers are still restricted by social distancing requirements which hinders the roll out of training and fitting in delegates who miss dates.

Cohort 15 included 5 delegates from West Midlands NHSE, specifically the Urgent and Emergency Care leads and the black country ICS EPRR lead.

An additional trainer became accredited to deliver the QSIR programmes and will start to deliver elements of the programmes during Q4.

During Q4 a piece of work to confirm the QI training status of colleagues across the Trust commenced with Workforce Intelligence to ensure that our ESR reflect the training undertaken.

# Capacity & Capability

## QI Training – Monitoring Progress

- The QI project registry has been rebuilt since the migration to NHS.net
- All historic and live/active QI projects known to the QI Team have been uploaded to the registry
- The link is accessible to ALL Walsall Healthcare Staff using their usual login credentials
- Link Here


Discussions commenced during Q3 to support the production of a similar project registry for QI Team at The Royal Wolverhampton NHS Trust.

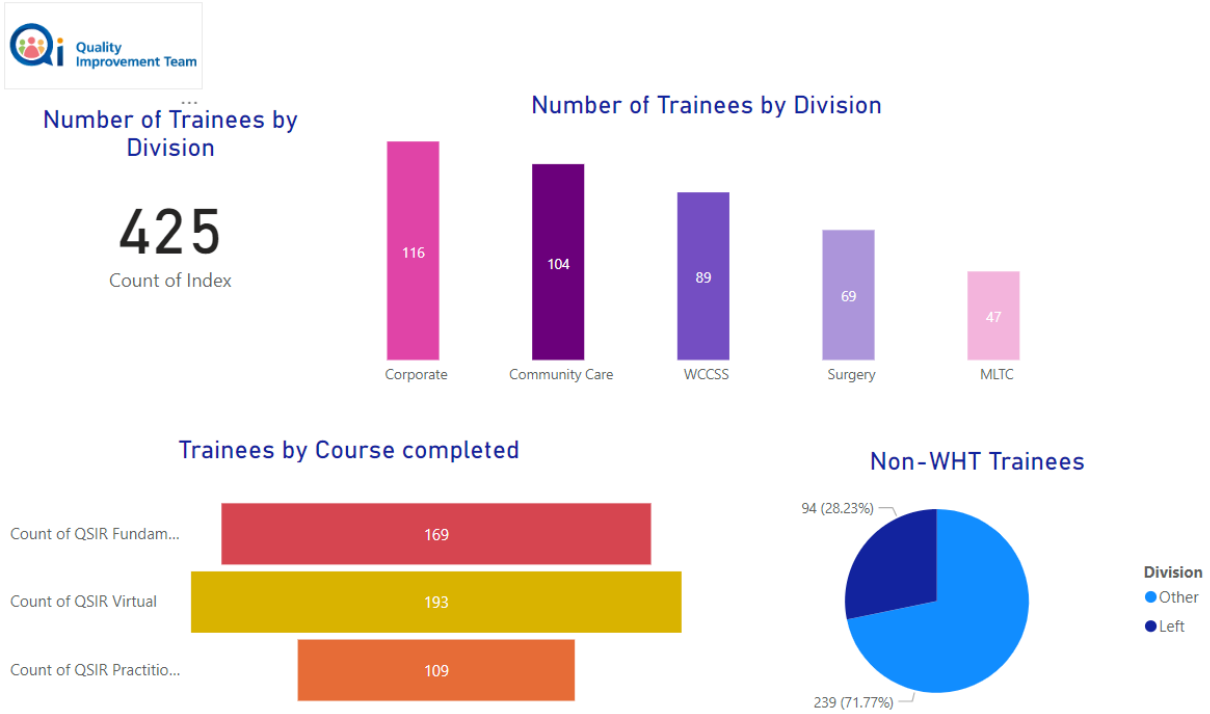
The screen shot above shows the main screen without selecting a care group and this also shows the number of people trained in any of the QSIR Programmes. This dashboard is accessible using this link Care Group Dashboard Link for WHT staff.

# Capacity & Capability – Care Group Register

A further dashboard was initiated during Q3 to show how many colleagues have undertaken QI training through the formal programmes.

The total number of Trainees is irrespective of whether delegates have completed multiple courses.

This number excludes the staff who have left the organisation or are not employed by WHT (blue pie chart). The majority of these attended the virtual on-line sessions we are regularly approached by the national team to fit others onto existing courses. WHT is one of the largest QSIR training providers in England.



# Capacity & Capability

## Service / Profession specific QI Training

The QI team supported the SAS Doctors training during Q3 with a specific QSIR Fundamentals programme exclusively for them. This was the start of a development programme led by the Clinical Lead for SAS Doctors and was well attended.

The regional Deanery for Anaesthetics has commissioned the team to deliver further training and time was spent confirming the content to be run.

## Facilitation of Sessions

The Faculty of Research and Clinical Education (FORCE) requested facilitation of an Insights Discovery session. Insights Discovery is a psychometric tool which can support teams in communicating more effectively and promotes efficient and effective working. One of the QI Team is an accredited trainer for this programme and delivered this. Other session on Insights have been facilitated earlier in the year.

Members of the QI Team have supported the national Improvement Capability Building and Delivery team in the development of a new QSIR Virtual training package which went through its alpha and beta tests during Q3 with a view to it being launched in Q4.

# Capacity & Capability

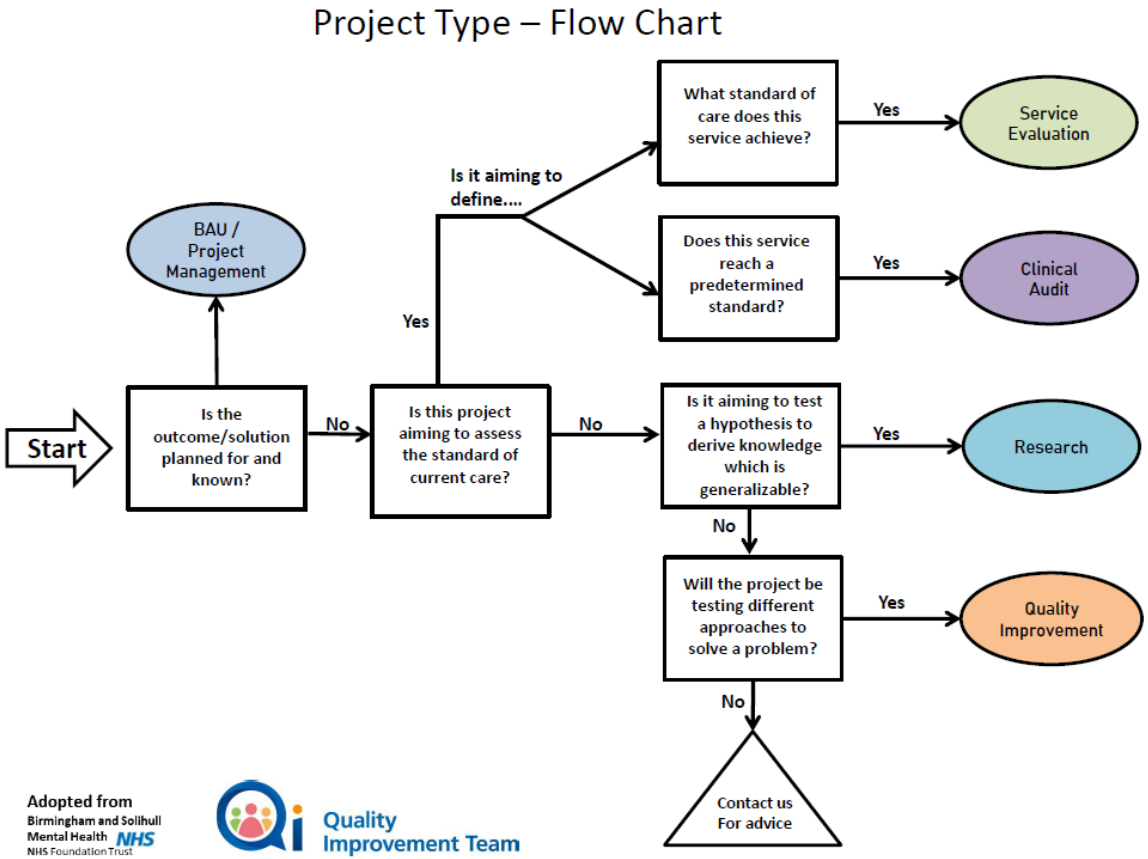
## Clinical Audit & Research

The QI team has been working alongside the Clinical Audit team and the Research team to develop communications to go out across the organisation setting out the difference between QI projects, Clinical Audit and research work. The outcome of this work will be sent out during Q4.

The chart to the right is the high level flow chart which sets out the differences between the three types of approaches

## Training Schedule for 2023-24

The Team has set out the proposed training through 2023-24 and have actively started to advertise and recruit to the training sessions.



Quality Improvement Team

Walsall Healthcare NHS Trust

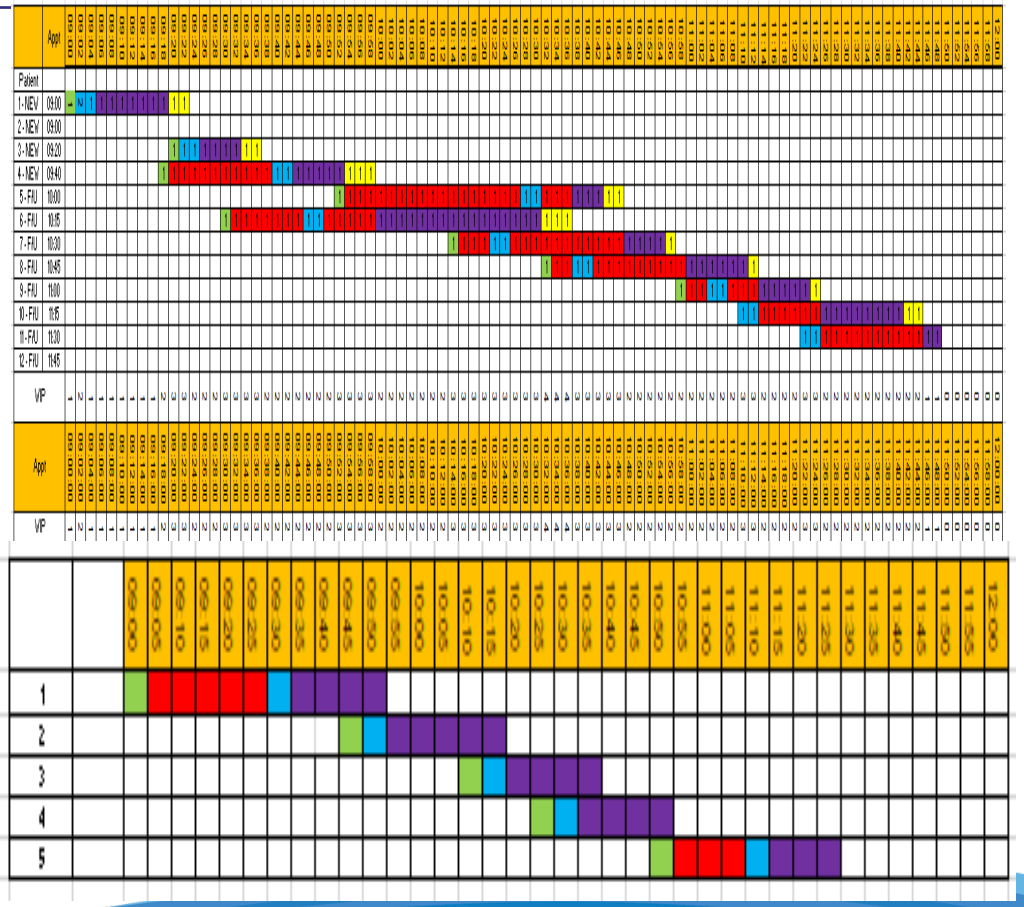
# Patient & Work Flow

Health Care Systems Engineering (HCSE)

HCSE principles have been applied to measuring the patient flow through the nephrology clinic took place during November 2022.

The image to the right is a Gantt chart showing the flow of patients through two separate clinics. Work is continuing with the team to improve the flow through the clinic. The area of note (red lines) are where patients waited.

During Q3 one member of the team completed HCSE Level 1 and will be publishing in the Journal of Improvement Science during Q4

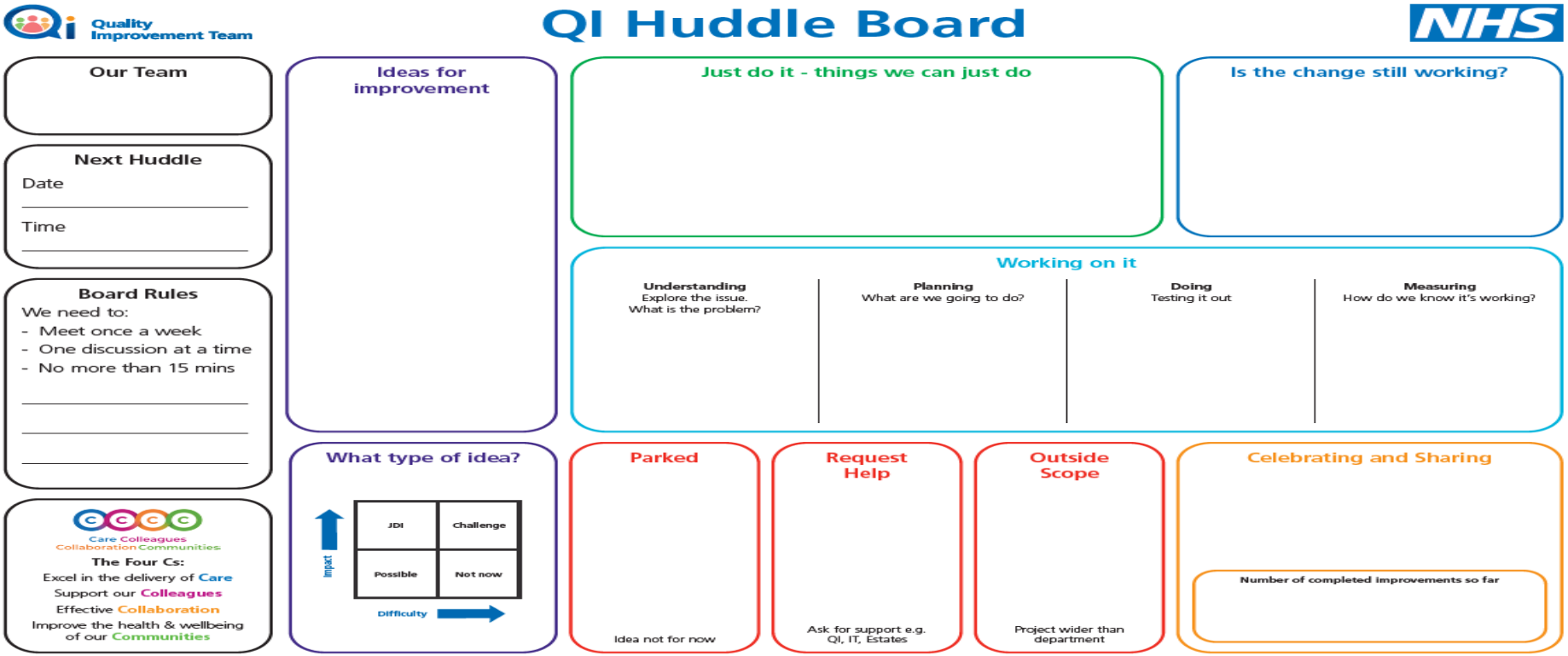


Quality Improvement Team

Walsall Healthcare NHS Trust

# QI huddle board – what is it?

- It's a quick, stand-up discussion (15 mins max), that takes place regularly (at least weekly), placed in an accessible area e.g. staff room, MDT room. (It is not a Safety huddle)
- Open to everyone, all staff, all roles, bands, professions and specialties
- As a group, the team will decide which improvements to work on, supported by QI Team to guide on improvement tools and support improvement ideas



Quality Improvement Team

Walsall Healthcare NHS
NHS Trust

# Patient & Staff Safety

QI Huddle Boards

- Joint training and development session with QI Teams across RWT and WHT as an introduction to QI Huddle Boards
- QI Team updated and approved Huddle Board designed with support of communications team
- 10 new boards purchased for across both organisations
- WHT board locations are given in the table
- Huddle boards for the Portering teams at RWT, WHT and Cannock will be installed and training delivering during Q4 (in conjunction with RWT QI Team).

| Location | Status |
|---|---|
| Cardiology | Restart Jan 2023 |
| NNU | New Leads Identified |
| Ward 23 | Active |
| Delivery Suite | On hold |
| Gynae OPD | Active |
| Chemotherapy Neonatal Unit | Restart Jan 2023 |
| South Locality Team - Jubilee House | Launching Jan 2023 |
| Theatre 10 | Proposed |
| Imaging | Proposed |
| Community Therapies / Specialist services | Proposed |
| Performance and Information | Proposed |

# Patient & Staff Safety

Paediatric Assessment Unit (PAU)

Facilitated a session with PAU as a start to looking at the pathways through the service before moving into the new building alongside Paediatric ED. Further sessions were planned but due to operational pressures have been delayed.

Eat Drink, Dress, Move to Improve (EDDMI)

The QI team have been supporting the Associate Director for AHPs in setting out how to approach the introduction of the EDDMI approach which had been undertaken at RWT. The team supported the identification of measurements which could support the project being undertaken with a QI approach.

# Plans for Quarter 3 2022-23

Capacity & Capability

- Additional Trainers undertaking the Accreditation process for QSIR delivery
- Delivery of Health Care Systems Engineering mini-masterclass – a half-day session on improving patient flow in unplanned care.
- QSIR Practitioner, Fundamentals and Virtual cohorts subject to social distancing rules where needed
- Continued delivery of the 2022-23 Training Programme

Patient Flow

- Support work in Paediatric Assessment Unit prior to move to new building, a number of sessions have been set up
- Apply HCSE principles to a clinic in another specialty
- Facilitation workshop for the integrated Dermatology Service (Feb)
- Facilitation workshop for Pharmacy team – Medicines Management programme of work (Jan)

# Plans for Quarter 3 2022-23 continued

**Patient and Staff Safety**

- QI Huddle Board Train the Trainer to take place prior to larger roll out of Boards across WHT & RWT
- Support the Medicines Management Programme by ensuring a quality improvement approach is adopted and helps to structure what changes are made

**Other Developments**

- Further develop the Community of Practice to maintain interest in QI for delegates who have completed QI Training
- Continued implementation of the actions from the QI Board Action plan particularly focussing on the roll-out of huddle boards, arranging Divisional and Care Group Fundamental training sessions, linking Executive walkabouts with QI and marketing 'offer' for the QI team.
- Work more closely with the QI Team in Wolverhampton to develop a consistent offer across both organisations
- Recruit to the outstanding Divisional Clinical Lead posts
- Marketing strategy to encourage identification and registration of QI projects from across the divisions

| | | | |
|---|---|---|---|
| **Meeting of the Trust Board Committee<br>Wednesday 8th February 2023** | | | |
| **Director of Midwifery 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:<br>Approve ☐ Discuss ☒ Inform ☒ Assure ☒ | | |
| **Assure** | • 100% of women received 1:1 care in labour | | |
| **Advise** | • CQC patient survey results have been released and the service is working through an action plan. Results will be shared with staff and with the MVP.<br>• There were 2 SIs in December, 1 of which are being investigated via the HSIB.<br>• Managing acuity remains challenging due to staff sickness and maternity leave. | | |
| **Alert** | • | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | • BAF 1: Safe, high quality care<br>• 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 ☐ | | |

# Director of Midwifery Report

## 1. PURPOSE OF REPORT

The purpose of the report is to provide a monthly update to assure the Trust Board of the following items;

- Resource
- Patient experience
- 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 December 2022. The service has continued its active recruitment. Maternity leave is currently at 6.8% on delivery suite and there was in spike in sickness absence in December to 12.7%. absence was largely due to colds/ flu and covid. These absences contributed to the acuity data in graph 1 below.
The service currently have 18 internationally recruited midwives and are working to support their full integration. 10 of our internationally educated (Fellowship) midwives have now successfully registered with the NMC with the other 8 having dates in place to complete their OSCE.

Table 1

| | | | Annual Leave | Other Leave | Parenting | Sickness | Study Leave | Working Day | Total |
|---|---|---|---|---|---|---|---|---|---|
| Women's Services (Are) | Delivery Suite - Nursing | | | | | | | | |
| | | Registered Midwives | 15.5% | 1.4% | 6.8% | 12.7% | 1.7% | 1.1% | 39.3% |
| | | | | | | | | | |
| | | Unregistered Nurses | 15.1% | 2.1% | | 11.0% | 1.4% | | 29.6% |

## 2.2. Activity within the Maternity Unit

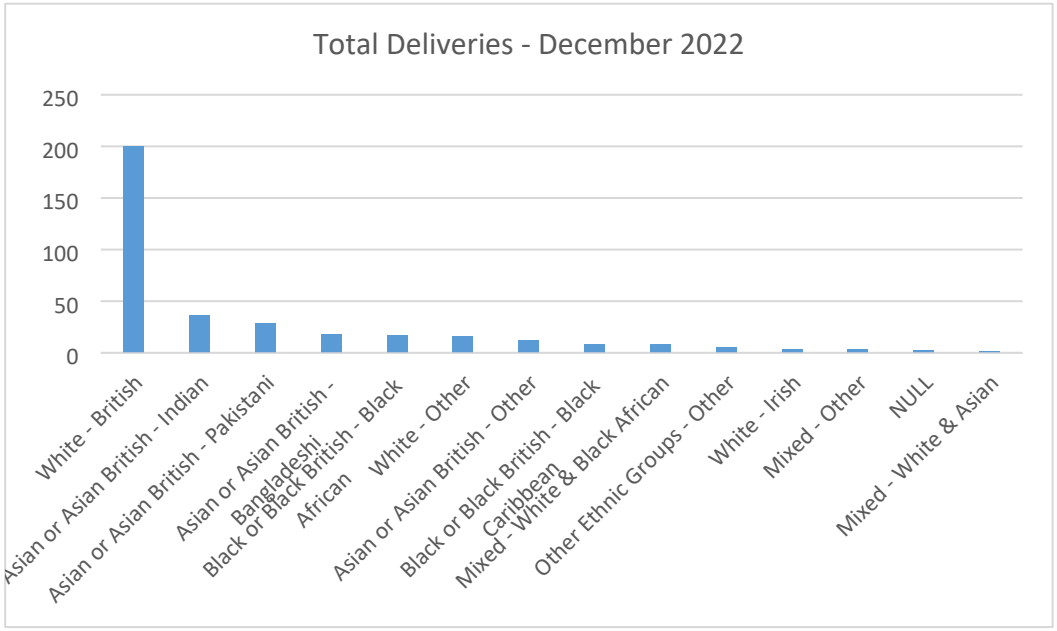
Table 2 highlights the delivery activity within Maternity Unit on a month by month basis.

December had the highest activity in a single month related to birth that the service has seen for over 2 years. Table 3 demonstrates the demographic data. The service was able to maintain 100% 1:1 care in labour by using it's escalation policy, this includes deploying specialist midwives and manager to support during periods of high acuity.

Table 2. Birth Activity

| Month | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sept 22 | Oct 22 | Nov 22 | Dec 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No: Births | 298 | 287 | 331 | 284 | 300 | 285 | 288 | 312 | 325 | 297 | 324 | 358 |

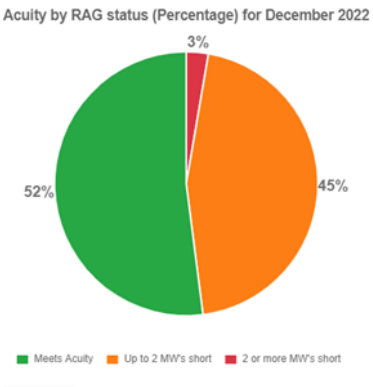
Table 3



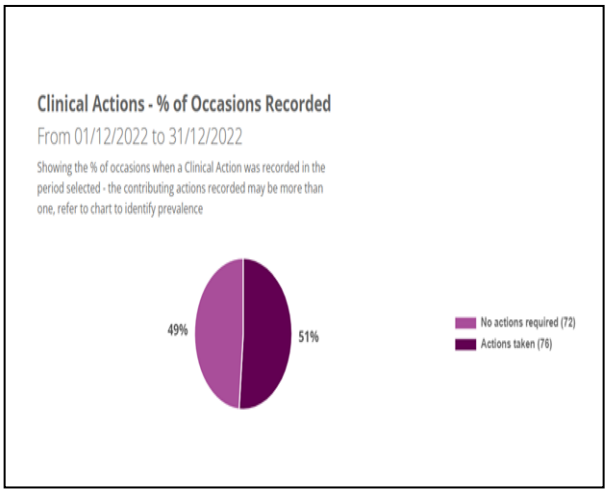

## 2.4 Acuity

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 Dec. was 52%. (See Graph 1). Graph 2 outlines that 49% of the time there was no action required and outlines that action was taken 51% of the period. Graph 3 outlines the specific actions taken to maintain safety. The main action taken is delay in induction of labour, please note this does not indicate 27 patients were delayed but relates to 27 episodes of delays at the time of the acuity being completed out of a possible 186 episodes. Graph 4 outlines the number of management actions taken.

Graph 1




Graph 2



Graph 3

## Number & % of Clinical Actions Taken

From 01/12/2022 to 31/12/2022

| | | | |
|---|---|---|---|
| CA1 | Decline in utero transfer | 2 | 2% |
| CA2 | Delay in accepting transfers | 0 | 0% |
| CA3 | Delay in commencing IOL as per trust guidelines | 8 | 9% |
| CA4 | Delay /cancel planned procedures e.g.ECV,Cervical suture | 0 | 0% |
| CA5 | Delay in transfer of cases to theatre e.g. perineal repair, MROP | 0 | 0% |
| CA6 | Delay EI. LSCS >24hrs | 2 | 2% |
| CA7 | Delay in continuing IOL as per Trust guideline | 74 | 86% |
| | Total | 86 | |

Graph 4

## Number & % of Management Actions Taken

From 01/12/2022 to 31/12/2022

| | | | |
|---|---|---|---|
| MA1 | Redeploy staff internally | 58 | 53% |
| MA2 | Redeploy from community | 0 | 0% |
| MA3 | Redeploy staff from training | 2 | 2% |
| MA4 | Staff unable to take allocated breaks | 12 | 11% |
| MA5 | Staff stayed beyond rostered hours | 5 | 5% |
| MA6 | Specialist midwife working clinically | 4 | 4% |
| MA7 | Manager/Matron working clinically | 3 | 3% |
| MA8 | Staff sourced from bank/agency | 0 | 0% |
| MA9 | Utilise on call MW | 0 | 0% |
| MA10 | Escalate to Manager on call | 25 | 23% |
| MA11 | Maternity Unit on Divert | 0 | 0% |
| | Total | 109 | |

## 3.0 Patient Experience

The CQC patient survey was published on the 11th January 2023. There has been steady improvement in some areas for the service although there continues to be a need to focus on areas in antenatal and care after birth. See data below. The service is working through an action plan and will also share the survey results with staff and the Maternity Voices Partnership (MVP). Please see full report and actions in appendix 1

Table 4

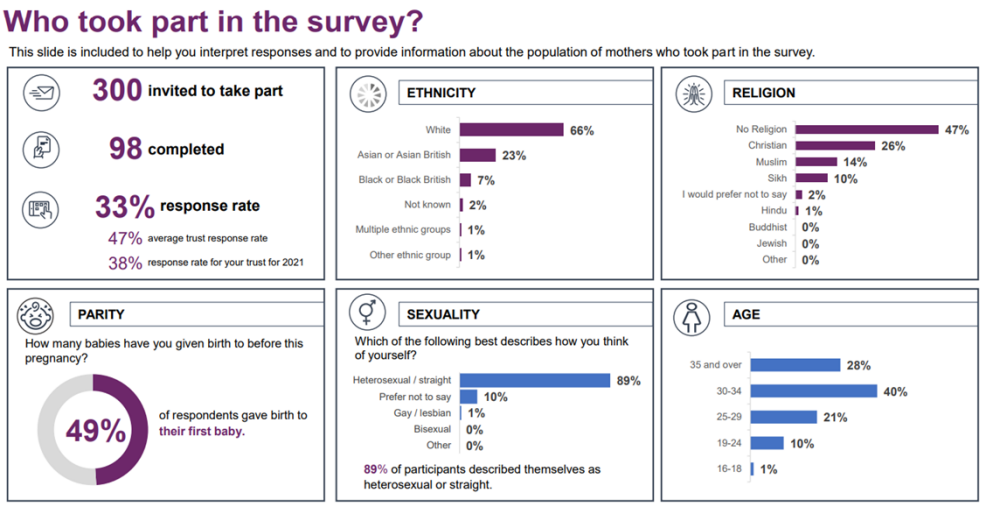
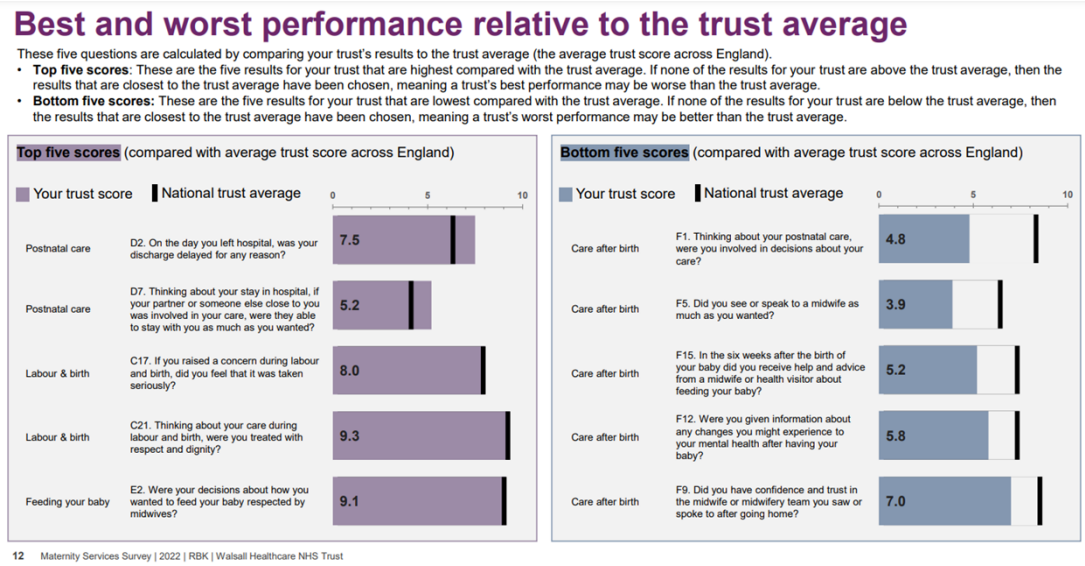


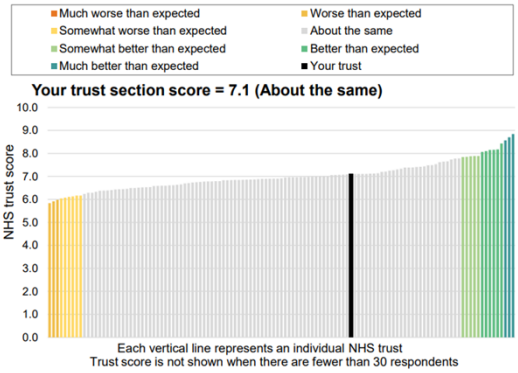

Table 5

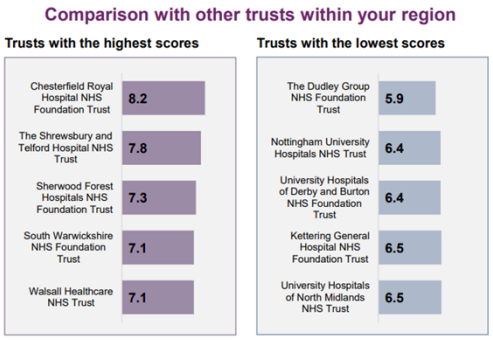


# Care in hospital after birth

## Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in hospital after birth' is calculated from questions D2 and D4 to D8. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



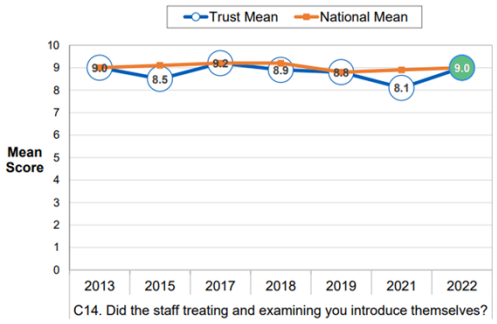



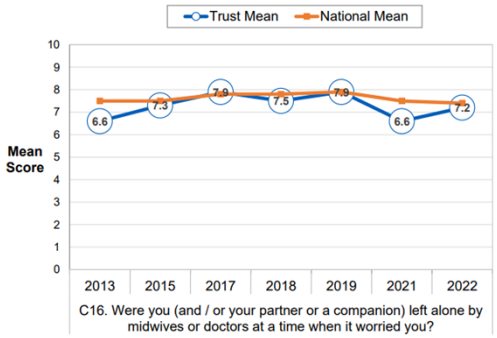



# Trends over time - Labour and birth

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

**Staff caring for you**



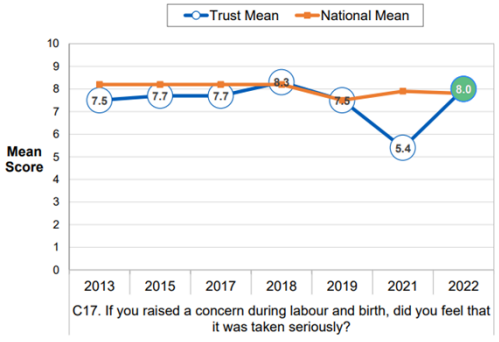

*This shows a significant increase in the trust mean for this question for 2022 compared to 2021*
*This shows a significant decrease in the trust mean for this question for 2022 compared to 2021*

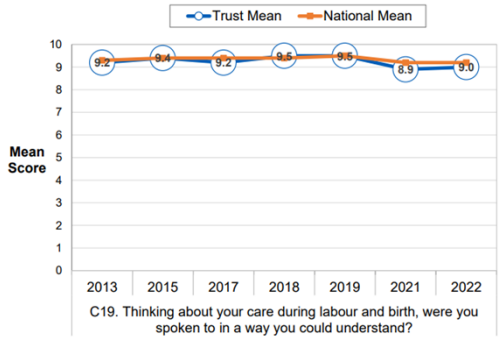


# Trends over time - Labour and birth

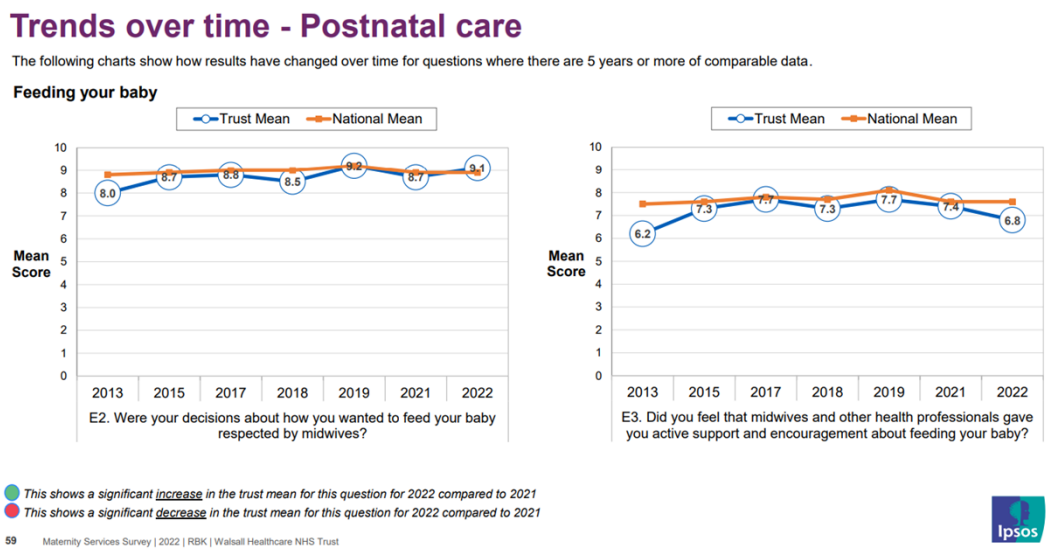
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

**The birth of your baby**




*This shows a significant increase in the trust mean for this question for 2022 compared to 2021*
*This shows a significant decrease in the trust mean for this question for 2022 compared to 2021*




## 4.0 Serious incidents

There were 2 serious incidents in December. 1 of which have been accepted for investigation by the HSIB.

## 5.0 RECOMMENDATIONS

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

Walsall Healthcare NHS
NHS Trust

# *Results from the CQC 2022 Maternity Survey*

Jo Wright, Deputy Director of Midwifery, Gynaecology and Sexual Health

Care for patients at home whenever we can

Support more patients to live longer and to be cared for at home whenever it is safe to do so

Walsall Healthcare NHS
NHS Trust

# Current position

National Maternity Survey 2021 sent to women in February 2022

34 questions
121 Trusts

302 mothers were included in the survey

98 respondents = 33% response rate

National Maternity Survey 2022 received 11.01.2023 disseminated to senior team 16.01.2023

# Patient experience is important

Good service user experience results in;

- *Higher levels of service user satisfaction*
- *Higher levels of staff engagement and satisfaction in their work*
- *Consistent positive associations between patient experience, patient safety and clinical effectiveness*
- *Enhance the reputation of the service provider*
- *Increased demand to access service due to positive experiences*

# *What were our results compared to other Trusts?*

- **The Trust was better than the average on 1 question**
- **The Trust was about the same as the national average on 34 questions**
- **The Trust scored worse than the average on 15 questions (this is overall)**

***much worse than most trusts for 2 questions**
***worse than most trusts for 5 questions**
***somewhat worse than most trusts for 8 questions**

# What were the main themes identified in the 2022 Survey

1. Choice
2. Involvement in care
3. Communication
4. Feeling safe

# The Trust was better by 10% or more than the average on 1 question

**On the day you left hospital, was your discharge delayed for any reason?**

There is an ongoing programme of quality improvement to strengthen the discharge process in maternity


Improve our financial health through our robust improvement programme

Walsall Healthcare NHS
NHS Trust

## The Trusts was about the same as the average for majority of questions

---

19 questions which showed an improvement in 2022 compared to 2021

4 Questions which showed a worse score in 2022 compared to 2021

3 Questions which showed the same score in 2022 compared to 2021

There was not data for comparison available on all questions


Improve our financial health through our robust improvement programme

Walsall Healthcare NHS
NHS Trust

# WHT was much worse to somewhat worse

**Were you offered a choice about where to have your baby?** ↓

**Did you get enough information from either a midwife or doctor to help you decide where to have your baby?** ↓

**During your antenatal check-ups, did your midwives listen to you?** ↑


Improve our financial health through our robust improvement programme

Walsall Healthcare NHS
NHS Trust

**Did you have confidence and trust in the staff caring for you during your antenatal care? (no comparison from 2021)** ↓

**At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?** ↑


Improve our financial health through our robust improvement programme

Walsall Healthcare NHS
NHS Trust

# Conclusion

- There has been a slight improvement on the Trust having less worse and much worse scores than 2021
- The scores in the category “results were about the same” have also shown an improvement on the 2021 scores
- There was no change on the number of categories that the Trust was better than other Trusts


Improve our financial health through our robust improvement programme

Walsall Healthcare NHS
NHS Trust

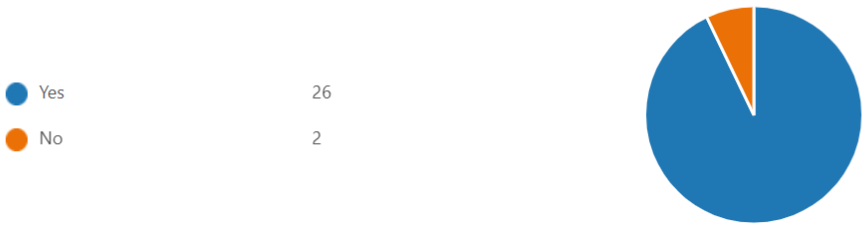
# Actions

- Disseminate the findings of the survey to all maternity staff groups
- Discuss results in all staff group meetings and divisional meetings
- Formulate an action plan to address any concerns raised in the CQC survey
- Repeat the survey with the question which were rated worse than other Trusts to sense check if there is any current improvement.

Experience of maternity care at Walsall Healthcare NHS Trust

28 Responses

1. During your antenatal check-ups, did your midwives listen to you?

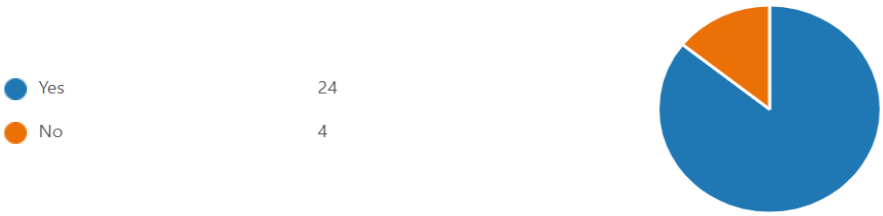



2. Responses

No one listened to me

Was inconsistent regarding being seen by someone who care and listened or someone who didn't

3. Did you have confidence and trust in the staff caring for you during your antenatal care?




4. Responses

My one midwife outstanding the one before caused tissue damage in my hands and after the good midwife in active labour no one listened to my wishes

I felt like my wishes an preferences were not take seriously and the care towards me was not very good

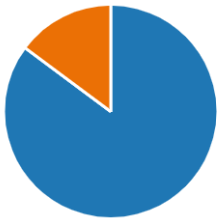
nobody seemed to no what to do

They would contradict themselves with everything they said

5. Did you get enough information from either a midwife or doctor to help you decide where to h baby?

More Details Insights

| | |
|---|---|
| Yes | 23 |
| No | 4 |



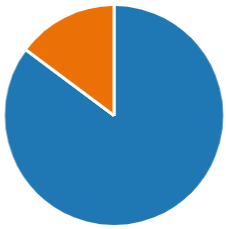
6.

| |
|---|
| Felt pressured to choose Manor Hospital as I was told that I wouldn't be able to go through with the first blood tests if I didn't choose Manor and would have to wait for an appointment. As it was the first time pregnant, I didn't feel confident enough to wait and wasn't reassured about choosing other options. |
| I expressed I wanted to be referred to good hope and this was not the case also it wasn't advised due to the cooling process my baby needed I could have been referred to a hospital able to provide this care (Postnatal) |
| They would only tell you to go research and let them know what you want |

7. Were you offered a choice about where to have your baby?

More Details Insights

| | |
|---|---|
| Yes | 23 |
| No | 4 |



| Q8 | Name | Responses |
|---|---|---|
| 1 | anonymous | As above. |
| 2 | anonymous | I had my baby on a bed where i stay for induction |
| 3 | anonymous | NA |
| 4 | anonymous | N/A. |

9. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

More Details  Insights

| | |
|---|---|
| Yes | 21 |
| No | 6 |

10.

Responses

**Responses**

| |
|---|
| Hospital told me I didn't pass the assessment questions so not in labour and to have a bath, I was in labour and bath made worse |
| Was given good advice and treatment in triage, however once in the ward, I didn't feel listened to. Labour had begun many hours prior, but the midwives on the ward seemed to think I was exaggerating the pain I was in. When they finally asked to check, I was 4cm dilated and had to be rushed to the delivery suite which was quite traumatic. Being on the ward during this whole time, when visitors were allowed, I struggled to manage the pain and was more focused on keeping as quiet as possible. I felt this situation could have been handled a lot better. |
| I was supposed to have a C-section which I still wanted and have been advised if the midwives had listened and done this c section me and baby would have been home with no issues instead I haemorrhage and my baby is in neonatal |
| I was in labour and I called the maternity Triage. They advised me to contact the community midwife and their lines are only open in the afternoon. |
| Because i was told different things by different people and no plan was really there |
| Most horrible and traumatic experience I have been through |

# Patient Experience Divisional Update

## Quality, Clinical Effectiveness and Safety

### Involvement

Women, partners and their families will be involved in all decisions that affect their childbearing journey.

As part of enhancing a woman and family centred service women, partners and families will be invited to participate in initiatives that impact on their care.

### Engagement

It is essential that women, their partner's and families are participants in shaping the care and the services we provide.

The Maternity Services Partnership will be central to help shaping and guiding our services.

Health care professionals at each point of contact will provide opportunities for service users to be part of the MVP and we will also gather their thoughts and ideas to enhance our services.

### Experience

Childbirth is a life event, the experience of which can have far reaching ramifications.

Healthcare professionals involved in maternity services will commit to having a shared vision with services users detailing what excellent care is.

Staff will be supported to achieve this to ensure that women, partners and families have positive experiences through every encounter with our service.

## Patient Voice

**Local and National Surveys – Friends and Family – Concerns, Complaints and Compliments**

# Patient Experience Divisional Update

## Improvement Pillar one – Involvement

Pillar one – Involvement

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

### Our Commitment to you:

1.Women will receive enough information from midwives and doctors to help them to decide where to have their baby.

2. Women will be offered a choice about where to have their baby. This will include birth on the delivery suite, the alongside midwifery led unit and homebirth.

3. The information that women receive will be available in a way that they can understand.

4. Information will be available to service users on several platforms.

5. The discharge planning process will commence on admission with assessment and planning to ensure that maternity services continue to provide timely discharge for women.

### How we will deliver this:

Ensure that the information that service users receive is easy to understand and delivered in a way they can comprehend be that language or educational attainment level.

Information that women receive must be evidence based and up to date so that they can make informed decisions about their care and preferences

Information will continue to be delivered in several ways: this will include verbal, via maternity electronic records, written and via smart devices

On admission and during their stay healthcare professionals and service users will confirm discharge planning and needs to ensure a smooth discharge process

### Measuring success

All groups with special characteristics will have information that meets their needs. This will be measured via patient feedback surveys with 95% being rated as good.

All patient information will be available via the maternity electronic records system and in written format tailored to individuals by July 2023

The maternity services website will have embedded the accessibility App Reachwell by July 2023

# Patient Experience Divisional Update

## Improvement Pillar two – Engagement

Pillar two – Engagement

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

### Our Commitment to you:

Respect that the time that women and their families have with us is valuable

During every contact with our services women and their families will be listened to and their thoughts feelings and concerns acted upon.

Ensure that the information we provide is consistent and not conflicting so that their is confidence in our services.

The MVP will work in close partnership with maternity servicesso that the voice of service users is front and central in decions around care ad planning

Do no harm to women and their families by maintaining clean and safe service user areas

Conduct Maternity Saftey Champions walks to give assureance the voice of women is heard

### How we will deliver this:

Wherever appointments will be joint so that women do not have to attend the hospital on numerous occasions.

There will be clear documentation of service user discussions within the maternity services records

Childbirth is an individual and subjective process, however information given to women must be in line with the local guidance where this does not exist national guidance.

Work along sidethe MVP in all aspects of the maternity services and Maternity Saftey Champions walks will take place monthly

Infection control, Health and Safety policies should be always adhered to.

### Measuring success

All appointment schedules to be reviewed in line with national guidance by July 2023

Documentation will be audited monthly with a focus on assessing if choice and information is being given to women with 95% being the standard for good.

Ensure there is a system in place by July 2023 electronic or manual that will display waiting times to service users.

The MVP meetings will take place monthly with service users and staff. The MVP lead will also meet with the DoM on a BIMonthly basis.

All ICP and Health and Safety controls to be adhered to, ICP measures should be at 95% and ICP training should also be consistently at 95% by September 2023

Monthly record and actions completed for Maternity Saftey Champions walks

# Patient Experience Divisional Update

## Improvement Pillar three – Experience

Pillar three – Experience

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

**Our Commitment to you:**

1. Women, their partners and families will have trust and confidence in the staff caring for them.

2. Women will be given appropriate advice and support when they contact a midwife or the hospital

3. Women, their partners and families will continue to experience timely discharge when ready to go home.

4. Ensure that there is a central point where all patient experience data and outcomes are collated and held.

**How we will deliver this:**

Sourcing customer service training so that all staff know what good customer care looks like and understand their responsibilities in marinating it

Benchmark maternity services against local and national services

Learnning and sharing experiences with our Local Maternity System.

Involing staff and service users in The Fifteen Steps for Maternity – Quality from the perspective of people who use maternity services programme

Ensure service user related feedback is accessable to staff feedback

Appoint patient experience lead to support service

**Measuring success**

Customer service training commenced by July 2023

90% attendance at the LMNS Engagement and Advisory forum

Complete Maternity 15 Steps assessment by July 2023

Appoint Patient experience Lead for Maternity by May 2023

All inpatient areas to display and disseminate patient experience data to staff and women by March 2023

95% of patients would recommend our services in the Friends and Family Test

We improve our rating in line with or better than other Trusts as per CQC Maternity Service Survey rating

| **MEETING OF THE PUBLIC TRUST BOARD**<br>**Wednesday 8th February 2023** | | | |
|---|---|---|---|
| Infection Prevention and Control Q3 Update | | | |
| **Report Author and Job Title:** | Amy Boden<br>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** | • The Trust are achieving targets with all Gram-negative bacteraemias | | |
| **Advise** | • The IPC Team have been supporting clinical teams towards the end of Quarter 3 following a significant increase in respiratory viral infections circulating in the community. | | |
| **Alert** | • There has been a continued increase in C.*difficile* toxin acute acquired cases. The Trust are currently over trajectory for the financial year.<br>• There is 1 MRSA bacteraemia to report for this financial year at end of quarter 3.<br>• Elements of the IPC BAF have been updated to reflect 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 | 9 |  |
| 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 | 12 |  |
| 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

### 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; 28% for Influenza and 24% for COVID (at 9.1.23). 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.

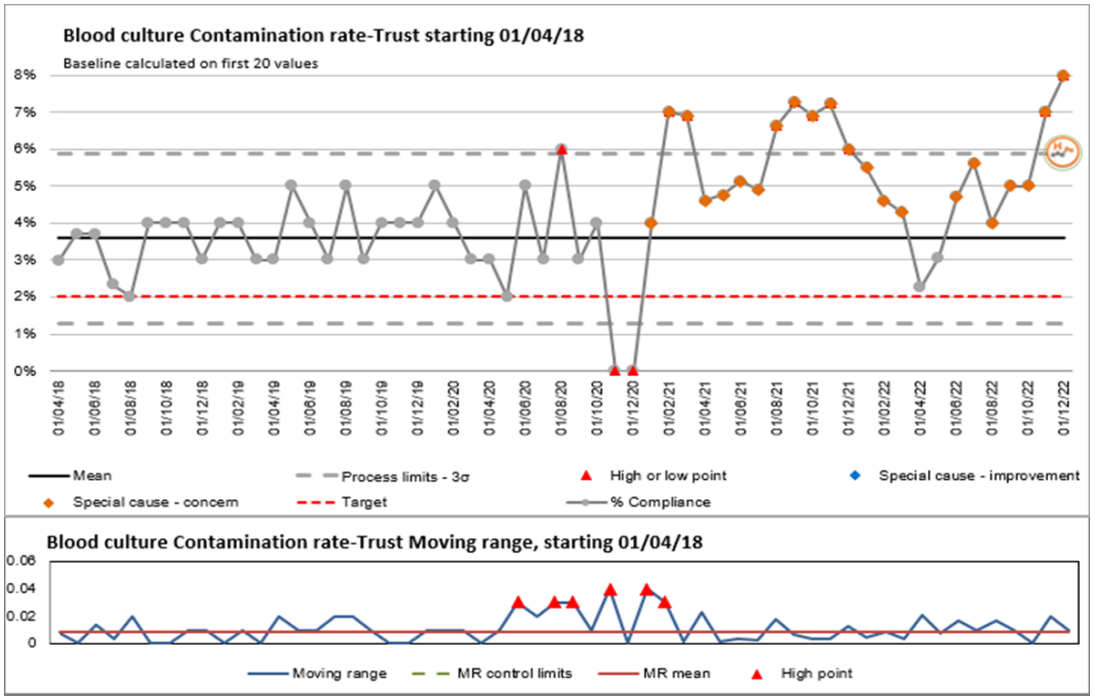
### Ability to isolate patients

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. From December, increasing challenges in isolation demand were observed due to increase presentations on a variety of seasonal respiratory viruses, predominantly COVID-19 and Influenza A, and also combined infections proving difficult to create appropriate cohorts.

Isolation or cohorting plans follow a robust, collaborative Respiratory Viruses Risk Assessment across Walsall Healthcare and Royal Wolverhampton. This is reviewed at the combined restrictions group meeting and includes actions that can be taken during extremis.

### Blood Culture Contaminants

There has been an increasing trend in blood culture contaminants at the Trust; this impacts on correct antibiotic treatment for patients presenting with sepsis, potential delays in treatment and impacts antimicrobial stewardship. The IPC Team have worked in combination with the Trust FORCE Team to improve competencies in individuals obtaining blood cultures, and are now scoping for other options to improve contaminant rates.



**Antimicrobial Stewardship**

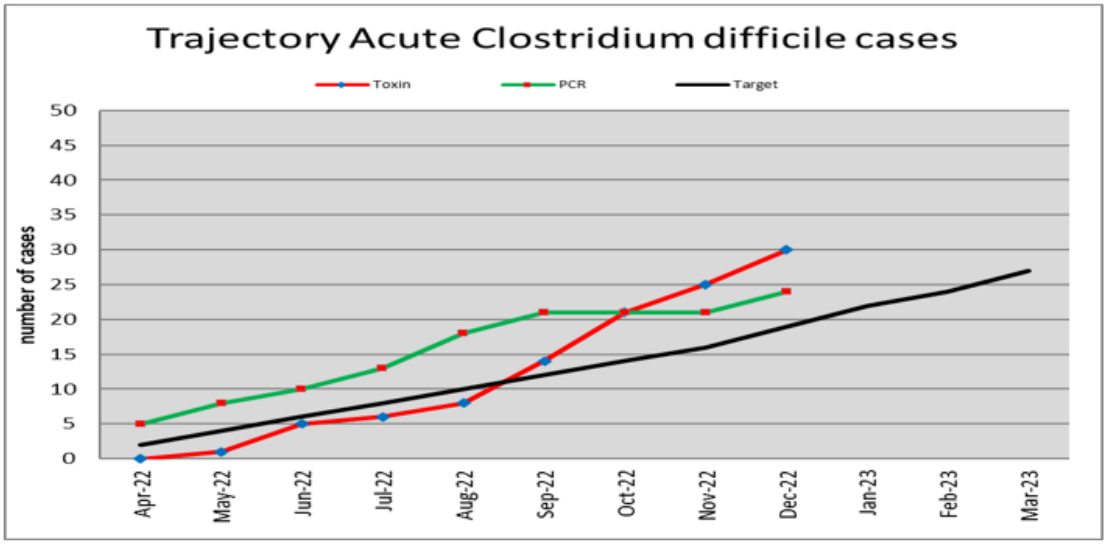
Recent investigations into health care associated *C.difficile* have identified improvements needed in antibiotic prescribing. This includes not meeting Trust MicroGuide standards when prescribing for hospital acquired pneumonia or urinary tract infections. The IPC Team in combination with the antimicrobial pharmacist and consultant microbiologist are supporting Qi projects to improve prescribing for these system infections. This has been registered with the Trust Qi Academy. A business case to prevent pneumonia is currently under review to implement a Mouth Care Team across Walsall Healthcare and Royal Wolverhampton.

**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 following a continued increasing trend in C.difficile cases since September 2022. Amongst cases in Quarter 3, a Period of Increased Incidence (PII) has been identified within MLTC division, with 3 cases with the same ribotyping (002).

| 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 | 4 | 5 | | | |
| 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 | 25 | 30 | | | |



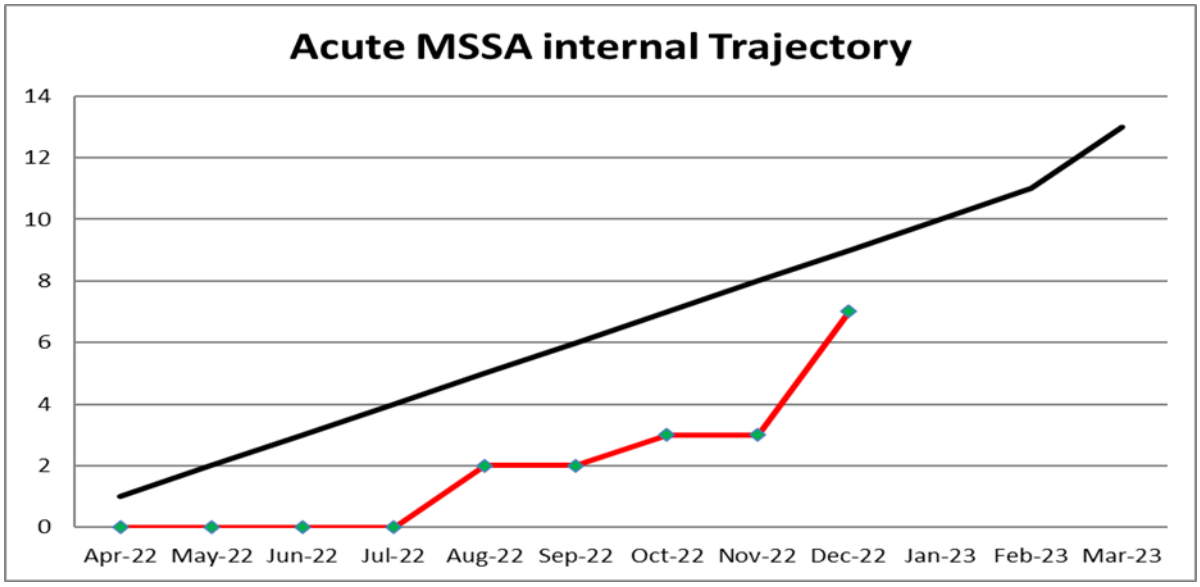

The IPC Team have undertaken a review of C.difficile cases and formally presented for the PII meeting. This has identified learning for ensuring stool samples are obtained from first episode of diarrhoea symptoms and prescribing improvements required as highlighted earlier in the report. The IPC Team are also recruiting 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 has been 1 MRSA bacteraemia this financial year, confirmed in December 2022. This was attributed to maternity services. The patient had been in hospital for 2 days prior to obtaining blood cultures. The post infection review highlighted blood culture contaminate as source of result. Learning identified included improvements in documentation of peripheral cannulas and VIP score monitoring at a frequency of three times a day. Details above in the report highlight improvements needed in blood culture contaminate rates at the Trust.

**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. There has been an increase observed in MSSA bacteraemias in December 2022. 1 case has been deemed unavoidable for a patient with multiple risk factors; the other 3 cases are scheduled for a cluster review with the IPCT in January 2023.




**Gram-negative Bacteraemias**

National target for E.coli bacteraemias at the Trust are 50 for the year. 26 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. 6 acute acquired cases have been reported for the financial year to date, with 2 cases for quarter 3.

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. The team are also working on a project to standardise approaches to urinary catheterisation through the introduction of a new product and education.

**Outbreaks and Incidents**

COVID-19: 110 bay closures for COVID-19 contact monitoring have taken place during Quarter 3. Bays are restricted to closely monitor contacts and enhance IPC restrictions.

Influenza: 20 bay closures for Influenza contact monitoring have taken place during Quarter 3. Bays are restricted to closely monitor contacts, assess for prophyalxis and enhance IPC restrictions.

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. In December 2022, NHSE published Influenza Management principles; these have had a full review from the collaborative Infection Prevention Teams and are incorporated in the combined risk assessment.

MRSA: An MRSA outbreak is ongoing on Ward 3 at time of report. There are a total of 13 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 IPC team are working with facilities to develop a bed team cleaning service to enhance cleaning of beds and bedside equipment, to minimise indirect transmission of organisms.

**End of Report.**

| MEETING OF THE PUBLIC TRUST BOARD – [insert date of meeting] | | | |
|---|---|---|---|
| CQC Inspection Report | | | |
| **Report Author and Job Title:** | Cody Long<br>Group Deputy Director of Assurance | **Responsible Director:** | Kevin Bostock<br>Group Director of Assurance |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☐ Discuss ☐ Inform ☒ Assure ☒ | | |
| **Assure** | • The CQC inspected the trust from September to November 2022 in the core services of: Children and Young People, Medical Care and Surgery and Well Led.<br>• | | |
| **Advise** | • Following factual accuracy and rating challenge for surgery the trust received the final published report 25 January 2023. | | |
| **Alert** | • The published report evidences the following change in profile:<br>• ***Medical Care*** *– From Inadequate to Requires Improvement*<br>• ***Surgery*** *- From Requires Improvement to Good*<br>• ***Childrens and Young People*** *– Remained the same – Good*<br>• ***Well Led*** *– Remained the same – Requires Improvement*<br>Report for information- appendix 1 | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | This report provides information in relation to monitoring the progress against:<br><br>BAF 1: Safe, high quality care | | |
| **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** | Excel in the delivery of Care | a) Embed a culture of learning and continuous improvement<br>b) Prioritise the treatment of cancer patients<br>c) Safe and responsive urgent and emergency care<br>d) Deliver the priorities within the National Elective Care Strategy<br>e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations | |
| | Support our Colleagues | a) Be in the top quartile for vacancy levels<br>b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing<br>c) Improve overall staff engagement<br>d) Deliver improvement against the Workforce Equality Standards | |

# Walsall Healthcare NHS Trust

## Inspection report

Moat Road
Walsall
WS2 9PS
Tel: 01922721172
www.walsallhealthcare.nhs.uk

Date of inspection visit: 20 September 2022, 04 October 2022, 05 October 2022, 09 November 2022, 10 November 2022
Date of publication: N/A (DRAFT)

## Ratings

| Overall trust quality rating | Requires Improvement |
|---|---|
| Are services safe? | **Requires Improvement** |
| Are services effective? | **Requires Improvement** |
| Are services caring? | **Outstanding** |
| Are services responsive? | **Requires Improvement** |
| Are services well-led? | **Requires Improvement** |

# Our findings

## Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Overall summary

**What we found**

### Overall trust

Walsall Healthcare NHS Trust provides local general hospital and community services to around 260,000 people in Walsall and the surrounding areas. The trust is the only provider of NHS acute care in Walsall, providing inpatients and outpatients at the Manor Hospital as well as a wide range of services in the community.

Walsall Healthcare NHS Trust is working in collaboration with the Royal Wolverhampton NHS Trust under the leadership of a joint chair and chief executive.

Between 20 September 2022 and 10 November 2022, we carried out an unannounced inspection of three of the acute services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

We inspected Children and Young Persons services using our focused inspection methodology. We also inspected Medical and Surgical services. We inspected these services, at Manor Hospital, as our intelligence suggested there may have been a deterioration in the safety and quality of care provided. In addition, in Medical services, we needed to follow up a section 29a warning notice, issued to the trust in March 2021, as we found significant improvement was required to the nurse staffing of the service, the governance of the service and how they provided patients with a safe discharge.

We did not inspect any other services at Walsall Healthcare NHS Trust because our monitoring process had not highlighted any concerns. We will re-inspect these services as appropriate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed ‘is this organisation well-led’. We inspected the well-led key question between 9 and 10 November 2022. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England. There was not a separate ‘Use of Resources’ assessment in advance of this inspection.

# Our findings

Following our core service inspection, we served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify the trust that the Care Quality Commission had formed the view that the quality of health care provided by Walsall Healthcare NHS Trust in relation to the management of medicines, including prescribing, administration, recording and storage, in Medical services required significant improvement.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement and caring as outstanding.
- We rated two of the trust's acute services as good and one as requires improvement.
- In rating the trust, we took into account the current ratings of the five acute services and four community services not inspected this time.
- Safe processes and systems were not always in place to manage the prescribing, administration and storage of patients' medicines and medicine related documents. Services did not always control infection risk well. Care records were not always complete. In the Surgery service staff did not always assess risks to patients in relation to venous thromboembolism (VTE).
- In the Medical Care service, arrangements to ensure assessment of patient's mental capacity or deprivation of liberty were not robust.
- Services for children and young people did not always take account of patients' individual needs.
- Service leaders did not always run services well and information systems were not always reliable.

However:

- We found improvements during our inspection of how well led the organisation was.
- Services mostly had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff mostly assessed risks to patients and acted on them. Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided kind care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and had access to good information. Key services were available seven days a week.
- Across all services staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Although people could not always access the service when they needed it, the trust was working hard to ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- Services planned care to meet the needs of local people and made it easy for people to give feedback.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

# Our findings

**How we carried out the inspection**

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Outstanding practice

We found the following outstanding practice:

**Trust Wide**

- The trust had worked with system partners to increase employment opportunities for people in the community who were long term unemployed and people from ethnic minority groups.
- A team effort to ensure gold standard care for patients with hip fractures had resulted in a national award for the trust which was now rated as second best in the region for its service.
- There was exceptional performance in the emergency department at Walsall Manor Hospital where the trust had some of the highest same day emergency care (SDEC) rates in the country and consistently the lowest ambulance handover delays in the region.
- Patient, carer and public engagement and involvement was exemplary.

**Manor Hospital**

**Children and Young Persons**

- The patient experience used the 15-step challenge tool to improve patient experience. This included children in developing the tool and participating in order that their views and contributions were heard and valued.

**Medical**

- The diabetes service had received several awards for improvements for care of people admitted to hospital with diabetic emergencies.

**Surgical**

- The service received a clinical audit award from the healthcare quality improvement partnership for work on the trust's neck of femur (NOF) pathway. This was an improvement as the trust had recently been a (NOF) outlier.

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the trust MUST take to improve**:

# Our findings

We told the trust that it must take action to bring services into line with three legal requirements. This action related to two core services and trust wide.

**Manor Hospital**

**Trust Wide**

- The provider must ensure all levels of governance and management function effectively and interact with each other appropriately and there is a risk management framework in place that ensures there are assurance systems in place, and performance issues are escalated appropriately through clear structures and processes. Regulation 17: Good Governance.
- The provider must ensure they act in an open and transparent way with people receiving care or treatment from them and apply the duty of candour for notifiable safety incidents. Regulation 20: Duty of candour.

**Medical**

- The provider must ensure safe process and systems are in place to manage the prescribing and administration and storage of patients' medicines including medicine related documents. Regulation 12: Safe care and treatment.
- The provider must ensure there are appropriate systems in place to ensure infection control risk is minimised. Regulation 12: Safe care and treatment.
- The provider must ensure the design, maintenance and use of facilities and premises keep people safe. Regulation 12: Safe care and treatment.
- The provider must ensure staff identify and quickly act upon patients at risk of deterioration. Regulation 12: Safe care and treatment.
- The provider must ensure records of patients' care and treatment are complete, clear and are stored securely and provide all required information for staff providing care. Regulation 12: Safe care and treatment.
- The provider must ensure patients who lacked capacity to make their own decisions or were experiencing mental ill health were appropriately supported and measures to limit patients' liberty were appropriately applied. Regulation 11: Need for consent.

**Surgical**

- The provider must ensure that venous thromboembolism assessments are carried out. Regulation 12: Safe care and treatment.

**Action the trust SHOULD take to improve:**

**Trust wide**

- The provider should ensure work continues to increase the uptake of training developed and released by the National Guardian Office (NGO).
- The provider should ensure work continues to progress the digital agenda.
- The provider should ensure a quality strategy is in place to provide a framework to build, standardise and innovate in order to deliver high quality, safe and effective care, and a positive patient experience.

# Our findings

- The provider should ensure work continues to increase compliance with the duty of candour regulation.
- The provider should ensure work continues to strengthen the work of the sub-committees and non-executive directors in order to ensure all levels of governance and management functioned effectively and interacted with each other appropriately.
- The provider should ensure work continues to develop supplementary plans to give assurance that the financial plan would be delivered.
- The provider should ensure work continues to develop a risk management framework that would ensure there were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes.

**Manor Hospital**

**Children and Young Persons**

- The provider should ensure all staff recovering paediatric patients in the theatre recovery area are trained in either paediatric immediate life support (PILS) or, European paediatric advanced life support (EPALS).
- The provider should ensure the voice of the child is consistently captured in the records.
- The provider should ensure the outpatient's department has an appropriate number of nurses available to staff the outpatient's clinics.
- The provider should ensure patient records are consistently completed on all wards.
- The provider should ensure systems and processes are in place on ward 21 to safely store medicines.
- The provider should consider engaging staff in safeguarding supervision.
- The provider should consider reviewing outpatient appointments for children and young people to avoid appointments late in the evening.
- The provider should consider reviewing the environment in the outpatient's department to make it child-centred.

**Medical**

- The provider should ensure doctors, nurses and other healthcare professionals work together as a team to benefit patients and support each other to provide good care.
- The provider should ensure staff use an appropriate tool to help assess the level of pain in patients who are non-verbal.
- The provider should ensure to ongoing checks on the effective management of venous thromboembolism assessment.
- The provider should ensure the sepsis audit includes all key management measures for sepsis as identified within the trust policy.
- The provider should ensure timely psychosocial assessments and risk assessments are completed for patients thought to be at risk of self-harm or suicide.
- The provider should ensure there are appropriate arrangements in place when a patient is transferred between wards and other clinical staff to keep them safe.

# Our findings

- The provider should ensure the policy which includes the management of younger people between 16 and 21 years is reviewed and is shared with staff to ensure best practice is followed.
- The provider should ensure the programme to complete mandatory training which includes safeguarding adults and children level 3 and basic life support is completed.

**Surgical**

- The provider should ensure that patient weights are consistently recorded on drug charts.
- The provider should ensure all staff adhere to infection prevention and control practices.
- The provider should consider safe storage of equipment in theatres.
- The provider should ensure there is a robust system in place to improve monitoring of post-operative complications.
- The provider should ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line with national standards.
- The provider should ensure enough suitably qualified nursing staff are available on every shift to keep people safe.

## Is this organisation well-led?

**Requires improvement**

Our rating of well-led stayed the same. We rated it as requires improvement.

- Not all leaders had the necessary capacity to lead effectively, succession planning was in its infancy and the stability of the board was under development.
- There was no quality strategy in place providing a framework to build, standardise and innovate in order to deliver high quality, safe and effective care, and a positive patient experience. This was planned to be in place by January 2023.
- Work was underway to ensure all staff felt knowledgeable, encouraged and supported to raise concerns and the culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents.
- Governance processes were in place throughout the trust and with partner organisations. However, these were in their infancy with some leaders not yet clear about their roles and accountabilities.
- Systems to manage performance effectively were under review. Relevant risks and issues and actions to reduce their impact had been identified but there was work to do to ensure they reflected the strategic objectives realised through the group strategy.
- Work was underway to ensure the board collected reliable data and analysed it. Technology improvements were in their infancy, with some not yet realised meaning staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

However:

# Our findings

- Overall, leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders had regular opportunities to meet, discuss and learn from the performance of services.
- The trust had plans to cope with unexpected events. The board were clear that their decision-making avoided financial pressures compromising the quality of care.
- Information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. The trust collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

### Leadership

**Overall, leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, not all leaders had the necessary capacity to lead effectively, succession planning was in its infancy and the stability of the board was under development.**

The trust was run by the chair and a board of directors made up of 13 executive (ED) and nine non-executive directors (NED). Of these, five executive directors and six of the non-executive directors were voting members of the trust board.

Leaders described the board as a unitary board with the EDs and NEDs making decisions as a single group and sharing the same responsibility and liability. However, during some of our well led interviews we found a lack of clarity regarding roles and responsibilities of some board members and an element of discord between some board members. In addition, the stability of the board was uncertain with several new appointments under the semblance of a group appointment and seven NEDs due to end their tenure of appointment in 2023.

Overall, leaders had the skills, knowledge and experience that they needed, both when they were appointed and on an ongoing basis and were united in their understanding of the challenges to quality and sustainability. Leaders were in the process of identifying the actions needed to address challenges.

Leaders understood and managed the priorities and issues the service faced. There was a good understanding of the challenges of mental health needs in the population and work was underway with local mental health partners to respond to the increased demand for mental health support in the population.

# Our findings

In 2021/22, the directors individually updated their declarations to confirm continuing compliance with the Fit and Proper Person test. The trust had implemented the current required standards for Fit and Proper Person checks, including declarations, periodic Disclosure and Barring Service (DBS), periodic fit and wellness checks, appraisals and cross-checking with other information in the public domain.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of three executive directors and three non-executive directors to determine the necessary fit and proper person checks had been undertaken. We found all files were fully compliant with FPPR.

Leaders were visible and approachable in ward and department areas. During our core service inspections, we heard many examples where EDs and NEDs had visited clinical areas. Recently the senior nursing teams had introduced an idea called #BackToTheFloorFriday across both organisations, Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust. The ask was that senior nurse leaders cleared their diaries on Fridays wherever possible to be out and about in clinical areas, visiting, auditing or undertaking a clinical shift and overseeing care and listening and supporting patients and staff.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership including for example, development programmes in place for leaders at all levels across the organisation and regular board development days.

A succession plan was in place however, this was in its infancy. A number of NEDs were coming to the end of their term in 2023 and the trust was actively recruiting to replace them.

### Vision and Strategy

**The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. While there was no quality strategy currently in place, this was planned to be in place by January 2023.**

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The trust was guided by four strategic objectives which combined to form the overall 'vision' for the organisation. Underpinning these were the trust's values, a set of individual behaviours that were in place to guide staff in order to deliver effective care for all.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners. Senior leaders engaged with staff to agree the values and individual behaviours that they wished to project in their working environments. During our core service inspections, staff told us they knew and understood what the vision, values and strategy were, and their role in achieving them.

The trust recently revised their vision 'to deliver exceptional care together to improve' to reflect the trust's ambition for safe integrated care, delivered in partnership with social care, mental health, public health and associated charitable and community organisations.

There was a strategy for achieving the priorities and delivering good quality sustainable care. The trust's five-year strategy (2022-2027) was a joint strategy for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). It reflected the closer working relationship between the two trusts under the leadership of a joint chair and

# Our findings

chief executive. The strategy was based around four strategic aims, referred to as the Four Cs: Care, Colleagues, Collaboration and Communities and incorporated feedback from colleagues working for both organisations as well as the public and external stakeholders. For example, the integrated care board and other providers. The strategic aims were underpinned by strategic objectives; more specific measures used to measure achievement.

The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The trust had recognised that the communities of Wolverhampton and Walsall often had poorer health outcomes than the nation as a whole and were characterised by some of the highest levels of deprivation. Life expectancy was generally lower and many risk factors associated with poor health (for example, physical inactivity) were higher. Through the strategy the trust was committed to positively contributing to the health and wellbeing of the communities served and delivering action on health inequalities.

There were systems in place to monitor and review progress against delivery of the strategy and local plans. It was to be the role of the sub-committees to routinely monitor the achievement of the strategic aims and objectives, reporting into the trust board.

There was no quality strategy in place. We were told this was under development and there were plans to have a quality strategy in place by January 2023. A quality strategy would provide a framework to build, standardise and innovate in order to deliver high quality, safe and effective care, and a positive patient experience.

### Culture

**Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. Work was underway to ensure all staff felt knowledgeable, encouraged and supported to raise concerns and the culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents.**

Most staff felt supported, respected and valued and felt positive and proud to work in the organisation. We saw during our core service inspections, there were cooperative, supportive and appreciative relationships among staff. Feedback from staff was largely positive with staff speaking highly of the executive leadership team. The inclusivity and leadership culture, whilst improved from our last inspection, still had a way go and there was a framework in place to deliver this.

Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. We saw improvements had been made with the safety culture, with staff feeling encouraged to report patient safety incidents. This included knowing what to report and feeling confident to report. However, there were still improvements to be made in relation to ensuring systems were used effectively and that staff understood and learned when things did not go to plan.

The culture centred on the needs and experience of people who use services. People who used the service and others were involved in regular reviews of how the service managed and responded to complaints.Complainants were given the option of being involved in actions identified as part of their complaint and going forward this was to be an "opt in" as part of the trust's final response letters. Complainants were also given the option of sharing their story as a "lived experience" and becoming a part of the Patient Involvement Partner (PIP) programme, which was led by the patient experience team.

# Our findings

In August 2021 the trust enrolled in the Parliamentary and Health Service Ombudsman (PHSO) early adopter scheme, as part of which, they were given access to the PHSO model complaints handling policy, as well as a maturity matrix to help the trust identify areas for improvement.

During 2021/22 a total of 4082 contacts were received by the patient relations team which included a total of 361 written complaints. This included nine informal to formal complaints and four Member of Parliament (MP) letters (an increase of 81 complaints overall for the year compared to 2020/21) and an average of 16 contacts per working day.

The total number of complaints resolved was 371, with 27 complaints upheld, 116 not upheld and 213 partially upheld. Seven complaints were withdrawn within this period.

The patient relation team were committed to 'getting it right first time' with their complaint responses, this was evidenced by their low numbers of reopened complaints; 27 complaints were re-opened between April 2021 and March 2022 which equated to 7.2%.

During our inspection of well led we reviewed five complaint responses. All responses were clear and transparent throughout. We noted that responses to complaints were very empathetic and compassionate. It was clear from our review of complaints that there was a definite focus on the patient and/or their loved ones.

Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. Sickness absence was monitored and reported each month through the governance framework. Particular challenges were addressed through bespoke support and through management and human resources interventions.

Through our well led interviews, we heard some examples of excellent working to secure the future workforce of the organisation. We saw examples of an innovative and sustainable approach, working with partners, which had brought benefits to the community and economy.

The culture did not always encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.

For the reporting period October 2021 to September 2022, compliance with the duty of candour regulation had been variable (stage one compliance 69%, stage two compliance 38%). The board was sighted on the improvement work which was required in record keeping for duty of candour and accessibility of the data for audit. Professional duty of candour was required to be recorded in the patient medical records, making this a mandatory field on the new governance risk and compliance system which was in the implementation phase and was to be functional from January 2023.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken as a result of concerns raised. The trust had 1.8 whole time equivalent Freedom to Speak Up Guardians (FTSUG). Trained through the National Guardian's Office (NGO), the FTSUG service supported colleagues to escalate patient and staff safety concerns which when appropriately addressed contributed to establishing a culture of openness and safety. A FTSUG coordinator and nine confidential link staff supported the team.

# Our findings

The Freedom to Speak Up (FTSU) index is a metric for NHS trusts, drawn from four questions in the NHS annual staff survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident. The 2021 FTSU index score for this trust was 74.4% and below the national average of 79%. The FTSUG team felt this score may well have been attributed to a new executive leadership team and increased activity following the COVID-19 pandemic.

A new speaking up question was included in the 2020 NHS Staff Survey. The question asked respondents whether they feel safe to speak up about anything that concerns them in their organisation. The results of this question also showed a strong positive correlation with the FTSU index. In this trust, 59% of staff responded positively to the question. These cultural metrics indicated the organisation would have to improve speak up culture in order to contribute to establishing a culture of openness and safety.

The number of concerns raised through contact with the trust's FTSUGs for the period 1 April 2022 to 30 June 2022 was 23 of these, 20 cases related to a behavioural element. For example, worker safety/wellbeing, bullying or harassment and other inappropriate attitude or behaviours).

Two training modules had been developed and released by the National Guardian Office (NGO). This e-learning package was available to all NHS trusts. The purpose was to raise awareness of and the value of speaking up in improving the safety culture within an organisation. In this trust, the modules had been included in a suite of training that could be accessed via mobile devices however, only four per cent of the workforce had undertaken the Speak Up or Follow Up training as recommended by the NGO. Leaders had oversight of training compliance and significant work was in progress to increase the uptake of this training.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. However, no area had achieved the trust target of 90% compliance. Overall trust performance for appraisal (PDR) compliance as of September 2022 was 81%, compliance in three areas was 50% or less. These included, the governance directorate, the operations directorate and transformation and strategy.

There was a strong emphasis on the safety and wellbeing of staff. In November 2021 the trust was successful in being awarded £25,000 from the NHS England and Improvement (NHSE/I) Voluntary Services Fund. The funding was granted on the basis that the trust supported staff wellbeing through volunteer roles and involvement. The NHSE/I team reviewed the range of projects funded and had selected the volunteering projects at Walsall Healthcare NHS Trust as an area to celebrate and highlight.

Equality and diversity were promoted within and beyond the organisation. The trust's aim was to ensure the diverse needs of patients, partners, communities, service users and staff were provided for and that patient involvement and experience when using services and the reputation of the trust as a place to work was improved. The board was committed to further improve workforce performance and culture and had signed up to a pledge:

*"We, your Trust Board, pledge to demonstrate through our actions that we listen and support people. We will ensure the organisation treats people equally, fairly and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you".*

# Our findings

The trust's equality, diversity and inclusion (EDI) plan described the vision and direction when implementing equality and diversity and inclusion within the trust both for service users and workforce. Developed in 2021, the plan set out aims and objectives and key priorities for the trust. The plan was continuously reviewed to align with the trust's improvement programme. The next step was to work with stakeholders to co-create the action plan that would support the delivery of EDI outcomes.

The governance and accountability frameworks in place within the trust were used to measure and evaluate performance on the action plan developed to support the EDI plan. This took place through the EDI Group which was a multi-disciplinary staff group including EDI champions, patient experience lead, staff side representatives and executive lead and was chaired by a non-executive director (NED) of the trust board. The people and organisational development committee which was a sub-committee of the trust board had oversight and reviewed progress on a regular basis in order to provide assurance to the trust board.

The trust had made significant improvements in the workforce indicators of the Workforce Race Equality Standard (WRES). Workforce demographics as of April 2022 showed, 32% of the workforce were from ethnic minority groups. This was currently higher than the ethnic minority population in Walsall which was approximately 23.1%. In addition, the trust had made significant improvements in relation to workforce representation of colleagues from ethnic minority groups at a senior level (Band 8a and above). This had significantly increased overall within the trust over a two-year period from 18.0% in 2020 to 25.5% as of 31 March 2022.

However, not all staff, including those with particular protected characteristics under the Equality Act, felt they were treated equitably. WRES data showed, in all four of the National NHS Staff Survey indicators, staff from ethnic minority groups were treated less favourably than their white counterparts. To continuously improve the trust's approach to EDI, the trust had identified key areas of focus and included for example; increased focus on improving the WRES /WDES (Workforce Disability Equality Standard) staff survey cultural indicators (reducing incidences of bullying, harassment and abuse and discrimination).

### Governance

**Governance processes were in place throughout the trust and with partner organisations. However, these were in their infancy with not all staff clear about their roles and accountabilities. Leaders had regular opportunities to meet, discuss and learn from the performance of services.**

Governance structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were in their infancy. During our interviews with executives, it was clear there was an understanding of what needed to be the focus to drive assurance at board.

Leaders were enthusiastic about the direction of travel, not only for the trust but for the system as a whole and had taken steps to address shortfalls and had started to put arrangements in place that would provide the information and assurance needed. This included system-wide training across the Integrated Care System (ICS) ensuring staff at all levels were clear about their roles and understood what they were accountable for, and to whom and ensuring the right people were in the right role.

NHS England and Improvement had carried out a trust wide review of accountability and governance in March 2020 and a limited scope governance review of the Surgery division in September 2021. The themes (structures, data / technology, leadership / accountability / strategy, culture / engagement, risk and improvement) from the two NHS England and Improvement reports had local action plans that had been mapped and were included in previous CQC requirements as well as local action plans and the governance function repurposing work that was underway.

# Our findings

The governance function had been reviewed in the last ten months with a co-design and engagement process including representatives from NHS England and Improvement and commissioners, The Royal Wolverhampton NHS Trust, the trust's central governance team, and divisional leadership teams. This had resulted in a redesign and business case.

The improvements included a complete governance team restructure, technology improvements with an electronic governance risk and compliance system and patient safety system for quality standards monitoring, audit, quality Improvement and policy management.

There were also plans to create 'golden thread' dashboards at five levels, department, care group, division, trust, and the two trusts (group). This would ensure that consistent data was collected, interpreted, acted upon, and escalated for decision with clarity from floor/ward to board.

The alignment work between the trusts was to result in a group assurance function incorporating governance and risk. The previous governance frameworks for each trust were to be replaced by a group wide assurance framework which was currently under development and consultation, this was to ensure uniform delivery and oversight across both organisations. A Gantt chart, project management tool, was in place to monitor and review progress.

Throughout our well led interviews we were told further work was needed to strengthen the work of the sub-committees and non-executive directors in order to ensure all levels of governance and management functioned effectively and interacted with each other appropriately. Much of the scrutiny of performance and quality of care was undertaken through meetings of the board's sub-committees; performance and finance, quality and safety, people and organisational development and research, digital and innovation. In addition, committees in common were in place ensuring scrutiny of performance at a group level.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The trust worked in partnership with 14 other health and care organisations as part of the Healthier Futures Integrated Care System (ICS) serving 1.5 million people in the Black Country and West Birmingham. Working with other key partners, people and communities, the partnership aimed to improve the health and wellbeing of local people by working together. Working as part of the ICS was Walsall Together; a partnership of health, social, housing, voluntary and community organisations that were working together to improve physical and mental health outcomes, promote wellbeing and reduce inequalities across the borough.

**Financial Governance**

The trust had set a financial plan to break even in 2022-23. The achievement of this plan was recognised as being a challenge and risks had been flagged, although there had not yet been agreement to change the forecast. The trust was developing supplementary plans to give assurance that the financial plan would be delivered.

The finance team appeared well-embedded in the trust's operational divisions and relationships both internally and at place level were said to be good. The term 'place' refers to the geographical level below an ICS at which most of the work to join up budgets, planning and service delivery for routine health and care services (particularly community-based services) will happen. The team leveraged their ability to respond by working in collaboration with group colleagues at the Royal Wolverhampton NHS Trust.

The trust had a private finance initiative (PFI) and also a large retained estate. It had a significant backlog maintenance requirement for its size at more than £27m; and limited capital resources for rectification. In addition, we were told that the trust was in active debate with its PFI provider about structural works to give assurance about fire safety.

# Our findings

## Management of risk, issues and performance

**Systems to manage performance effectively were under review. Relevant risks and issues and actions to reduce their impact had been identified but there was work to do to ensure they reflected the strategic objectives realised through the group strategy. The trust had plans to cope with unexpected events. The board were clear that their decision-making avoided financial pressures compromising the quality of care.**

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions however, arrangements were under review at the time of our inspection. A risk management strategy was in place however, this was an interim strategy and whilst it articulated the direction of travel for the trust, there was very little detail to support how the strategy was to be achieved. Despite this, there was a shared understanding of risks across the organisation and alignment between recorded risks and what staff said was 'on their worry list'.

Work was underway to develop a risk management framework that would ensure there were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes. Development of non-executive directors was recognised as key to holding risk owners to account and ensuring risk assurance systems were regularly reviewed and improved.

A trust risk register (TRR) was in place that identified relevant risks and actions to reduce their impact. The TRR was a combination of both local risks and corporate risks. There were 752 risks within the TRR, broken down as:

- Level 1 - Departmental Risks = 315 risks
- Level 2 - Care Group Risks = 252 risks
- Level 3 - Divisional Risks = 156 risks
- Level 4 - Corporate Risks = 29 risks.

All risks were to be reviewed at least once annually to ensure the details captured accurately reflected the current position of a captured risk and the details of its; controls, assurances, and actions. Our review of the TRR (dated July 2022) showed a number of risks were out of date for review. The board were fully sighted on this and a robust TRR improvement plan was currently in place. As part of this improvement plan the head of risk management and compliance, as well as the four divisional governance advisers, were working with the divisions to complete a data cleanse as the trust moved to a new risk management system. January 2023 was currently the provisional date for the trust to go live with the risk management system.

As of 13 October 2022, there were 116 risk that had not been through a data cleanse within the last 12 months (down from 504 out of 881 risks), and 189 risks overdue a risk review (down from 443 risks out of 881 risks).

Additional actions in the improvement plan included for example, dedicated risk management support and risk review meetings at divisional level, revision of risk management tools and templates and training of the new system to applicable trust users.

A board assurance framework (BAF) was in place that brought together in one place all of the relevant information on the risks to the board's strategic objectives. We found the BAF to be very detailed and were unable to see when, or if, risks had been reviewed and/or updated. For example, one risk had been identified as 'high risk', we could not see where action had been taken to reduce this. We were told, during our well led interviews, that the BAF was to be refreshed, using a new template and reflecting the group strategic objectives. In the interim, the board had agreed to stick with the current BAF as they transitioned to the group strategy.

# Our findings

There were processes to manage current and future performance. These were under review to align to the new strategy and group structure. Current processes were recognised by the board as producing unreliable data that did not always provide the board with the required level of assurance. An example of which was a failure to identify the medicines management concerns we had identified though our core service inspection. Technology improvements, system-wide training and development of the board were all seen as key in managing performance going forward. Throughout our well led interviews, it was clear the board were fully sighted and had started to implement changes to ensure that quality of care and patient experience were driving future plans.

Benchmarking data (including NHSE/I published data, Model Hospital and GIRFT (Getting It Right First Time)) was also routinely included within committee and board reports to further add context to the trust-reported performance.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. During 2021/22, there were a number of national clinical audits programmes and national confidential enquiries covering NHS services that the trust provided that were suspended due to COVID 19 subsequent waves.

During 2021/22 the trust participated in 100% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The trust had an overarching emergency preparedness, resilience and response policy (EPRR). This policy set out the strategic framework for the management of emergency planning, business continuity, response and recovery within the trust. It was linked to the trust's vision, strategy and values in which readiness in the face of incidents, emergencies and disruptions and organisational resilience were key components. The aim of the policy was to ensure that the trust had high quality, strong performance and standards for EPRR with robust arrangements and governance.

The trust also had a specific business continuity management policy. This business continuity policy facilitated the rapid and efficient mobilisation of trust services in the event of an incident disrupting normal service delivery. This policy was complemented by business continuity plans (BCPs) detailing how individual services performed in the event of disruption by defining and prioritising its activities and services, detailing contingency arrangements during the disruption and, when the disruption has passed, how all services would be restored.

Governance for EPRR arrangements were managed through the EPRR steering group. The purpose of this Steering Group was to facilitate the trust's preparedness, overall resilience and ensure response capability was in place to these types of incidents and emergencies.

When considering developments to services or efficiency changes, the impact on quality and sustainability was assessed and monitored. The performance, finance, and investment committee provided a forum for the trust board to seek additional assurance in relation to all aspects of financial and general performance, including performance against nationally set and locally agreed targets.

### Information Management

**Work was underway to ensure the board collected reliable data and analysed it. Technology improvements were in their infancy, with some not yet realised meaning staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

# Our findings

The board had an understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Information was used to measure for improvement, not just assurance. However, the quality of data presented to the trust board was collected manually and therefore subject to human error and not wholly reliable. Board members relied on other sources and professional curiosity to support this data.

Key performance indicators that were monitored through the National contract and those metrics that the trust measured for operational efficiency and patient safety were reported in the integrated quality and performance report. Reviewed through the quality, patient experience and safety (QPES) committee, the report was presented monthly to the trust board.

There were clear service performance measures, which were reported and monitored, and we saw work was in progress to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. We were told this would enable action to be taken when issues were identified.

A digital strategy had been developed in collaboration with external stakeholders and would focus on using technology to improve trust performance. Currently in draft, the strategy was due to be presented at board at the end of November 2022.

Work was underway to progress the digital agenda with a direction of travel evident. Current information technology systems were described as ineffective in monitoring and improving the quality of care. Technology improvements and plans to create 'golden thread' dashboards were already underway to enable better ward to board assurance. However, significant risks remained in relation to patient records and medicines administration, which were both currently in paper format. The aspiration to have an electronic patient record across the integrated care system (ICS) had yet to be realised and was reliant upon a full business case and significant investment. In addition, funding for an electronic prescribing and medicines administration (ePMA) system had not yet been secured.

It was clear from our review of board papers and meeting minutes that quality and sustainability both received sufficient coverage in relevant meetings at all levels. All staff had sufficient access to information. However, work was underway to ensure there was appropriate challenge at board.

Arrangements were in place to ensure that data or notifications were submitted to external bodies as required. This included, but was not limited to, the Care Quality Commission, commissioners and the local authority.

The Data Security and Protection Toolkit (DSPT) is an online tool that enables relevant organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care (DHSC), notably the 10 data security standards set out by the National Data Guardian in the 2016 Review of data security, consent, and opt-outs.

All organisations that have access to NHS patient data and systems must use this Toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Organisations either achieve a status of 'standards met' by providing evidence against the mandatory requirements, or 'standards not met'. The 2021/22 DSPT for this trust was submitted on 30 June 2022 and achieved a status of 'standards met'.

# Our findings

There were robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. Lessons were learned when there were data security breaches. The trust had a framework in place to manage personal data incidents that utilised subject matter expertise from information governance, digital services, informatics, data quality, health records and systems administration.

Risks to personal data were managed and controlled in accordance with the trust's data protection policy and the incident reporting and management policy. Incidents were reviewed by the information governance steering group (IGSG) which was chaired by the chief finance officer, who had been appointed as the senior information risk owner (SIRO). Membership also included the trust's chief medical officer who had been appointed as the Caldicott guardian, the director of assurance and data protection officer. During the period 2021/22, four incidents were referred to the Information Commissioner's Office as meeting the criteria for external reporting.

All staff received data security training as part of their corporate induction upon joining the trust, with annual data security awareness and information security training mandated for all staff. Ongoing knowledge, skills and training requirements were supported by a comprehensive suite of policies, and guidance was provided to users to ensure access to personal data was appropriate.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. The trust collaborated with partner organisations to help improve services for patients.**

Patient, carer and public engagement and involvement was exemplary. People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups. The trust listened and acted upon the views of its patients, relatives, and carers with protected characteristics. The introduction of the programme of the Patient, Carer, and Staff Experience Stories to trust board allowed patients with a protected group and staff to attend the trust board to give accounts of their experience of care. This had been extended to the quality and patient experience committee (QPEC), clinician forums, and frontline teams. The chaplaincy team also introduced an encounter form to capture the type and frequency of support provided. The SPaRC (Spiritual, Pastoral and Religious Care) form was introduced alongside faith profiles and was initiated following a patient story regarding access to chaplaincy, particularly from the Sikh faith.

People who use services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. This included people in a range of equality groups. The patient partner programme was introduced in 2021. Workstreams, where partners had expressed interest in involvement, included the end of life steering group, the Acute Medical Unit (AMU) Improvement plan, the oncology nurse specialist out-of-hours survey and the patient experience group. The patient partners were broadly representative of the nine protected groups.

Patient partners had been involved in the development and codesign of new ward Information boards. A patient partner was actively involved in a faith-based improvement arising from a poor patient experience. This resulted in the purchase and distribution of 30 hand-held, pocket-sized devices with pre-enabled microchips that were programmed to play a range of Sikh prayers and hymns. They assisted with daily worship at a time when patients were unable to visit their normal place of worship and found it difficult to attend the trust chaplaincy sacred spaces, or when visiting was restricted.

# Our findings

The patient relations and experience team increased opportunities for patients to provide feedback and for trust staff to respond to the 'near time feedback with real time action'. In addition to the Friends and Family Test and complaints, concerns and compliments, the Mystery Patient Scheme was initiated. The mystery patient feedback was collected via a bedside/departmental poster which also included a link to provide friends and family feedback via a QR code linked to the area.

The Mystery Patient Scheme was introduced to the organisation in August 2021 and provided patients with the opportunity to share their experience of their recent visit and support staff to improve the services provided. The scheme was anonymous which enabled the patients to provide honest feedback about all areas of their visit.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. This included those with a protected equality characteristic. The trust had established a number of staff networks for race, gender and lesbian, gay, bisexual, and transgender (LGBTQ) equality. The aim and purpose of these was to ensure that staff with a protected group had a voice and could influence decision making across the organisation with regard to equality, diversity and inclusion (EDI). Each staff network had an executive sponsor and met regularly to progress activities related to race, gender and LGBTQ matters. The chairs of the staff networks also attended the trust's EDI steering group (EDIG) which reported into the people and organisation development committee (PODC); a subgroup of the trust board.

The trust had worked with system partners to increase employment opportunities for people in the community who were long term unemployed and people from ethnic minority groups.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The trust worked in partnership with health, social, housing, voluntary and community organisations as part of 'Walsall Together', an integrated care partnership between organisations that planned and delivered health, mental health and social care services locally.

Healthwatch Walsall had regular contact with the trust and in 2021/22 provided feedback reports on patient views regarding communication and end of life care. The report on communication was shared with the patient experience team and changes were made to the telephone system within the Patient Advice and Liaison Service (PALS) to accommodate concerns regarding call handling.

A member of the Healthwatch team sat on the trust learning matters editorial group throughout 2021/22 and contributed via independent scrutiny to the inclusion of articles that shared learning from feedback and actions arising from complaints, incidents and mortality reviews.

Healthwatch Walsall was commissioned by Walsall Together to undertake patient, service user and residents' engagement to ensure they were fully represented in the decision-making process on the future delivery of services and service change.

There was transparency and openness with all stakeholders about performance. A Walsall Together partnership board, with senior representation from each organisation, met on a monthly basis to provide strategic oversight and operational coordination for the services in scope. All organisations had signed an alliance agreement which set out how they would work together to deliver sustainable, effective and efficient services.

# Our findings

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

There were systems in place, across the group structure, to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Group working had impacted positively on long-standing issues for staff and was seen as improving services for patients. An example of this was the exceptional performance of the emergency department at Walsall Manor Hospital, which had consistently high performance. The trust had also benefitted from moves to reduce use of agency staff.

A change in culture had enabled leaders and staff to strive for continuous learning, improvement and innovation. The trust had embraced quality improvement (QI) and had a well-established QI academy and training programme delivering Quality, service improvement and redesign (QSIR) training and more recently, Healthcare Systems Engineering.

There were standardised improvement tools and methods, and staff had the skills to use them, and staff were encouraged to regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance. Organised training sessions had taken place for the two boards (in the group structure) on quality management systems and making data count. Training had been made available to staff from across the trust, integrated care system (ICS) and wider and specific training programmes had been set up for staff groups such as for example, regional anaesthetics trainees, intensive care and theatre staff, pharmacy and senior nursing teams.

The trust's QI strategy set out how staff were supported to improve the services and care they delivered to patients. Recognising that everyone had a role in quality improvement, the strategy was in place to help develop sustainable improvement changes through the embedding of a recognised programme of training across the group structure and continued support of QI in the wider context.

The continuous QI team at The Royal Wolverhampton NHS Trust and QI academy at Walsall Healthcare NHS Trust had been integrated to become the 'Quality Improvement Team'. As a result, QI had become central to the group strategy.

There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Throughout the trust, we felt a palpable energy for QI and saw staff were committed to continually learning and improving services. We heard of numerous examples of projects that had significantly led to improvements and innovation for the benefit of patients. Examples included, but were not limited to:

The division of surgery contributed 73 projects to the latest QI annual awards. The winning project came from within Surgery, based on improving prompt mobilisation post femur fracture.

A team effort to ensure gold standard care for patients with hip fractures had resulted in a national award for the trust which was now rated as second best in the region for its service. Reduced hospital stays, less time in theatre for patients, a decrease in mortality rates and improvements in the timeliness of pain relief had all been achieved as a result of the QI work carried out by the neck of femur team at Walsall Manor Hospital.

# Our findings

Funded through the trust and Walsall Together, virtual wards set up to help people manage COVID-19 patients at home, as well as support those with long COVID, were being expanded in Walsall to include patients with respiratory conditions and Chronic Obstructive Pulmonary Disease (COPD). More than 1,800 people had been cared for through virtual wards that were put in place to reduce the length of time people were in hospital or prevent them from having to go in at all.

The group structure had received praise from executives at NHS England and Improvement for their innovation in community services resulting in, developing a national community nursing plan and delivering a community nursing safe staffing tool.

There was a recognition of the importance of research and the trust were working collaboratively across the group structure and wider ICS to maximise impact. This included participating in appropriate research projects and recognised accreditation schemes. Successes included, the introduction of an electronic patient record in the emergency department (ED) during the pandemic, achieving Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation standards for endoscopy services, leading research in Dermatology, the community Nephrology service pilot, to deliver Chronic Kidney Disease (CKD) services differently across Walsall through development of a cohesive, integrated primary and secondary care pathway for patients with CKD, Ask EARL electronic interface in ED, some of the highest same day emergency care (SDEC) rates in the country, a strong advanced clinical practice (ACP) model in Emergency Medicine and growing model in Acute Medicine, winner of the Rowan Hillson Inpatient Safety Award for participation in the Diabetes DEKODE Project and runner up in the Health Service Journal awards for the Covid Safe at Home Pathway.

Participation in and learning from internal and external reviews was effective, including those related to mortality or the death of a person using the service. Learning was shared effectively and used to make improvements. Deaths at the trust were recorded using the Clinical Outcomes Review System (CORS). This enabled review and discussion at service and directorate morbidity and mortality meetings. A proportion of deaths also went through a more detailed review. Detailed case record reviews were undertaken using the Royal College of Physician's Structured Judgement Review (SJR) methodology for any death meeting one of 11 defined categories.

Specialties could also undertake additional detailed case record reviews as part of their own mortality review processes and feed any lessons learned from these into the mortality surveillance group. Paediatric and maternal or neonatal deaths were reviewed using the Child Death Overview Panel (CDOP) and MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) tools respectively.

As part of this inspection we looked at the trust's processes for reviewing deaths. The trust used the structured judgement review (SJR) methodology. We reviewed five cases where a SJR had been carried out. We saw the care received by patients who had died had been effectively reviewed, areas of learning had been identified and the reviews supported the development of quality improvement initiatives when problems in care were identified.

Learning from reviews of deaths, including those reviewed by detailed case record review, was discussed, and shared through local specialty and directorate mortality meetings. Themes from these meetings were shared at the trust mortality surveillance group.

As part of this inspection we reviewed the Root cause Analysis (RCA) Investigation reports for five serious incidents. It was clear from our review that significant work needed to take place to ensure RCA investigations were robust and effective. This was confirmed through our interviews at this inspection. We were told an improvement plan was

# Our findings

underway that had already identified our concerns following an external review conducted in January 2022. We found, two different RCA templates in use, a lack of clarity around the time afforded to individuals to carry out investigations and support given to staff who had been involved in the incident and limited indications of whether there had been patient, family or carer involvement.

| Key to tables | | | | | |
|---|---|---|---|---|---|
| **Ratings** | **Not rated** | **Inadequate** | **Requires improvement** | **Good** | **Outstanding** |
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| **Symbol *** | →← | ↑ | ↑↑ | ↓ | ↓↓ |

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

## Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires Improvement →← Jan 2023 | Requires Improvement →← Jan 2023 | Outstanding →← Jan 2023 | Requires Improvement →← Jan 2023 | Requires Improvement →← Jan 2023 | Requires Improvement →← Jan 2023 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Ratings for a combined trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Acute locations | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement | Requires Improvement |
| Community | Requires Improvement | Good | Outstanding | Good | Outstanding | Outstanding |
| Overall trust | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Outstanding ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 |

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Rating for acute services/acute trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Manor Hospital | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Good ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 |
| Overall trust | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Outstanding ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 |

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Rating for Manor Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Inadequate ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Good ➔➔ Jan 2023 | Good ↑↑ Jan 2023 | Requires Improvement ↑ Jan 2023 | Requires Improvement ↑ Jan 2023 |
| Services for children and young people | Good ➔➔ Jan 2023 | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 | Good ➔➔ Jan 2023 | Good ➔➔ Jan 2023 |
| Critical care | Good Jul 2019 | Requires improvement Jul 2019 | Good Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 | Requires improvement Jul 2019 |
| End of life care | Good Dec 2017 | Requires improvement Dec 2017 | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 |
| Outpatients and diagnostic imaging | Good Dec 2017 | Not rated | Good Dec 2017 | Requires improvement Dec 2017 | Good Dec 2017 | Good Dec 2017 |
| Surgery | Requires Improvement ➔➔ Jan 2023 | Good ↑ Jan 2023 | Good ↑ Jan 2023 | Good ➔➔ Jan 2023 | Good ↑ Jan 2023 | Good ↑ Jan 2023 |
| Urgent and emergency services | Requires improvement Nov 2020 | Good Jul 2019 | Good Jul 2019 | Good Nov 2020 | Requires improvement Nov 2020 | Requires improvement Nov 2020 |
| Maternity (inpatient services) | Requires improvement Oct 2021 | Requires improvement Oct 2021 | Good Aug 2018 | Requires improvement Aug 2018 | Requires improvement Oct 2021 | Requires improvement Oct 2021 |
| Maternity | Requires improvement Nov 2020 | Good Nov 2020 | Good Jul 2019 | Good Jul 2019 | Requires improvement Nov 2020 | Requires improvement Nov 2020 |
| **Overall** | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Good ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 | Requires Improvement ➔➔ Jan 2023 |

## Rating for community health services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Community health services for adults | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 | Outstanding Dec 2017 | Good Dec 2017 |
| Community health services for children and young people | Requires improvement Dec 2017 | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 | Good Dec 2017 |
| Community end of life care | Good Dec 2017 | Good Dec 2017 | Outstanding Dec 2017 | Outstanding Dec 2017 | Outstanding Dec 2017 | Outstanding Dec 2017 |
| Overall | Requires Improvement | Good | Outstanding | Good | Outstanding | Outstanding |

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Manor Hospital

Moat Road
Walsall
WS2 9PS
Tel: 01922721172
www.walsallhospitals.nhs.uk

## Description of this hospital

Walsall Manor Hospital is an acute general hospital that serves a population of around 270,000 across Walsall and surrounding areas.

The hospital has 550 acute beds and provides a wide range of services including a 24-hour accident and emergency department.

# Medical care (including older people's care)

**Requires Improvement**  

## Is the service safe?

**Inadequate**  

Our rating of safe stayed the same. We rated it as inadequate.

### Mandatory Training

**The service provided mandatory training in key skills to staff and most staff had completed it.**

Most staff received and kept up to date with their mandatory training. Mandatory training was provided both by eLearning and face to face. Information provided identified overall 85% of staff were up to date with mandatory training which was below the trust target. Ward managers and senior managers matrons told us whilst most staff had received mandatory training, some new staff required basic life support and safeguarding adults and children level 3. Ward managers and senior managers told us all remaining staff were booked to complete mandatory training modules by the end of November 2022.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were required to complete mandatory training in a range of topics including safeguarding adults and children, information governance and data security, equality and diversity, conflict resolution, fire safety, health and safety, moving and handling, dementia awareness and infection prevention and control.

Clinical staff completed training on recognising and responding to patients with mental health needs, and dementia. More than 90% of staff had received training in dementia awareness. Senior managers said additional training would also be provided for new international staff in dementia awareness.

A senior manager said the medical and long-term conditions (MLTC) division had the highest number of patients admitted with a mental health condition in the previous month. Mental health training was not mandatory; however, training modules were available. Information provided identified 43% of eligible staff within MLTC division had undertaken level 1 mental health awareness training. De-escalation and breakaway training were also available and 50% of AMU staff had received this training with plans for this training to be available trust wide. From November 2022 further training had been arranged to include caring for complex mental health patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff confirmed they received email alerts and could access the electronic system to check so they knew when to renew their training. Local managers had oversight of their staff completion of mandatory training. Staff compliance with mandatory training was also part of the regular care group review meetings.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, compliance with level 3 adult and children's safeguarding training was below the trust target**

# Medical care (including older people's care)

Staff received levels 1, 2 and 3 adult and children's safeguarding training which met national safeguarding training guidance. More than 90% of staff had received safeguarding adults and children level 1 and 2. However compliance with level 3 adult and children's safeguarding training was significantly below the trust target (46% of staff safeguarding children and 71% for safeguarding adults). Managers said all staff had this training booked to be completed by the end of November 2022.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff said they made safeguarding referrals for patients who had been admitted with pressure sores or there were other similar concerns.

Female Genital Mutilation (FGM) training was included in the safeguarding training. Nursing staff had good awareness of female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Trained staff knew how to make a safeguarding referral and who to inform if they had safeguarding concerns. Some health care assistants said if they had any concerns, they would ask the ward manager or trained nurse to make the referral on their behalf if needed.

A senior manager said the safeguarding level 3 training included training in learning disabilities and autism.

The service had a safeguarding adult at risk policy and a safeguarding children and young people policy. Both of which were in date, version controlled and reflected national guidance. Staff were supported by ward managers, matrons the senior management team and the safeguarding leads to raise issues and report safeguarding concerns. Staff made safeguarding referrals to the local authority.

Whilst staff understood the importance of maintaining confidentiality about patients care and treatment, care records were not locked on most wards we visited.

### Cleanliness, infection control and hygiene

**The service mostly controlled infection risk well. However, staff did not always clean equipment and or use control measures to protect patients, themselves and others from infection.**

The trust had monthly infection prevention control audits, these were divisional wide and provided scores for individual wards. Dependent on the score the areas were either rated red (lowest scores), amber (some improvements required) or green (meeting targets). Based on the scores given action points were created. Wards in the MLTC division had 90% compliance with infection control and prevention standards. This included areas of the environment, sharps, personal protective equipment, linen, waste, hand hygiene and isolation. Ward managers shared improvements when needed during staff meetings.

There was an extensive refurbishment programme in place however some areas were in a poor state of repair including missing ceiling tiles, torn flooring, damage to door frames and walls which compromised effective cleaning and infection control. Some wards faced challenges with the environment which compromised infection control requirements.

Ward areas were generally clean and housekeeping staff regularly cleaned ward areas. However, bed spaces on wards 1, 2 and the acute medical unit were not always cleaned after being used by covid patients. Toilets outside of covid contact bays were not restricted to covid contact patients only increasing the potential risk of cross infection to other patients.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. Covid patients on ward 1 within the covid contact bays used toilets on the wider ward. There was no cleaning of these toilets in between patients and no signs to restrict usage to covid contact patients only. The recent infection control audit (August 2022) identified insufficient commodes were available on most wards to ensure sole use for designated patients to reduce the risk of cross infection.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed some staff not wearing appropriate PPE when handling infectious patients or adhering to infection and prevention control methods including 'donning and doffing', gloves, masks and hand washing. In addition, rooms with infectious patients were not always labelled to alert people to the risk of infection or to wear appropriate PPE.

The most recent quarterly hand hygiene audit in June 2022 identified 97.5 % compliance with hand hygiene. A further audit identified improvement was required with staff compliance around 75% which was below the trust target of 90%.

The trust screened all patients within 24 hours of admission for MRSA. The MLTC division was 80% compliant with MRSA screening.

### Environment and equipment

**The design, maintenance and use of facilities and premises did not always keep people safe. However, staff were trained to use equipment and managed clinical waste well.**

The design of the environment did not always follow national guidance. The trust had an extensive refurbishment programme in place which included medical wards and departments. During our inspection wards 16 and 17 were being refurbished and had moved on to other wards until November 2022. The new acute medical unit was due to open in February 2023.

However, whilst there was a refurbishment programme in place day to day issues compromised patients, staff and the visitor's safety. Blocked fire exits were seen on several wards with adhoc nursing stations, medical equipment and ward televisions. Door frames were split with sharp edges posing a health and safety risk and items of broken equipment had been left in windows alcoves. We also observed several electrical leads crossing floors that posed a significant trip hazard.

Staff carried out daily safety checks of specialist equipment for example resuscitation trolleys.

Patients could reach call bells and staff responded quickly when called. All patients throughout the inspection had their call bells within easy reach and call bells were answered in an appropriate time. We did see a broken staff call bell in one toilet on the acute medical unit which had been left to dangle over a toilet cistern.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps. Sharps bins seen were appropriately labelled and stored correctly.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. However, records did not always confirm staff identified and quickly acted upon patients at risk of deterioration.** Staff used a nationally recognised tool to identify deteriorating patients. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. Records seen showed early warning scores were recorded as part of

patient's electronic observations. A score of above 5 triggered to the outreach team on the electronic system and the team would contact the ward to discuss patient's management. Information provided by the trust identified for the last three months no medical ward met the trust target for timely patient observations. This increased the risk of patients not having timely review and treatment by a doctor if they deteriorated.

The trust used a red stamp in the patients notes which identified possible deterioration and what escalation had been undertaken. Several patients' records seen did not include the red stamp, confirm when the patient early warning score had triggered or actions (and timing of those actions) undertaken. Calls from the outreach team were not always recorded in patients notes to confirm patient's management.

Staff completed risk assessments for each patient on admission or arrival to a new ward using a recognised tool, and reviewed this regularly, including after any incident. Staff completed assessments for the risk of pressure ulcers, falls and nutrition. Generally, doctors completed venous thromboembolism (VTE) although there was some confusion whether this was a medical or nursing task. Risk assessments were repeated when anything changed with the patient.

Staff knew about and dealt with any specific risk issues. The MLTC division had identified VTE assessment as a matter of concern and had a quality improvement project in place. An audit had been undertaken of all patients who did not have a VTE assessment during the first two weeks of September 2022. The audit identified 60% who did not have a VTE assessment had been discharged the same day. The division also identified a discrepancy between the electronic VTE assessment and prescriptions for prophylactic treatment. The audit confirmed patients did receive the correct treatment when required to reduce the risk of venous thrombosis.

The trust had a sepsis information campaign with posters highlighting sepsis and its treatment on all wards. Staff said part of the outreach team included one person dedicated to sepsis management each day who contacted them when patients triggered for potential sepsis and advised them on patient treatment and management. The trust performed well when compared with other trusts for antibiotic therapy within the hour, which had improved consistently since the initiation of the sepsis team. However other key information about sepsis management was not reviewed including the timeliness of observations and escalation of potential sepsis.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. The mental health team included a lead nurse for mental health (Monday to Friday), a matron for mental health and clinical nurse specialists who worked over seven days (including twilight shifts). Mental health staff could be contacted by an urgent bleep between 8am and 6pm. Out of hours staff were able to access mental health advice by contacting the local mental health trust switchboard.

Staff did not always complete or arrange timely psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We spoke with two patients who had previously self-harmed. They were anxious and could potential self-harm again, but no psychological assessment had been completed. We escalated our concerns to the trust who took appropriate actions to support these patients.

Staff did not always share key information to keep patients safe when handing over their care to others. Several staff reported a need to improve patient handovers (from one ward to another). Several staff said things were often not handed over and meant patients may not receive timely care and treatment.

There was a nurse handover at each shift change when key information was shared. We did see one handover /safety huddle which included doctors and other staff but was largely doctor driven with little interaction from other staff.

Doctor handovers were undertaken over the phone or in person at the end of the day to the on-call team.

## Staffing

### Nurse staffing

**The service had recruited enough nursing and support staff with the right qualifications, skills, training and experience to meet patients' needs keep patients safe from avoidable harm and provide the right care and treatment. However, not all staff were in post at the time of the inspection. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service did not always have enough nursing and support staff. Staff said staffing had improved although short term sickness rates meant they were frequently short staffed. Wards did not always have enough staff to care for all patient's needs. Ward managers said staffing had been reviewed and increased and as a result there appeared to be a shortage until new (additional) staff were in post. During the inspection, we observed an incident on ward 14 where a patient was identified in their notes as requiring 1:1 care to keep them safe and reduce their risk of falling. However, despite staff requesting this, an additional member of staff was not allocated to provide 1:1 care.

We reviewed staffing rotas (for the wards we inspected) for 27 June 2022 to 2 October 2022. We found mostly wards were staffed with the required staffing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Ward managers and matrons reviewed nurse staffing every morning reviewing the actual versus the planned required staffing. When needed staff were moved from one ward to another to mitigate against and provide safer staffing. The trust used a "red flag" system to identify staffing risks and concerns. There were twice daily staffing reports with a 72-hour forecast report for the weekend staffing to identify if additional staffing would be required.

Ward managers discussed staffing concerns with their matrons and any concerns were escalated to the staffing hub meetings. Matrons joined the trust virtual staffing hub (across all divisions) where any gaps in staffing and/or additional support were discussed. If staffing was not met this was escalated to the director of nursing to support a request for specialist agency staff. However, during the inspection, several wards we visited reported staffing shortfalls with the greatest concerns highlighted on wards 1 and 14, it was not evident if this had been appropriately escalated.

Ward managers could adjust staffing levels daily according to the needs of patients. Ward managers on several wards told us a review of staffing levels had recently been undertaken against patients' needs and staffing had been increased.

The trust provided a summary of actual against required staffing within the medicine and long-term conditions (MLTC) between 27 June 2022 and 2 October 2022. Information identified registered nurse staffing was generally below the actual staff requirement whilst clinical support workers staffing was above the required numbers.

The service had reducing vacancy rates. The trust had recruited to most of its vacancies. In May 2022, a business case for additional nurses had been agreed and as a result vacant positions had increased, although there were more staff employed. Ward managers confirmed successful recruitment and with ongoing recruitment overall vacancies would continue to decrease.

The service had reducing turnover rates. The divisional board review identified staff turnover as improving in August 2022.

Sickness rates were largely aligned to the waves of covid infection in the local community with staff sickness deceasing and increasing alongside community covid infection rates.

The service had reducing rates of bank and agency nurses. Staff absences were covered, when possible, with existing staff, staff from other wards or bank staff. The number of bank and agency staff had reduced with the recruitment of additional staff. Information provided by the trust confirmed agency staff use as minimal.

Managers limited their use of bank and agency staff and requested staff familiar with the service. If there remained a need for additional staff, regular agency staff who were familiar with the service were requested. Information provided identified agency staff use was agreed as to support specific requirements for example mental health patients requiring 1:1 care, additional bed capacity, restrictions due to a covid outbreak or to ensure the safe external transfer of patients.

Managers made sure all bank and agency staff had a full induction and understood the service.

### Medical staffing

**There were appropriate arrangements in place to ensure the service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

The service had enough medical staff to keep patients safe. The trust had historically struggled to recruit but had successfully increased the number of doctors and consultants. Most of the posts had been recruited to however not all staff were in post at the time of the inspection. Recruitment of doctors included international recruitment and included additional training opportunities, a buddy scheme and support with accommodation.

Actual medical staffing had increased, information showed an increase of filled shifts for all grades of doctors in the last three months.

There was an AMU consultant of the day to support junior doctors to provide them with an identified point of contact. They had changed the roles of the two on call registrars to fairly distribute workload. The trust had recruited new clinical fellows and redesigned the rota for on call for AMU doctors.

The service had reducing vacancy rates for medical staff. There had been extensive recruitment of all grades of doctor in the last twelve months. This had been achieved by providing additional support for doctors, reduction in workload and increased teaching opportunities for junior doctors.

The service had reducing rates of bank and locum staff. The division had four bank locum consultants and the remainder were on the NHS locum contracts all of whom were seeking specialist recognition via the certificate of eligibility for specialist registration route. The trust identified by the end of November 2022 they hoped to significantly reduce their reliance on locum doctors. The junior doctor agency spend was expected to increase over the next three months as temporary cover was needed to cover rota positions which had not yet been filled substantively.

Managers made sure locums had a full induction to the service before they started work. New international doctors had six weeks supernumery before they started.

# Medical care (including older people's care)

The service had a good skill mix of medical staff on each shift and reviewed this regularly. AMU was staffed by the AMU consultants until 5pm with an on-call medical consultant in the evening. There was additional consultant cover in both the ambulatory care and frailty units until 8pm. Consultants were supported by registers and junior doctors.

### Records

**Records of patients' care and treatment were not always complete, clear or stored securely and did not always provide all required information for staff providing care.**

Patient notes lacked detail and did not provide all information about the care and treatment. The trust mostly used paper records with patients' observations recorded on the electronic system. On most wards records of the patient current admission was available in ring bound folders. However, we found paper records from within the folder frequently fell out and had not been put in date order and in some cases were in the wrong patient's folder. This meant it was difficult for staff to identify patients current and previous treatment needs and there was a risk they would not receive the care they required.

When patients transferred to a new team, records were not always available or complete. The temporary folders accompanied the patient to their new ward and included a handover sheet which summarised their care needs. However, several staff on different wards said information provided was frequently incomplete, not available or inaccurate.

Records were not stored securely. Records were not always stored securely in lockable cupboards on all wards. The ward manager on the acute medical unit said new patient records trolleys which were lockable had been ordered and would be available soon. The lockable 'fob' trolleys were available on some wards however they also were unlocked. Records of patient's current admission on ward 4 were in the locked trolleys although their medical records were kept unlocked under the lockable trolleys.

### Medicines

**The service did not use systems and processes to safely prescribe, administer, record and store medicines.**

Staff did not follow systems and processes to safety prescribe and administer medicines. Some prescriptions charts seen on inspection were illegible and we could not be assured of the accuracy of administration of medicines records.

We found that some prescribed medicines were not available to administer to patients. Preventer inhalers (those used to prevent a patient having breathing difficulties) were not available for four patients.

Medicines used in the treatment of glaucoma were not available for administration to a patient. Failure to manage glaucoma will lead to sight loss.Patient weights were not recorded on prescription charts. Additionally, the nurse assessment record for four patients recorded mid upper arm circumference (MUAC) and not the actual patient weight. There was a risk of having insufficient medicine dose to have the required effect or too much medicine which would cause side effects.

Poor diabetes management resulted in a patient experiencing extreme hyperglycaemia (high blood sugar levels).

We found that one patient had been without their pain-relieving medicines or an alternative for 6 days

# Medical care (including older people's care)

Wards did not always store and manage all medicines and prescribing documents safely. We were not assured that medicines were stored within manufacturers recommended temperatures to maintain effectiveness. For example, the fridge on one ward was over filled with medicines and assurance was not available to show that medicines stored at room temperature were kept within the manufacturers temperature range.

We found that some medicines were out of date and available to be administered to patients on two wards. This included medicines used to treat infections. The date of opening was not in place for some shortened shelf-life liquid medicines once open. There was a risk these medicines would not be as effective once past their new expiry dates.

On one ward we saw the administration of a controlled medicine was not witnessed by a second person as required by trust policy.

Pharmacists reviewed the patients' medicines on admission to the hospital. However further follow up was not evident to ensure required medicines were prescribed and available with required changes made.

We were not assured about the robustness around sharing alerts and reported incidents due to the significant concerns identified around medicines. Some wards were able to tell us how medicine errors had informed change. For example, AMU had developed a teaching programme for management of ketoacidosis and use of sliding scale insulin.

However, the allergy status for patients were completed appropriately on the prescription charts checked during the inspection. Oxygen was prescribed appropriately, where it was being administered to patients.

Registers for monitoring controlled medicines were completed regularly and found to be accurate during the inspection.

Emergency medicines were stored on resuscitation trolleys in accessible areas with required checks on content and expiry dates.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

No never events had been reported within the medicine division. Managers shared learning with their staff about never events that happened elsewhere and learning was shared trust wide.

Staff reported serious incidents clearly and in line with trust policy. In the last 12 months there have been a total of 55 serious incidents reported across all categories. This also included ward closures and infection outbreaks. There was a process to review all serious incidents, these investigation reports reviewed identified areas of good practice and areas for improvement. Staff we spoke with were aware of serious incidents within their own division.

# Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent, and mostly gave patients and families a full explanation when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence changes had been made as a result of feedback. Following reported medicine errors additional training had been provided on management of patients requiring sliding scale insulin and management of ketoacidosis. In oncology additional actions had been implemented to ensure timely identification of potential infection in a peripherally inserted catheter (PICC) which is a specialist line and may provide intravenous fluids, blood transfusions, chemotherapy or other medicines. The learning had been shared trust wide and included trust wide education and a PICC passport which provided additional assessment of the site area.

Managers investigated incidents. The trust had a framework for investigation of incidents and depending on the incident and potential harm would determine the type of investigation and level of seniority required for final sign off the incident and investigation.

## Is the service effective?

**Requires Improvement** 

Our rating of effective stayed the same. We rated it as requires improvement.

### Evidence-based care and treatment

**The service mostly provided care and treatment based on national guidance and evidence-based practice. However, managers did not always ensure effective checks were in place to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff mostly followed up-to-date policies to plan and deliver care according to best practice and national guidance. Clinical practice guidelines were available and reflected guidance.

There were some systems in place to check patients received services and evidence-based care which met best practice. However, these systems were not always effective. The trust did undertake sepsis audits. However, information provided only included compliance with antibiotics administered within 60 minutes. No information was provided to confirm timely escalation of potential sepsis or other key management aspects of sepsis treatment.

The policy which included the management of young people between 16 and 21 had been identified for review in May 2020 but had not been reviewed. The current policy identified young people between 16 and 18 particularly if they were vulnerable should be accommodated on the children and young people's ward. We observed this was not the situation and young people were not given a choice about being placed on an adult's ward.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. There were no adults admitted under the MHA to the wards we visited at the time of our inspection. However, staff told us how they worked closely with the mental health team if a patient required assessment or treatment under the Act. Staff working with people who were detained also had support from the safeguarding team to ensure patients' rights were protected.

# Medical care (including older people's care)

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. service made adjustments for patients' religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered a choice of food at each mealtime. Patients said they had plenty of food choices and the food was mostly good. Staff confirmed cultural diets were available on request. The trust performed well in comparison to other trusts in the CQC Inpatient audit 2021 (published September 2022) for staff providing enough help to patients (who required assistance) to eat their meals and patients describing the hospital food as good.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded totals of food and fluid regularly throughout the day to ensure timely identification of patients whose fluid or dietary intake was insufficient. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The nutritional screening tools we looked at were accurately completed and when needed included additional action such as referral to a dietician.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and generally gave pain relief in a timely way.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff said the trust currently had no pain tool for patients who lacked understanding or were unable to communicate verbally. Staff said the end-of-life team were currently looking at alternative suitable pain tools.

Patients received pain relief soon after requesting it. Staff were prompted to ask patients about pain when recording their observations electronically. Patients were asked on a scale 1 to 10 to describe their pain with 10 being the highest. Staff said they would go back to the patient 30 minutes later to check the pain relief had been effective.

Staff prescribed, administered and recorded pain relief accurately. Generally, patients received pain relief as prescribed. However, we found one patient who was without their pain-relieving medicine for 6 days.

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The service participated in relevant national clinical audits. Audits included the National Audit for End-of-Life Care, National Lung Cancer audit, National Bowel Cancer audit and National Oesophagastric audit

Outcomes for patients were similar to other similar services. When audits identified a need for improvement this was undertaken. For example, a cancer clinical nurse specialist had been appointed to ensure increased patient access to a cancer nurse special. The trust also provided new services and increased diagnostic sessions for earlier detection for bowel and lung cancers.

Managers and staff used the results to improve patients' outcomes. A new service which followed British Thoracic Society guidance was in place. The new service had increased early detection of lung cancer by increased and regular monitoring of the patients with pleural tumours. Pleural tumours are found in the pleural space; the cavity between the lungs and chest wall that contains lubricating pleural fluid. The service provided a training programme for pleural procedures. Data from the new pleural clinic identified 66 hospital admissions were avoided in the last year.

A procedure called endobronchial ultrasound (EBUS) that allows doctors to investigate patients' lungs and take samples was now available within the trust. This had resulted in shorter waiting times for patients and patients getting histology results quicker. This ensured those patients who required further treatment received more timely treatment.

The diabetes service had been part of a project called Digital Evaluation of Ketosis and Other Diabetic Emergencies (DEKODE) to review the management of diabetic ketoacidosis and other diabetic emergencies. Ketoacidosis is a serious complication of diabetics which can be life threatening. Over the last 12 -18 months, the hospital had identified improvement in the management of diabetic emergencies. The study identified the hospital patients performed well compared to its peers. The length of stay was shorter by one day at the trust (2.3 days as opposed to 3.3 days for other hospitals) in the study.

In addition to the DEKODE project the diabetic team have identified a 50% reduction in the number of diabetic patients who have had amputations in the last three years.

Information about patients who received same day emergency care (assessment and treatment) within the medical division was identified as 23% of patients which was stable. Information identified 23% of patients had returned directly to their usual place of residency.

The service had a low risk of readmission. Managers monitored information for patients readmitted to hospital within 48 hours and seven days. The information provided showed readmission rates were stable and minimal.

The divisional board discussed readmission rates for the division compared to other similar services and found the service performed well.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and when required used information from the audits to improve care and treatment. For example, documentation, risk assessments, consent, management of deteriorating patients and discharge. Managers shared and made sure staff understood information from the audits and implemented changes in practice when required.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust had reviewed staffing and increased availability of more experienced nurses including more ward sisters to provide additional support to other junior staff.

Managers gave all new staff a full induction tailored to their role before they started work. The trust had recruited to a large number of posts. The induction for new starters was a structured and supportive introduction to the trust and ward or department. It included an introduction to the trust values, policies and procedures in addition to an introduction to their role and their immediate work area. All newly qualified staff had access to a preceptorship programme and specific learning opportunities to support them in their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. The trust reported current appraisal rates for staff in the MLTC division as 82% at the end of August 2022 which was below the trust target. The trust identified there was a delay in uploading appraisals onto the electronic system but compliance with appraisal continued to increase. There was a plan in place to ensure at least 90% of staff had an up-to-date appraisal by the end of December 2022.

The practice education facilitators (PEF) supported the learning and development needs of staff. Ward managers said the PEFs had a key role in supporting the new international and newly qualified staff. However, they were limited availability of the PEFs to support other staff. We did see the number of more experienced nurses (band 6 and above) on wards had increased which gave additional support and teaching opportunities for nursing staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Wards had weekly safety huddle for all staff and most wards also had monthly team meetings. Notes of the both the safety huddle and ward meetings were available for staff who were unable to attend. Staff said key information from the weekly safety huddle was shared at each staff handover for the following week.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity for learning through clinical skills workshops and leadership sessions and staff could apply for formal courses through the training needs analysis process.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff in several areas spoke positively about the support they had been to develop their careers and improve patient care provided.

Managers made sure staff received any specialist training for their role. Nurses had identified link or champion roles in specialist subjects. This included clinical and non-clinical subjects, such as infection control, tissue viability and safeguarding.

Managers identified poor staff performance promptly and supported staff to improve. Managers monitored staff performance and when required ensured additional training opportunities were available. However, if performance failed despite additional support and training a more formal process would be instigated.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals did not always work effectively as a team to benefit patients and their care.**

Staff held regular and mostly effective multidisciplinary meetings (MDT) to discuss patients and improve their care. Staff of different grades and specialities attended regular safety huddles which were mostly weekly except for AMU which held daily safety huddles. We observed one safety huddle on AMU however it was mainly doctor focused and provided little discussion from other professionals present. Staff told us the room they had previously used was no longer available and their current room was too small making attendance difficult.

# Medical care (including older people's care)

Multidisciplinary meetings were held daily (Monday to Friday) to discuss oncology cancer patients for each including breast, lung, bowel and skin cancers. There were additional weekly multi-disciplinary team meetings to discuss patients with pleural nodules which may develop into lung cancer.

Staff did not always work effectively across health care disciplines and with other agencies when required to care for patients. We observed doctors and nursing staff in some areas worked separately and were unclear of roles and responsibilities to ensure patients received high quality and effective care. For example, there was a lack of clarity around roles to ensure patients mental capacity or risk of venous thrombus was appropriately assessed.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants the trust was supported by visiting oncology consultants from another trust who were available Monday to Friday and were available to provide advice and support to other clinicians. However, doctors in AMU were not aware of these arrangements and were unclear who to ask for advice on patient management.

### Seven-day services

**Most key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds including at weekends on most wards. Most patients were reviewed by a consultant daily. However, in some areas such as respiratory and oncology a consultant was not available seven days a week but were available to provide telephone advice.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Allied health professionals (physiotherapists, occupational therapists, dietitians and speech and language therapists) covered core hours between 8.30am to 4.30pm from Monday to Friday. In addition, the physiotherapy and occupational therapy service was available on an ‘on-call’ basis and could offer support at weekends for more urgent cases such as in the respiratory speciality.

Doctors said there had been delays in receiving some laboratory results since the pathology service had been centralised. Radiography services were available 24 hours a day.

The oncology service was nurse led. Whilst the current service was Monday to Friday there was a business case to increase it to six and eventually seven days a week.

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff displayed healthcare literature. For example, the respiratory wards and oncology displayed information about smoking cessation.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Nurses gathered information concerning the patient's individual physiological, psychological, sociological, and spiritual needs. The assessment identified current and future health care needs of the patient. The alcohol screening and referral tools and smoking cessation tools were completed for all patients.

# Medical care (including older people's care)

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Patients who lacked capacity to make their own decisions or were experiencing mental ill health were not appropriately supported. Measures to limit patients' liberty were not appropriately applied.**

Staff did not fully understand how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. However, staff did not always complete 'best interest' paperwork and frequently no capacity assessment had been completed to confirm the patient did not have capacity to consent to an aspect of their care or treatment.

Staff did not always assess patient's mental capacity appropriately. Some records identified the patient had capacity, but this was contradicted in other records with no mental capacity assessment completed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. However, staff did not always follow the Mental Capacity Act 2005 or deprivation of liberties safeguards (DoLS) when caring and treating patients who lacked capacity and needed some form of physical intervention in their best interests. We found not all patients who had a Deprivation of Liberty safeguards in place had their mental capacity appropriately assessed. This meant patients were being deprived of their liberty unlawfully.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) however they were not completed appropriately. Information provided by the trust identified good compliance with the completion of MCA and DoLS. Information was over a three-month period and included 26 patients of which 25 patient records were appropriately completed. We did not find MCA assessments were appropriately completed and this meant DoLS were not appropriately completed.

Staff told us oversight of DoLS was undertaken by the safeguarding team whom they could contact if they required any support. However, the majority of DoLS records we saw during the inspection were not completed accurately or were incomplete for example not dated or no mental capacity assessment recorded. We were not assured current arrangements for oversight were effective.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw staff gaining verbal consent to undertake tasks with patients, such as providing personal care or taking vital monitoring readings.

Staff made sure patients consented to treatment based on all the information available. Staff sought patient's permission before they received any type of medical treatment, test or examination. This was done based on an explanation by a clinician.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they were required to complete training as this was part of their mandatory training. Compliance was over 90% for staff having received this training at the time of the inspection.

# Medical care (including older people's care)

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The safeguarding team did undertake ward visits to support staff in mental capacity and DoLS records and were also available to give telephone support. One ward sister told us they were working with junior staff to show them how to complete the DOLS applications.

## Is the service caring?

**Good** 

Our rating of caring stayed the same. We rated it as good.

### Compassionate care

**Most staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff mainly had conversations with patients about their care behind closed curtains and as discreetly as possible to maintain their privacy.

Several patients on the acute medical unit (AMU) told us the care they received was “fantastic” and staff had been “brilliant”.

The trust performed well in comparison to other trusts in the CQC Inpatient audit 2021 (published September 2022) for patients saying they were not bothered by noise at night from staff or other patients and they were able to discuss their condition or treatment with hospital staff without being overheard.

Staff were compassionate and caring with patients who were at end-of-life care. A patient had passed away during the inspection and staff were seen comforting the family and making appropriate arrangements for privacy and dignity.

The discharge team had a robust set of criteria to ensure patients were still able to be discharged appropriately and safely. The staff ensured patients were suitably dressed for their discharge and gave food parcels to patients where appropriate. Staff also followed up patient discharges 72 hours later via a third party who signposted them to additional agencies where necessary.

Some younger patients and their parents said they did not feel comfortable or safe on an adult ward and their individual needs were not considered particularly around autism and mental health. Staff mostly spoke to patients in a respectful or dignified way. However, we observed one patient with dementia spoken to in a patronising manner regarding them wanting to go to the toilet.

Staff mostly respect patients personal, cultural, social and religious needs of patients. However, another staff member undertaking a meal round was observed being disrespectful to a patient which was perceived by the patient to be because of their social situation and/or culture.

# Medical care (including older people's care)

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff sat with patients who were emotionally distressed to calm them and to give reassurance. One patient receiving end of life care said staff had been “lovely and supportive” whilst they had received uncomfortable tests.

### Understanding and involvement of patients and those close to them

**Staff supported patients and their loved ones to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Records confirmed patients who required end of life care and their loved ones were given choices about treatment options. Where it was identified patients lacked capacity there was evidence of family or next of kin being involved in patient care and involvement in end of life wishes.

## Is the service responsive?

**Good** ↑↑

Our rating of responsive improved. We rated it as good.

### Service planning and delivery to meet the needs of the local people

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the changing needs of the local population. The numbers of inpatients within the MLTC division had increased in the last 12 months, the trust had increased bed capacity in response and particularly in areas such as AMU to ensure the needs of the local population was met.

The service had access to areas such as the ambulatory care unit which had reduced hospital admissions. The ambulatory care unit had four senior advanced nurse practitioners and two trainee advanced nurse practitioners assessing patients and providing treatment to avoid a need for a hospital stay.

The service worked with others in the wider system and local organisations to plan care. The trust had increased investment in community support services which included rapid response services, community nursing and virtual wards for covid and respiratory conditions to reduce readmission rates within the medical service.

The frail elderly service provided acute medical support in order to avoid inappropriate admission to hospital and to facilitate a safe discharge from the emergency department. During the covid19 pandemic a unit which was part of the respiratory ward to provide additional respiratory support had been developed.

There had been a business case to increase the provision of consultant oncology advice, diagnosis and treatment capacity to ensure patients had access to timely cancer care. The business case included an oncology service that was accessible 52 weeks per year and capable of consistent delivery of cancer treatment within 62 days of referral.

The oncology and haematology day services had been upgraded and moved away from inpatient wards to minimise the risk of cross infection of their vulnerable patients with reduced immunity. If a patient, however, did require treatment, they would be admitted to a ward with that specialist such as the respiratory or gastroenterology wards with support from the oncology nurse specialists. The service had a business case in place to increase the number of specialist chairs from 14 to 22 to ensure patients had more timely access to treatment.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were clear they would be supported by managers whenever possible to avoid mixed sex breaches. The trust reported 13 mixed sex breaches during August 2022 within the coronary care unit (CCU) at a time of extreme capacity pressure on the service. The patients all required a cardiology bed, not a CCU bed and as there was no clinical need were reported as mixed sex breaches.

Facilities and premises were appropriate for the services being delivered. The trust had an extensive refurbishment programme in place to ensure facilities and the premises safely and appropriately met patients' needs. The new acute medical unit was to bring further improvements and was identified as an exciting time for the team. The plans for the new AMU included two higher monitoring bays with increased nursing support.

### Meeting people's individual needs

**The service was inclusive but did not consistently take into account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Arrangements were in place to support patients living with mental health problems and dementia. Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems and dementia. Whilst the trust had arrangements in place to support mental health patients there was a lack of arrangements in place to support patients who had a learning disability. The safeguarding lead identified this was an area of focus.

Patients who were 21 years and under and had a learning disability were not always placed in an appropriate care setting for their needs or given a choice between an adult or a younger person ward area. Information provided by the trust identified there had been 366 patients under 21 years admitted to an adult ward. The trust policy had been due to be reviewed in May 2020 but with changes in a matron this had not been undertaken.

The policy identified all young people under16 years and those who were identified as vulnerable until their 18th birthday would go to ward 21 (the paediatric and young person ward). The trust policy identified patients between 16-18 were given the choice about whether they went to an adult or young person's ward. During our inspection, we found this was not the situation. Doctors and nurses said patients over 16 were admitted onto adult wards. One patient told us they felt unsafe and scared on AMU due to their age, developmental disability and mental health condition. We did not see any recognition of vulnerable patients under 21 years asked about choice about going to a children/ young person's area or an adult ward.

# Medical care (including older people's care)

Wards were designed to meet the needs of patients living with dementia. Ward 2 was designed to be the dementia care ward and provided additional support for patients living with dementia. Staff used reminiscence therapy to assist patients (particularly with memory impairments) in recalling and sharing events from their past through listening to music, watching news reports of significant historical events, playing games and karaoke and watching films.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff working in cancer services worked closely with Macmillan to ensure patients received additional advice and support when required.

The service had information leaflets available in languages spoken by the patients and local community. The population of Walsall was ethnically diverse. Staff had electronic access to leaflets in other languages which could be printed off when required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to access interpreters or signers when needed and were able to use a translation service for patients for whom, English was not their first language.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

### Access and flow

**People could mostly access the service when they needed it and usually received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Waiting times for cancer review and treatment had been problematic since the covid-19 pandemic. However, information provided for the three months between June and August 2022 showed improvement with cancer waits. The trust performed better than other similar services in meeting cancer waiting time targets.

More than 90% of patients were seen within two weeks for a skin and upper gastrointestinal cancer review whilst there had been some improvement previously for lung cancer no information was available for August 2022.

Gastroenterology had an efficient process for triaging all referrals called the Referral Assessment Service (RAS). A business case had been submitted for an extra consultant and middle grade doctor which would further address the demand and capacity issues for endoscopy services.

The gastro service was achieving the standard for the 62 day wait from referral to treatment. The dermatology service had consistently met the 62 day wait although problems with pathology results had delayed treatment to patients for August 2022. The 62 day wait for lung cancer was not met as treatment was dependent on another local trust. The specialty was moving this service to another local trust from October 2022 to address the delays.

Dermatology had commenced tele-dermatology and recruited to all consultant vacancies which had resulted in the specialty achieving the 2 week wait for August 2022 following a sustained improvement.

# Medical care (including older people's care)

Waiting times for oncology treatments from initial GP referral to commencement of first treatment did not meet national targets. Information for August 2022 showed 83% of patients requiring chemotherapy and 42% for hormone treatment received their initial treatment within 62 days.

Decision from the time seen to commencement of treatment within 31 days was met for all types of oncology treatment (excluding surgery which was provided by another local trust). Cancer services within the trust were supported by consultants from another local trust and a team of oncology nurses which had improved waiting times for oncology services.

Managers and staff worked to make sure patients did not stay longer than they needed to. Senior managers spoke proudly of work undertaken to reduce the length of stay for patients and in September 2022 this was nine days. Average length of stay within MLTC division over the last six months compared favourably with other similar services.

The service moved patients only when there was a clear medical reason or in their best interest. One of the primary reason's patients were moved was due to infection prevention and if patients were identified as covid positive on non-covid wards. Generally, patients were moved to one of the covid wards with most patients going to ward 3. Managers monitored patient moves between wards and services and ensured patients moves were kept to a minimum.

Staff did not move patients between wards at night. In 2020 the trust identified a need to improve patients being moved at night as a quality indicator. As part of the quality improvement initiative the opening hours of the discharge lounge were increased with the closing time extended from 5pm to 10pm. This reduced the number of out-of-hours transfers taking place in the division from an average of 24% to 18%. In addition, the MLTC division had expanded the junior doctor rota in August 2022 to increase medical cover and enable tasks to be completed earlier in the day to enable timely discharges and transfers. This has resulted in 14% of patients out of hours transfers between wards in August and 13% in September.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. Managers in oncology services said only in extreme situation were appointments and treatments cancelled. For example, they had a recent failure of the specialist pharmacy room where chemotherapy was prepared. This meant chemotherapy treatment was not available and appointments were cancelled or were delayed. Ongoing delays in receiving chemotherapy from pharmacy meant patients had to wait for their treatment to be available. Managers said where possible they would make other arrangements but sometimes, they had to cancel patients. When patients had their treatments cancelled at short notice managers made sure they were rearranged as soon as possible and within national targets and guidance.

Patients who were ready for discharge were sent to the discharge lounge. Staff in the discharge lounge said they checked discharge arrangements for all patients including a check all required tests had been undertaken; social circumstances and suitability of the discharge destination, patients' medicines were available and correct and checks to ensure intravenous lines or canula needles had been removed.The trust increased the opening hours of the discharge lounge following a quality improvement initiative identified patients experience had improved. Staff said there were times wards were unable to discharge patients to the discharge lounge but 99% of patients were. Staff said it was much better for patient's safety and flow for them to go to discharge lounge and was better for the ambulance patients to go to the discharge lounge.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. Care group meetings discussed length of stay on each ward and identified actions to address increased length of stay when required.

Staff supported patients when they were referred or transferred between services. Staff acknowledged it was often difficult for patients who required treatment at another hospital as they had to wait for an available bed within the speciality service.

Managers monitored patient transfers and followed national standards. Staff transferred patients when they needed access to a specialist service or procedure not available at the trust. This would involve trust staff confirming the transfer with the physicians at the hospitals where the patient was to be transferred to.

Managers worked to minimise the number of medical patients on non-medical wards (referred to as medical outliers). The MLTC division had embedded the 'red line' that no medicine patients should be accommodated on a non-medical ward without serious considerations of all other options available. This policy ensured patients receive their care in the right place. The trust had significantly reduced the number of medicine outliers in other divisions with just 17 medical patients accommodated on other division wards in the last 12 months.

Suitable arrangements were not in place to ensure managers and staff started planning each patient's discharge as early as possible. When patients were admitted their medical and nursing records detailed home arrangements and any existing care received. However, records seen did not identify potential needs and a plan identified for discharge including referral to other professionals such as physiotherapists or occupational therapists.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Information asking patients and their visitors to share their experience of care were available all patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew how to advise patients on how to make a complaint in line with the trust's policy and procedure. Patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. There had been 96 formal complaints about medical wards between April 2021 and March 2022. The highest number (53) were about care, assessment or treatment. There was a process to investigate complaints locally, it was investigated by the manager and overseen by the quality matron. Complaints were recorded in a dashboard so were available for review by trust managers. Complaint investigations were shared at the monthly matron and care group meetings and potential themes discussed.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. The oncology service said they had improved assessment procedures for patients who had a specialist intravenous needle called a peripheral inserted central catheter (known as a PICC) line. The trust had changed the visiting policy to ensure patients who were vulnerable or had communication difficulties could see their loved ones. Arrangements identified nominated agreed visitors who were covid tested and were issued with visiting passes which were handed to the ward staff when they visited.

# Medical care (including older people's care)

## Is the service well-led?

**Requires Improvement** 

Our rating of well-led improved. We rated it as requires improvement.

### Leadership

**Leaders understood the priorities and issues the service faced; however, these had not been managed effectively. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

Medical services which included all medical wards, accident and emergency, the acute medical unit, ambulatory care unit, frail elderly assessment unit and community services were part of the Medicine and Long-Term Conditions (MLTC) division. Oncology and haematology services were a separate care group and part of the surgical division. CQC methodology includes oncology and haematology as part of the medicine core service. For more information about leadership please see the surgical core service report.

The division was split into care groups such as respiratory, elderly care, acute and diabetes. Each care group had a management team which included a consultant, nurse and manager who were responsible to the senior management team of the division. The MLTC division senior leadership were a triumvirate: a divisional medical director, divisional nurse and divisional senior manager. This leadership team were supported by deputy directors for medical, nursing and managerial. Operational and clinical leadership worked to support quality patient care, the trust's sustainability, and to effectively engage more fully in external partnerships.

Several of the MLTC wards had new ward managers, matrons and additional senior nurse roles. Ward managers and qualified staff we spoke with were highly motivated to provide high quality patient care but were clear of the challenges of their ward and areas for improvements.

The service supported staff to develop their skills and take on more senior roles. One ward had a recently appointed matron. Staff said whilst they were without a matron, they had been supported by the deputy director of nursing for the division. They said this support had continued from the deputy director of nursing, whilst ensuring support was also available for the newly appointed matron.

Leaders and managers said they have been supported to engage in further leadership training. One senior manager told us they have been supported to undertake a leadership course and felt had helped them to better understand compassionate leadership and enabled them to bring this to their day-to-day work.

During our inspection, we saw leaders were present on the ward and staff approached them for advice and support. Staff said matrons for their areas were visible, supportive and prioritised the right issues within their areas of responsibility.

Staff felt the chief executive and senor leadership team were supportive and gave examples of improvements made to the service particularly increased staffing and the refurbishment plan and improved services.

The trust had processes in place to ensure equality and diversity was promoted within and beyond the organisation. During our inspection, no staff members voiced concerns over the way in which they were treated from an equality and diversity perspective.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The trust had a set of values developed with its staff, the values underpinned everything staff did and included Respect, Compassion, Professionalism and Teamwork. Staff knew and understood what the vision, values and strategy were and actions to achieve them.

The trust strategy of the "4 Cs" was supported by the division: This was:

C- Excel in the delivery of care.

C- Support our colleagues.

C- Effective collaboration.

C- Improve the health of our communities.

Managers and staff were enthusiastic about the plans for their service which was aligned to the trust strategy and gave several examples of improvements to the services including staffing, skill mix and the developments of the service which were also part of both the division and trust strategy.

The MLTC division included community services and whilst community services were not inspected the division senior leaders identified community services as central in the support their strategy. The division's plans were in line with integrated care systems (ICSs) and the needs of the local population. This demonstrated senior leaders and managers worked effectively with the wider health economy. Staff told us they were on a journey and were in a much better place but acknowledged they were still not where they wanted to be.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted and provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.**

Staff spoke positively about the improved culture in the trust. Staff in cancer and oncology services said they were "Very proud of the service they offered now". The staff culture in AMU had improved with staff feeling more supported and improved feedback from patients.

Staff and managers said they were listened to and able to put views and suggestions forward for service improvement. Staff said if they had a concern, they would not hesitate to raise it.

# Medical care (including older people's care)

Staff and managers were enthusiastic about their service and were proud to tell us of their achievements and plans although acknowledged the trust was on a journey. One senior manager said ‘we're not where we would like to be yet, but we are going in the right direction, but it's a journey’

Senior staff acknowledged challenges remained in improving culture, trying to get doctors and nurses to work better together but identified huge improvements. Several workshops (some off site) had been held supported by two external people. The workshops had assisted improved communication and people's understanding of each other’s roles for example an Ambulatory care workshop helped to highlight the role of advanced nurse practitioners.

Staff spoke positively about career development opportunities. Several staff we spoke with said they had been appointed to their new position in the last six months. Staff spoke enthusiastically about their role and ensuring patients received high quality patient care. They said they had been supported in their new roles by matrons and senior managers.

### Governance

**Governance systems were in place but were not always effective. Staff were not all clear about their roles and accountabilities but there were regular opportunities to meet, discuss and learn from the performance of the service**.

The trust had identified improvement was required to governance processes and were beginning to implement them with increased governance support to the MLTC division. The new governance structure commenced in April 2022 to assist the service to support improvement and embed positive change.

The service held a range of meetings to share learning and monitor performance with middle and senior managers. There were monthly Divisional Quality Board (DQB) meetings held with divisional directors and senior managers. The monthly meeting included standard agenda items such as staffing, financial situation, review of risks, service delivery and care group highlight reports. Actions were identified for named staff with actions identified to improve service delivery when required and included an action log. Actions were discussed and reviewed at each meeting. However some information provided to the care group meetings was not always robust and challenged the effectiveness of the systems to provide assurance.

Managers had not effectively monitored how well the service followed the Mental Capacity Act. Whilst we saw new documentation for mental capacity assessment was available it was mostly incomplete. The service had undertaken audits of completion of DOLs applications which identified satisfactory compliance. However mental capacity assessments we saw were not completed appropriately.

The MLTC division was split into care groups with each care group having meetings with the division senior management team, as a minimum quarterly or more frequently when needed. The division used a standard agenda for all meetings with records available and included staffing, risks, complaints service performance (patient numbers and length of stay), incidents.

Ward managers completed monthly reports about the ward and had monthly meetings with their matron to discuss the ward performance. Ward managers were clear about actions required to improve the service and identified actions to review staffing, staff mandatory training, staff appraisals. However there was a lack of clarity of roles and responsibilities for some staff for example to reduce medicine errors and ensure VTE assessments were completed.

Meetings were chaired by the most appropriate person, with clinical leads and the director present. We saw a selection of meeting minutes and found them to be detailed and clear. Meetings were well attended and multidisciplinary, and actions were highlighted and reviewed at each meeting. Service leads confirmed that they met with the board regularly to discuss performance.

Each area had a weekly staff safety huddle except for AMU which had daily staff huddles, staffing and key information about the safety and performance of the service were discussed. Notes were taken at each huddle for reference for those staff who were unable to attend. It was noted meetings observed were not collegiate and were focused around doctors rather than a full team approach to fully benefit patient care. There was a weekly multidisciplinary (MDT) review of all moderate harm or above incidents to enable any required immediate actions to ensure safety. All moderate harm and above incidents were investigated, and a report completed of the findings and actions required with any associated learning shared with staff. Information was shared through meetings, minutes, and newsletters with other staff.

AMU senior leadership had appointed a governance facilitator to ensure they shared examples of good practice.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance however, these were not effective. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

Matrons and managers did undertake regular audits of patients care for each ward such as patient's records completion, medicines management and completion of mental capacity assessment and DoLS. However, these audits did not fully identify the failing which we found during the inspection.

There were departmental, care group, division and trust risk registers. Risk registers were monitored and updated within the department care group and the division quality board. The governance team were reviewing all risks alongide the divisional team to ensure appropriate actions were in place. Each risk identified was recorded on a register and summarised: a description of the risk, its cause and impact, the existing controls for the risk, an assessment of the consequences and likelihood of the risk happening with the existing controls, the risk rating: low, medium, high or very high and the overall priority of the risk. The governance senior team met monthly with the divisional management team to discuss divisional risks. A monthly risk report was taken to divisional quality board. Divisional risks and risks requiring escalation to the corporate risk register were discussed at a divisional performance review and taken to the risk management executive. The risk register reflected the risks staff, managers and we identified.

Leaders said financial pressures did not compromise patient safety and gave examples of increased investment to ensure patients safety. Information provided within business cases to improve service identified any potential harm to patients if the business case was not accepted or a failure to meet required standards.

The division had regular morbidity and mortality meetings for each care group as an opportunity for learning and reflection both within the care group and more widely in the trust. These provided a forum for staff to explore the management patients who had died and if patient care and treatment pathways were appropriately followed.

### Information Management

**The service collected data and analysed it. The quality of data was not always robust. Staff could find the data they needed and were able to understand performance, make decisions and improvements when needed.**

The service had improved information management systems. Managers said they were more assured of the accuracy of the information and data they received. However there remained some gaps particularly in the quality of some audits which did not provide accurate information about the service provided.

Managers reviewed all information to give them a picture of the quality of care provided. For examples they had systems to review identified incidents / complaints including patient falls and pressure ulcers against staffing. They were able to identify when staff required additional training for example in medicines management. Whilst audit results such as medicines audits, patient record audits and mental capacity assessment audits did not always reflect our findings. However senior managers confirmed similar concerns identified from other performance findings.

The trust had included a section in divisional and care group meeting called the patients voice which included a summary of all patient feedback in the previous month which included mystery patient and friends and family response. This enabled the service to see patients' feedback in a timely way. Feedback was shared with the ward who also had access to the monthly information.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

There were quarterly meetings to review friends and family results and "mystery patient information". The "mystery patient" was a newly introduced scheme which enabled patients and visitors with smart phone to provide an immediate reaction to the care they had received and when needed ensure a timely response.

Patient voice reports were included within the MLTC division and had been available since February 2022. The patient voice included all patient feedback, including compliments and complaints, friends and family survey results and mystery patient feedback. Feedback posters with a quick response (QR) bar code were available within ward areas.

The service had collaborated with partner organisations to help improve services for patients. There had been workshops with patient groups prior to moving into the new AMU building. Healthwatch had supported the trust to design some patient information leaflets to understand the role of AMU. The leaflet described the remit of AMU as an assessment unit and it was likely they would be moved again onto another ward for further treatment.

The trust had a "Macmillan hub" which was available to support patients who had cancer or a life limiting condition to promote their health and wellbeing.

Information was shared with staff via newsletters, email and face to face meetings. The trust had a meeting with executives on a Friday which staff could drop into during their break for tea and coffee and cake provided by the executives. The meeting was based on a Swedish idea and were called FIKA Friday. Managers said they had a good response from staff who appreciated the informality of the meetings and the cakes provided whilst giving executives an opportunity to hear direct from staff.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. Leaders encouraged innovation.**

# Medical care (including older people's care)

We saw many examples of improvements made to the service to enhance and improve patient care. Leaders encouraged innovation and spoke about quality improvement initiatives which had improved service delivery for example the changes to improve patient discharge arrangements. Improved services and service developments had been achieved by increased staff investment.

Clinicians spoke with enthusiasm and passion about their services and changes made to improve patient care. One example was the lung cancer service. A clinician told us with support from the medical director the service had enrolled onto a lung cancer improvement programme. Prior to the improvement programme there had been several reported incidents of patients who had pleural nodes who had developed lung cancer but was diagnosed at a late stage. There had been no incidents in the last 18 months of patients as patients are regularly screened and any cancer is detected earlier meaning treatment is more effective.

Since January 2021 the trust had a multi-disciplinary diabetes and renal clinic which had improved patient care, one of the first trusts (apart from large regionally and national centres) to provide this service. The trust had submitted their findings to national and international meetings and professional journals.

The diabetes service had received several awards for improvements identified as a result of the Digital Evaluation of Ketosis and Other Diabetic Emergencies (DEKODE) project. Diabetes staff were proud of these innovations and improvements made to patient care.

# Surgery

**Good**  

## Is the service safe?

**Requires Improvement**  

Our rating of safe stayed the same. We rated it as requires improvement.

### Mandatory training

**The service provided mandatory training in key skills to staff and most staff completed it.**

Most nursing and medical staff received and kept up to date with their mandatory training. Across all subjects and staffing groups training completion figures were at 89% overall which was slightly below the trust's target of 90%. The trust monitored key areas which required improvement and they included for example; fire safety, information governance, infection prevention and control, resuscitation and safeguarding children and adult level 3. Senior staff told us most staff who were not up to date had been booked to attend mandatory training. Staff reported that some face to face sessions had been cancelled due to staff shortages. Where this had occurred, staff were booked to attend the next available training session.

Not all staff were always given enough protected time to complete their mandatory training. We spoke to a foundation year one doctor who said they were up to date with their mandatory training. However, they had to complete it in their own time because wards were so busy, and they could not always be released to do the training.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were required to complete mandatory training in a range of topics including safeguarding adults and children, information governance and data security, equality and diversity, conflict resolution, fire safety, health and safety, moving and handling, dementia awareness and infection prevention and control.

Staff could access mandatory training in a variety of ways and included online e-learning and face-to-face sessions as appropriate. Staff were allocated dedicated time to complete 'face to face' mandatory training. Training was completed and entered onto the trust's electronic system where competences achieved following training could then be awarded.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff could access support from specialist teams and nursing staff when needed. Staff feedback about all aspects of this training was positive. Data provided by the trust following our inspection showed 93% of staff within the surgical division had attended dementia awareness training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Both nursing and medical staff told us managers gave them warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Nursing and medical staff received training specific for their role on how to recognise and report abuse. The trust had three safeguarding levels of training for nursing, medical and non-medical staff which were mandatory. Data provided by the trust following our inspection showed that staff either completed safeguarding adult or children level 1, 2 or level 3. Overall compliance for safeguarding children level 1-3 was at 91.1% and 90.2% for safeguarding adults levels 1-3 which was in line with the trust's target of 90%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff on ward 12 demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a safeguarding adult lead nurse and the safeguarding children lead nurse within the trust who could be contacted for additional help and support. There was a trust quarterly safeguarding steering group which was chaired by the director of nursing. Those at the meeting reviewed training compliance rates, any safeguarding process concerns, action plans from serious adult reviews and serious child reviews and incidents reported relating to safeguarding.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about safeguarding and some could give examples of when they had needed to act to safeguard patients.

The service had a safeguarding adult at risk policy and a safeguarding children and young people policy. The policies were version controlled, in date and reflected national guidance. Ward managers, senior managers and the safeguarding leads supported staff to raise, report safeguarding concerns and make safeguarding referrals to the local authority.

Nursing staff had good awareness of female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Nursing staff confirmed FGM was included in their safeguarding training.

Recognised recruitment procedures were followed, which helped to ensure staff were safe and suitable to work with people or children who received care from the service. Discussions with staff showed required employment checks were made before staff provided patient care. For example, checks of staff previous employment, work history and checks with the disclosure and barring service. This helped the trust to make safe recruitment decisions about an applicant's suitability.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. They kept equipment and the premises visibly clean. However, staff did not always use control measures to protect patients, themselves and others from infection.**

Not all staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gel and PPE. Masks were worn in line with trust policy. However, we observed some examples of poor infection prevention and control practices in ward 11 where not all staff wore appropriate PPE while taking blood and serving meals. This was raised at the time of our inspection.

# Surgery

Staff received training about infection prevention and control (IPC) and hand hygiene during their trust induction and annual mandatory training. Following our inspection, data provided by the trust showed as of October 2022, 77.1% of all staff groups within surgery had completed Infection Control Level 1 and 2 training which was lower than the trust's target of 90%.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There were recently refurbished areas such as theatres which had been designed to the latest national standards and included laminar air flow required for patients undergoing hip or knee operations.

The service generally performed well for cleanliness. Ward infection prevention and control performance was monitored. We reviewed infection prevention and control audits for July 2022 for wards 10, 11,12, 20a and 20b and overall compliance was at 92.3%. Auditors sent audit results to ward managers, matrons and the divisional director of nursing at time of completion. Any non-compliance was fed back to the area at the time of audit and action plans are owned by the areas.
Staff provided assurance and feedback at the infection control committee.

Staff used records to identify how well the service prevented infections. The service carried out quarterly hand hygiene audits and measured compliance against observed hand hygiene opportunities. The overall compliance for audits done in July 2022 was 97.2%. Staff reported quarterly hand hygiene audits to the IPC committee and these were escalated to quality committees.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaning equipment between patients. There was no evidence of high-level dust. Staff told us they would always clean equipment before and after use. We reviewed a selection of items including commodes, clinical observation and resuscitation equipment and found them to be clean as stated on the 'I am clean' label.

During our inspection, we found the general cleaning of the environment and furnishings in all ward areas was consistently of a high standard.

Staff worked effectively to prevent, identify and treat surgical site infections. Clinical staff adhered to the trust's being bare below the elbows policy. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three.

Hand hygiene gels were available for use at each entrance and throughout the ward, and there was hand hygiene advice displayed on the walls, which reminded staff, visitors, and patients to decontaminate their hands prior to entry. Appropriate PPE, such as masks, gloves and aprons were readily available for staff to use.

Equipment within theatres was cleaned in accordance with the NHS healthcare cleaning manual. We reviewed the theatre cleaning frequency and responsibilities document which listed the areas and equipment to be cleaned and who was responsible for ensuring the tasks were complete. We saw equipment being cleaned in theatres.

Infection rates within the surgical division were monitored. The surgery division monitored surgical site infections using a nationally recognised infection prevention and control pathology system. Staff presented themes and actions to the patient safety group ultimately the quality, patient experience and safety committee, which was a sub-committee of the board.

# Surgery

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly when called. Patients on ward 11 said staff responded quickly although there were occasional delays when everyone rang at once.

Bays situated close to the nurses' station were allocated to patients who were more dependent on nursing care and meant staff had better visibility of patients within them. For example, patients with mobility difficulties, at higher risk of falls, requiring closer monitoring or living with dementia. This was to reduce the risk of higher risk patients coming to harm and staff could respond more promptly.

The design of the environment followed national guidance. Surgical and anaesthetic equipment was available and fit for purpose and checked in line with professional guidance. For example, digital blood pressure monitors were all within electrical and biomedical engineering (EBME) service dates and visible stickers were seen to evidence it. Single use sterile instruments were stored appropriately and kept within their expiry dates. Surgical procedure packs, implants and consumable items were stored in a tidy and organised manner.

Staff carried out daily safety checks of specialist equipment. Daily and weekly checks of the trolleys were consistently completed, according to the recorded entries in their resuscitation books. During our inspection, we checked the resuscitation trolleys and saw all appropriate equipment was present and accounted for.

Equipment required in an emergency was available within theatres, in recovery and on most surgical wards. Resuscitation trolleys and equipment were standardised and the contents were checked daily. Resuscitation trolleys had a tamper proof tag, which assured staff that the trolley had not been used and the required equipment was available for emergency use. On ward 20b the resuscitation trolley was shared with ward 20c and was placed between both wards. The wards were next to each other and the resuscitation trolley was accessible to all.

The service had suitable facilities to meet the needs of patients' families. Patients with learning disabilities were often given side rooms so relatives could stay with them to offer support.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to mobility aids such as Zimmer frames and walking sticks which were adjustable and tailored for use by specific patients.

Staff disposed of clinical waste safely. Clinical waste was segregated and disposed of in separate clinical waste bins or sharp-instrument containers. We saw staff following waste management practices during our inspection and none of the waste bins or containers on the wards were unacceptably full.

We found equipment stored in corridors within theatres which was not in line with safety standards. We raised this with senior staff at the time of our inspection who said the department was currently undergoing a refurbishment and provision would be made for storage of equipment to mitigate risks.

## Assessing and responding to patient risk

**Staff did not always complete and update risk assessments for each patient. However, they identified and quickly acted upon patients at risk of deterioration.**

# Surgery

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The National Institute for Health and Care Excellence Guidelines (NICE) NG89 Venous thromboembolism (VTE) in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism), states the risk of VTE or bleeding needs to be identified as soon as possible after admission to hospital or by the time of the first consultant review. During our inspection, we found initial VTE assessment and reassessment was not carried out on nine out of 18 patients. Following our inspection, the trust provided figures around VTE performance which showed 42.3% compliance in July and 42% compliance in August across five surgical wards.

We looked at the quality report 2021/2022 and the trust generally had not achieved their target of 95% of all patients receiving a VTE assessment within 24 hours of admission. From May 2021 to April 2022 the overall compliance for surgery was at 92.4% which was slightly below the target. The service recognised VTE had been a focus of improvement and a quality improvement project was planned within the division of surgery. Consultants received a daily report of compliance and divisions received a monthly report to enable a focus on improving timely patient assessments.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used nationally recognised tools to assess patients' risk of developing for example, pressure ulcers and nutritional risks and escalated them appropriately. They also used a multi-factorial falls risk assessment to identify each patients' risk of falls and any associated risks with moving and handling. We saw these risk assessments were reviewed regularly and when patients moved wards or had a change in condition, they were reassessed.

The surgical division had at any given time, at least one member of recovery staff who was trained and certified to an appropriate level in life support. Following our inspection, data provided by the trust showed 88.6% of consultants and 100% at non-consultant level had received advanced life support training including 19.2% trained as trainers.

During our inspection, we reviewed seven patient records and found falls risk assessment had been completed for all patients, and care plans were in place for those patients that were deemed at risk of falls.

Staff undertook daily assessments for bed rail suitability where it was considered that bed rails may be useful. During the inspection, we saw that bed rails were used following an appropriate assessment that indicated bedrails would support a patient to safely remain in bed rather than rolling out.

We looked, in detail at sets of records across six wards and theatres which were a combination of paper and digital records on the trust's handheld Electronic Patient Record (EPR) system. We noted that they were usually fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

Staff knew about and dealt with any specific risk issues. All patient observations were entered into the trust's handheld EPR system. The system automatically screened for patients at risk of sepsis and an alert was sent to the nurse or doctor's mobile device. They then had the authority to deescalate through their clinical judgement or continue on the sepsis pathway.

The service ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist which was an improvement from our last inspection in July 2019. Staff carried out WHO briefs between 8.30 and 9am either in the anaesthetic room or in operating theatres. We observed the WHO checklist for safe surgery being used and

noted good practice in that patients were checked in by the surgeon, anaesthetist and anaesthetic assistant. Staff said any breaches of completing these safety checks resulted in an incident forms being raised. We looked at six records for patients who had just had surgery during our inspection and the WHO checklist was correctly followed and recorded in all cases.

There was a hospital wide standardised approach to deteriorating patients and a clear documented escalation process. The trust used the national early warning score (NEWS) to determine whether a patient's health was deteriorating and utilised an electronic system for recording patient scores. NEWS is a combination of observations that indicate whether a patient is deteriorating and what associated actions should be taken.

The trust could demonstrate it followed sepsis guidelines (NICE and the UK Sepsis Trust), to identify the sepsis triggers and commence treatment within the 'golden hour'. This was monitored monthly and was fed back to the surgical teams on a regular basis. A sepsis and outreach response team (SORT) was created in January 2022 within the trust amalgamating the critical care current outreach team alongside a newly formed sepsis team. Since the development of the SORT, the overall divisional performance for surgery in percentage of antibiotics completed within one hour had increased from 43.5% in October 2021 to 80.6% in August 2022.

The trust used an electronic system whereby patients' observations were entered and a score, relating to their level of deterioration, was displayed. If a patient's score was five or higher the ward doctor, on-call doctor or outreach service were contacted to carry out a review. Observation frequency was increased to review if the patient was deteriorating. If scores were rated five or above a sepsis screening tool was completed. Staff followed the Situation, Background, Assessment and Recommendation (SBAR) tool. This tool outlines the deteriorating patients' clinical details and symptoms when escalating to a senior medical member of staff. This ensured staff had all the information needed to respond appropriately. There were also designated quality champions on the wards which enabled training and feedback to take place at ward level.

The service put in a business case to the board in July 2021 for the introduction of a Sepsis Response Team led by a band 7 independent advanced care practitioner to support early identification of sepsis and the timely implementation of the sepsis Six within 60 minutes. The initial recommendation was around the initial introduction of rapid response team for 12 hours per day, 7 days per week to demonstrate the benefits of improved implementation of the sepsis six within one hour. The team will expand to 24/7 provided those benefits are delivered within 12 months and are expected to deliver a reduction in mortality associated with sepsis, a reduction in admission to ICU and a reduced length of stay for patients with sepsis.

All elective patients had a pre-operative assessment before admission to assess fitness for surgery and assist in the reduction of cancelled operations. All patients were seen on the day prior to surgery by the anaesthetist and surgical medical staff. All patients had consent for their operation taken before they came to theatre in line with trust policy.

Patients who were electively booked for theatres had a Methicillin Resistance Staphyloccocus Aureus (MRSA) negative swab result available prior to the operation taking place. No patients were admitted to the elective wards without a negative status. If no swab was available and the procedure was clinically essential then it was up to the consultant surgeon to make the decision to operate or not. The surgical division did not monitor compliance for MRSA. The trustwide overall compliance for MRSA screening on admission was at 76% and there was no action plan in place to improve performance.

The infection control team completed MRSA screening compliance and presented figures to the infection control committee on a monthly basis.

# Surgery

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Three nursing staff we spoke with knew how to get support from the mental health liaison support team.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information. Nursing staff had daily handovers and ward rounds to discuss each patients' needs. Staff highlighted staffing and workload issues, patients due for discharge and patients who were cohorted or required supervision. This ensured staff were continually updated on the plan of care for every patient on the ward and the nurse in charge maintained an effective oversight of the patients in their care. Staff told us they knew which patients were at risk of falls in each area and used an eye icon on the patient whiteboard to indicate they were under supervision.

### Nurse staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, actual nursing rotas did not always match planned numbers.**

The service had enough nursing and support staff to keep patients safe. Data provided by the trust following our inspection showed staffing levels were appropriate to deliver safe care and treatment to patients.

The trust had taken steps to increase staffing within the surgical directorate. The division had recruited 108 overseas nurses since the program began in March 2021, with a further 24 nursing staff in the pipeline to join the surgical division from September to November 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers completed and signed off allocated rosters eight weeks prior to the roster commencement date via a two-tier system. They put bank requests onto the system especially where gaps within the roster were identified to enable staff pick up shifts via the nurse bank. If any shifts remained unfilled 72 hours prior to the commencement of the shift, this was reviewed by the senior ward team and sent out to agency.

The divisional director of nursing, matrons and ward managers used a daily risk assessment for staffing on the wards. This was used to identify issues and escalate any gaps/shortfalls in staffing. The assessment also recorded daily acuity on each ward and aided in the decision making to ensure all areas were safely staffed.

The number of nurses and healthcare assistants did not always match the planned numbers. During our inspection we noted that on ward 20b the actual staffing did not meet the planned levels. Early shifts on the 29 September, 1,2 and 3 October 2022 remained unfilled despite being escalated to an agency. Similarly, on the day of our inspection, we reviewed staffing rotas on ward 12 and also noted gaps in the nursing rota. They required five nurses and had four nurses, and there was a nurse less than the planned number on the day prior to our inspection. Two nurses told us they could often only provide basic care to patients due to staff shortages. A theatre list had to be cancelled on the day of our inspection due to staffing issues.

# Surgery

Managers discussed the varying needs of the different wards at a bed meeting at 8am and arranged for staff to be redeployed in order to keep the service as safe and effective as possible. Staff confirmed they were occasionally moved to other areas to provide cover as a result of staff shortages. They clearly knew the staffing needs of each ward and any shortfalls or extra capacity in ward staffing. This meant they were able to work together to deal with immediate staffing issues such as sickness, emergency admissions and patients who were more acutely unwell than expected.

The surgical admissions unit, ward 12 was a 27 bedded unit which received patients from the emergency department and surgical ambulatory care unit. The ward was substantively staffed for 27 patients, although the budget reflected a 12 bedded unit.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff told us that if additional staff were required, for example to support one-to-one supervision of a patient, it was escalated to the ward sisters for authorisation. In other instances where the ward was short staffed and additional staff could not be redeployed to the ward, staff told us the ward sisters worked clinically to support staff. Staff also told us the team were flexible and changed their shifts to cover staff shortages.

In theatres staff used a staffing tool to help plan the number of staff required on each shift. There was a staffing board in reception showing who was on duty. A theatre staffing business case expanded the band 6 ratio within theatres giving further opportunity to staff within the department and providing an opportunity to recruit externally to enhance the skills and experience within the theatre complex.

The service had low vacancy rates of 1.4%. The service was oversubscribed in some areas and so flexed staff to cover staff shortages in areas as required.

The service had reducing rates of bank and agency nurses. Staff forward planning bank recruitment monthly and all bank staff attend a full induction programme to ensure they had the appropriate skills.

Sickness rates were mostly aligned to the waves of covid infection in the local community with staff sickness deceasing and increasing alongside community covid infection rates. The service reported an overall nursing sickness rate of 5.4% in October 2022. We reviewed the divisional action plan for July 2022 which highlighted anaesthetics staffing issues (consultant and junior workforces) around sickness and ability to cover the required demand. The rota co-ordinator and anaesthetic rota lead reviewed sickness data and shared an escalation plan for the reduction of elective lists in line with sickness.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers held workforce and agency review meetings monthly and on an ad hoc basis to monitor and review bank and agency use.

Managers made sure all bank and agency staff had a full induction and understood the service. We were shown how all agency staff were given an induction. All staff new to the surgical wards told us they had a supernumerary induction period and bank staff told us they had received an induction. Managers had no problems accessing the trust and clinical induction for new starters.

Arrangements for handovers and shift changes ensured people's needs were communicated. There were standardised handover procedures for nursing staff, both for shift handovers and discharge of patients. Each morning and night, during shift changes, the nursing staff carried out a handover from night to day and day to night shift.

# Surgery

The service had a surgical ambulatory care unit which provided 24-hour service although financially budgeted for a daytime only service.

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Foundation year doctors were always available and there were good consultant numbers and consultants conducted pre- and post-operative ward rounds each day.

The service always had a consultant on call during evenings and weekends. Orthopaedic or general consultant surgical cover was available 24 hours a day, seven days a week. Junior medical staff were supported by more senior staff if needed.

The service had enough medical staff to keep patients safe. The trust board had approved a £1.64M per year investment in 34 whole time equivalent (WTE) theatre staff and 4.6 WTE consultant anaesthetists, delivering a workforce that was both the right size and met association for perioperative practice guidelines. All theatre staff had been recruited since approval.

Funding had also been approved to expand recruitment of consultants in general surgery, therapists, breast advanced care practitioners, urology, trauma and orthopaedic consultants and additional independent practitioners.

The medical staff matched the planned number. The service had a good skill mix of medical staff on each shift.

The service had low vacancy rates of 3.84 for medical staff.

The service had low turnover rates for medical staff.

The service reported an overall medical and dental staffing sickness rate of 2.1% in October 2022.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Physiotherapists and occupational therapists attended and contributed to board rounds from Mondays to Saturdays and provided input on patient progress and care plans.

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.**

Patient notes were comprehensive and all staff could access them easily. The majority of records were paper based. However, the trust recorded a range of information on its electronic patient record (EPR) system. Patient demographic details (such as name, date of birth and address), referrals and blood and diagnostic tests were stored electronically.

# Surgery

We reviewed 18 patient records and found they were clearly written and legible. Most records were up-to-date and available to all staff providing care with all entries, dated, timed, signed and the designation of the person making the entry identified. Admission records and nursing assessments were legibly documented in keeping with national Record Keeping Guidelines. However, weight was not recorded on three out of 18 of them. There was a potential risk of patients not being prescribed the right medication dose.

Matrons completed monthly documentation audits and found no evidence of any recurring themes or trends requiring an action plan following a review. We requested monthly documentation audits but did not receive them from the trust. There are plans to review and amend the audit tool and the trust are currently in a training phase of a new integrated nursing documentation/risk assessment admission document.

Bed rail assessments, falls risk assessment, Malnutrition Universal Screening Tool assessments and all relevant risk assessments were completed in records we reviewed, with patient wishes documented in the assessments. Patients at risk of falls had a falls care plan in place.

When patients transferred to a new team, there were no delays in staff accessing their records. All the required information was available when patients moved between teams, services and organisations. Patient records were available upon discharge.

Recommended Summary Plan for Emergency Care and Treatment (RESPECT) and Do not Attempt Cardiopulmonary Resuscitation DNACPR records were properly recorded for patients who needed them.

Records were stored securely. Patients' medical and nursing records were centrally stored on site. On admission, patients' records were requested and stored securely in lockable trolleys either in corridors or store cupboards on the ward. During our inspection, we saw no notes trolleys left unattended when unlocked. We also saw that no patient identifiable data was left unattended or in public view and computers were locked when not in use. Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual account log-in details. Staff received training on information governance as part of their mandatory training programme.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff monitored and reviewed the effects of medicines administered.

Pharmacy technicians carried out random checks and audits on trolleys, fridge temperatures and controlled drugs. Pharmacists completed safety checklists which included antibiotics audits and there was good online resource on antibiotic stewardship. Pharmacists were visible on ward areas we visited.

Surgical wards had produced an antimicrobial audit report from April to June 2022 with the quarter two report scheduled for submission at the next medicines management meeting at the end of October 2022. The Commissioning

for Quality and Innovation (CQUIN) target for first quarter of submission was surpassed by 10%, with 89% compliance noted in appropriate prescribing. To further improve compliance, the service had sought support from medical and nursing teams to ensure urine sample taken at time of diagnosis were in line with guidance. Reports and action plans were reviewed during medicines management group meetings.

Staff completed medicines records accurately and kept them up to date. The management of controlled drugs was in line with legislation and NHS regulations. There was a controlled drug register which recorded drugs being booked into stock, administered to a patient and any destruction or return to pharmacy. Staff we spoke with were aware of the policies on the administration of controlled drugs. We reviewed the register and saw it had been completed in full.

Staff stored and managed all medicines and prescribing documents safely. Fridge temperatures were monitored by ward staff. Any discrepancies were acted upon immediately and staff were aware of what action to take if the temperatures were not safe for medicine storage. We reviewed data confirming medicines were stored within the recommended temperature range for safe medicine storage, all of which were correctly recorded. If temperatures were outside of required ranges, the pharmacy department were contacted.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacists regularly reviewed medicines charts to ensure patients were on the right medicines and the right dosage.

Staff learned from safety alerts and incidents to improve practice. The service had a robust system in place for reporting incidents and for receiving and dealing with medicines safety alerts. A medicines safety officer was involved in all medicine related incidents.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff throughout the wards we visited described the process for reporting incidents and were confident in using the system.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. In theatres there was a good awareness of incidents with senior and junior staff able to describe learning following recent events.

The service reported four incidents classified as never events from October 2021 to October 2022. Of the four reported never events, three were related to wrong site surgery and one to a retained foreign object. The trust carried out thorough investigations following the never events and now had additional systems in place including a system oversight for all medical staff following a never event which involved a locum doctor.

There was evidence that changes had been made as a result of feedback. For example, following a recent incident which involved a block, the service introduced a block trolley which contained laminated cards that stated “stop before you

block" which could be put on the trolley or on the plastic tray containing equipment for giving a block. We visited the trauma theatre anaesthetic room and were shown the block trolley. The ultrasound machine had stickers on it saying, 'stop before you block'. The theatre care plan had been redesigned with two sections that required confirmation of site before giving a block. These improvements were made to prevent never events from happening.

Theatre staff stored implants on a separate trolley, checking them at the beginning of a list and ensuring checks were done at the time of implant to prevent human error.

The service had introduced a new initiative in general surgery called "10000 feet and falling" which was taken from the air industry. Staff could shout out at any stage during a procedure if they felt a patient was deteriorating or was becoming unstable.

Managers shared learning about never events with their staff and across the trust. The trust held divisional governance monthly meetings, during meeting incidents were discussed, with learning across all clinicians.

Managers shared learning with their staff about never events that happened elsewhere. Nursing and medical staff were aware of a recent never event outside of the inspected activities and told us how it had been discussed and learning disseminated.

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported 50 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from September 2021 to September 2022. We reviewed five final investigation reports and found the serious incidents had been thoroughly investigated and included lessons learnt and recommendations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. Staff were familiar with the terminology used to describe their responsibilities regarding the duty of candour regulation.

Staff described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the patient and their relatives. The trust had identified concerns around culture within theatres and carried out an independent review in May 2022. During our inspection, senior clinicians spoke openly and positively about a shift in culture following a recent investigation into upper limb surgery.

Staff met to discuss the feedback and look at improvements to patient care. Leaders shared feedback following any improvements during safety huddles.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. Senior staff across theatres reviewed incidents for trends and to action when necessary to ensure patient safety.

## Is the service effective?

**Good** ↑

# Surgery

Our rating of effective improved. We rated it as good.

## Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies. Policies we reviewed were up to date and included a next review date.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not encounter patients who were subject to the Mental Health Act, but staff were aware of the code of practice and the policies that were in place.

Patients' physical, mental health and social needs were mostly fully assessed. Staff within the surgical division screened patients for pressure ulcers, falls, venous thromboembolism (VTE) and mental capacity throughout their admission. Practice was in line with the National Institute for Health and Care Excellence Guidelines CG92 (Reducing the risks for patients developing venous thromboembolism in hospital), QS86 (Falls in older people) and CG179 (Prevention and management of pressure ulcers). Within all 18 patient records we reviewed, although there were gaps in appropriately assessing for VTE, there was evidence most patients were fully assessed and/or screened on admission and daily using validated and reliable scales. This was an improvement from our last inspection.

The service followed NICE NG51 Sepsis: recognition, diagnosis and early management guidance and carried out ongoing local audits to monitor trust progress. The World Health Organisation safer surgery checklist was used within the theatre department to ensure all safety aspects were achieved and adhered to. Compliance was monitored by monthly audits, which showed that practice in theatres was good.

The service had processes in place to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff told us they followed the trust's Equality, Diversity and Inclusion policy when making decisions.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patient records reviews showed that patients' psychological and emotional needs were recorded.

Staff used technology and equipment to enhance the delivery of effective care and treatment and to support people's independence. Physio therapists carried out assessments to ensure patients had the right equipment prior to discharge.

Senior clinical leads told us that they are involved in contributing data for the national bariatric surgery register and this was completed by a specialist bariatric nurse.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients could choose from a wide range of foods that accommodated clinical needs, religious needs and personal preferences to promote eating. Every patient to whom we spoke was complementary about the quality and choice of the food that they were served.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patients' notes showed that patients who needed their fluid intake and nutrition monitored had this done by staff.

When patients had surgery, staff effectively managed nausea and vomiting. For example, we saw evidence of anti-sickness medicines prescribed in drug charts of patients who had recently had surgery.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients' notes showed that all patients had their nutritional needs assessed on admission and further assessments carried out as necessary. This included their weight.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff had good access to specialist input including from specialists in swallowing as well as dietitians.

Patients waiting to have surgery were not left nil by mouth for long periods.

Staff met the nutritional needs of patients. We saw patients who were unable to intake food orally during our inspection. The patients who required nasogastric and percutaneous endoscopic gastrostomy (PEG) feeding were supported appropriately by staff.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain**.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Wards had access to a specialist pain team during the day seven days a week including bank holidays.

Patients received pain relief soon after requesting it. A patient on ward 11 told us staff were responsive to their pain relief needs.

The surgical division and pain management lead consultant were currently auditing and reviewing the backpain pathway for acute spinal admissions and the pathway for management of chest injury and rib fracture pain. Staff planned to introduce a new policy which aimed to improve the accuracy of pain scoring and appropriate referral to the acute pain and critical care outreach teams. There were plans to carry out a 3-month audit assessing the efficacy of a new proforma for clerking patients presenting with back pain to the trauma team.

The service had a management of chest injuries and rib fractures pathway stated that a stepwise approach to pain relief medicines and regular reviews from a team of specialists, including medical, nursing, pain management and physiotherapy may reduce complications and mortality.

Staff prescribed, administered and recorded pain relief accurately. Patient records showed pain relief needs and medicines was recorded correctly.

# Surgery

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The service participated in relevant national clinical audits. They participated in audits such as the National Lung Cancer, National Bowel Cancer, National Oesogastric and Fracture Neck of Femur audits. Outcomes for patients were largely positive, consistent and met expectations, such as national standards.

During our last inspection, the surgical division did not have oversight of all their clinical outcomes because they did not always have the required staffing to ensure consistent and accurate input of data. This had improved during this inspection as they had recruited consultants who monitored patient outcomes.

Managers used information from the audits to improve care and treatment. Where there were shortfalls in performance managers took action to improve the standard of treatment.

Managers and staff used the results to improve patients' outcomes. The service recently received a fracture neck of femur (NOF) award which was an improvement from them being an outlier in NOF mortality a few years ago. They had carried out a lot of quality improvement projects with significant improvement made in the NOF pathway supported by therapy resources.

The perioperative medical assessment rate was 94.7% in December 2019, which was similar to the national standard of 92.8%.

The risk adjusted 30-day mortality rate for the National Emergency Laparotomy Audit was 7.7% which was similar to the national average of 9.3% in November 2019. Although the risk adjusted 30-day mortality rate for National Hip Fracture was at 10.6% and worse than the national average of 6.1% in March 2019, there had been an improvement as previous performance figure was at 11.3% in December 2018.

The risk adjusted 90-day post-operative mortality rate for National Bowel Cancer Audit performance was at 3.4% which was similar to the national average of 2.9% in March 2019.

Cancelled operations not treated within 28 days of non-clinical cancellation performance was at 15.5% which was similar to the national average of 23.7%.

The service had presented a business case for genomic testing to determine if chemotherapy would benefit node positive patients living with breast cancer. The test performs a deeper look into the genetic changes of individual cancer cells to determine the best cancer therapy. The purpose of this test is to better identify people who will or will not benefit from chemotherapy and reduce the chances of patients having chemotherapy by 70%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment and made sure staff understood information from the audits. The service conducted several audits including the theatre audit bundle, five moments of hand hygiene and surgical site infections. We reviewed surgical wound assessment audits carried out across various surgical ward areas and compliance figures ranged between 90% to 100% in July and August. We reviewed minutes of a surgical site improvement group meeting which was held in June and found a recent incident which was surgical site infection was discussed and included learning and recommendations.

# Surgery

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. There were three surgical outliers on day one of our inspection. From October 2021 to September 2022, the service reported 78 bed days of surgical outliers. These were almost entirely as a result of transfers of care to a surgical consultant. Staff said the trust adopted a no tolerance approach to both medical and surgical outliers.

Managers shared and made sure staff understood information from the audits. Theatre staff audited each step of the five steps of safer surgery. Results of the World Health Organisation observational audit was displayed on a board in theatres. We reviewed team brief, sign in, sign out, time out and team debrief audits for June, July and August 2022. Compliance ranged between 93% to 100%. Team leaders had an action plan in place and had a safety huddle at 8am daily.

### Competent staff

**The service made sure staff were competent for their roles. They held supervision meetings with them to provide support and development. However, managers had not appraised most staff's work performance.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff told us they had sufficient training and support to care for patients.

Managers gave all new staff a full induction tailored to their role before they started work. The professional development team within theatres developed a robust induction and competency package to support new starters. This included a 12-week supernumerary training period to support the development of recovery and scrub competencies for new starters with either no or limited theatre experience.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers identified poor staff performance promptly and supported staff to improve. Following our inspection, the trust provided appraisal rates within the surgical division. This data showed that appraisal rates for all staff across the surgical division was 72.7% which was lower than the trust's target of 90%.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The Trust had appointed an associate deputy chief medical officer to develop a programme to expand the role of physician associates advanced care practitioners to the trust.

The clinical educators supported the learning and development needs of staff. All newly recruited overseas nurses had pastoral care delivered by the clinical fellowship programme (CFP) and team force with allocated senior nurse support. The service provided accommodation to everyone during the pastoral care.

All Clinical Fellow Nurses (CFN's) had a nursing buddy assigned to support them with everyday queries or transition into the UK. The trust had a dedicated team to support the recruitment and support of CFNs.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The professional development team within theatres had commenced operating department practitioner apprenticeship course to support the development of the key skills band two staff required within the department.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were positive about this experience.

Managers made sure staff received any specialist training for their role. There were programmes in place across theatres to develop existing nursing and other staff at all levels through development opportunities including apprenticeships and registered associate programmes.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed working effective relationships between doctors, nurses, allied health professions, administration and housekeeping staff. Communication between them was clear, concise and respectful. This was observed on the surgical wards and within theatres.

We saw examples of MDT meetings convened to address the specific needs of patients. Meetings sometimes needed to be held “virtually” due to the COVID-19 pandemic, but we understood they always took place when needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff were positive about the contribution made by all members of staff and staff who were members of professions allied to medicine told us they felt valued.

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression. Staff had access to mental health specialists and that there was good consideration of patient’s individual mental health needs and anxieties of patients receiving specialist surgery such as bariatric surgery.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We saw that consultants carried out ward rounds seven days a week for most surgical specialties and where this was not the case patients were reviewed by suitably senior and experienced doctors.

Pharmacy and microbiology services were available throughout the week during the hours 9am to 5pm. At night and at weekends, on-call pharmacy support was provided.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Access to clinical investigations was available across the whole week. Services included, x-rays, magnetic resonance imaging (MRI) scans and computerised tomography (CT or CAT) scans.

Theatres were open five days a week, with an on-call service for out of hours. There was a 24-hour outreach on-call service. Trauma theatres provided seven day working.

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

# Surgery

The service had relevant information promoting healthy lifestyles and support on wards. The nature of much of the surgery provided by the unit meant patients needed to change aspects of their lifestyle either to prepare for or to take best advantage of the planned treatment. Patients told us that this was discussed in depth pre-operatively and they were given good support and guidance.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Printed material relevant to healthier living generally as well as specific to surgery was available on ward areas.

The pre-assessment clinic provided patients with information on how they could promote their fitness before their procedure. Staff reminded patients of the importance of eating a balanced diet, limiting alcohol intake and quitting smoking.

The trust was an NHS designated centre for weight loss surgery and offered a range of keyhole bariatric procedures. There was a team of specialist dietitians available for bariatric patients for weight management who worked Monday to Friday. Dietitians are a team of health professionals that assess, diagnose and treat dietary problems.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe the process for completing a mental capacity assessment. Training in relation to consent was made mandatory for all clinicians who consented patients.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients consistently told us that the risks and benefits of surgery were explained well and that they gave their explicit consent for surgery and any emergency procedure that might be needed. We were also told how relatives were invited into the discussions if desired.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff were able to explain the best interests' decision-making process. They gave examples of when it was recognised that patients needed extra support when consenting to treatment, such as when patients had a learning disability or were living with dementia. Staff told us they involved the patient's relatives and carers to provide further information about the patient's wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient.

Staff made sure patients consented to treatment based on all the information available. Patient's notes showed all patients had a record of their capacity and psychological welfare on admission and where an assessment was needed this had been completed.

Staff clearly recorded consent in the patients' records. We noted that consent forms were completed correctly and that these represented good conversations with patients where the risks and benefits of their surgery had been discussed.

# Surgery

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Theatre staff demonstrated good knowledge of the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Where patient's lacked relevant mental capacity during completion of 'ReSPECT' forms, we saw capacity assessments were completed and discussions with family were detailed. Staff told us that medical staff were responsible for completing mental capacity assessments. Senior nurses completed DOLS application forms electronically if required.

The safeguarding team carried out monthly ReSPECT form audits and presented the ReSPECT data to safeguarding committee each month. Overall compliance for July 2022 was at 96%. Due to retirement and awaiting new starter to commence in post, no ReSPECT audits were completed in August and September 2022.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

## Is the service caring?

**Good**  

Our rating of caring improved. We rated it as good.

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a ward round on ward 11 and patients were made aware of who staff were and why they were visiting them. The staff on the surgical wards were compliant with National Institute for Health and Care Excellence QS15 (Patient experience in adult NHS services), as patients were introduced to all healthcare professionals involved in their care and were made aware of their roles and responsibilities. We observed staff introduce themselves to patients in various ward areas we visited. This was an improvement from our last inspection where staff did not always introduce themselves to patients.

Patients said staff treated them well and with kindness. We spoke to six patients and they all said staff treated them with kindness and were enthusiastic about the care they had received.

# Surgery

Staff followed policy to keep patient care and treatment confidential. We spent time on wards watching the interactions between staff and patients. Staff ensured that treatment, personal care and private conversation took place behind curtains and moderated their voices to ensure privacy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. There was an increased awareness of the mental health needs of patients because patients were more isolated as a result of COVID-19 which was evident in patients' notes. Some patients told us that staff asked about how they were managing with restricted visiting and helped them to express their frustrations and anxieties.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff had access to a chaplaincy service and told us they would respond to the varying needs of patients.

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patient feedback demonstrated high levels of satisfaction for the emotional support received from staff and almost all responses were good or very good.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

### Understanding and involvement of patients and those close to them

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback demonstrated high levels of satisfaction for the compassion received from staff and almost all responses were good or very good. There were high scores in the Friends and Family Test survey for staff attitude, implementation of care and clinical treatment.

From April 2021 to March 2022 the surgical division received a total of 19685 friends and family test responses. Senior staff had included the Friends and Family Test QR code on every mystery patient poster in order to increase the responses across the entire division.

Staff supported patients to make informed decisions about their care. When reviewing patient notes we saw an example of where a patient had made an advanced decision about the care they wished to receive including not to receive cardiopulmonary resuscitation.

# Surgery

Patients gave positive feedback about the service. The trust had introduced a mystery patient scheme and from March 2021 to April 2022 surgical division received a total of 28 mystery patient responses. A patient who attended cancer services said, 'staff are very friendly and look after you well, well informed, treatment has been spot on and waiting times for appointments are good'.

## Is the service responsive?

**Good** 

Our rating of responsive stayed the same. We rated it as good.

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served.**

Managers planned and organised services, so they met the needs of the local population. At the time of our inspection, due to the COVID-19 pandemic, services had been, and continued to be reconfigured to deal with both the threat of the disease and also to ensure that patients who needed urgent surgery got it in as safe a way as possible.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The surgical wards knew which patients would be admitted to the wards or coming through from critical care or surgery they were able to plan bed spaces and manage those patients that arrived as emergencies. From October 2021 to September 2022, there had been one mixed sex breach which occurred as a result of placing a COVID-19 contact bedbound female in a side room where the side room was located within a male bay. The service had undertaken a risk assessment which considered the patient's complex nursing needs with regular involvement from the critical care outreach team, tendency to deteriorate and the risk of transferring them to an outlying ward.

Facilities and premises were appropriate for the services being delivered. Surgical services consisted of a pre-assessment centre, arrivals lounge, 11 theatres, two recovery areas and six surgical wards. The operating theatres were split into two suites. The west wing suite consisted of five operating theatres, which were used for emergencies, general surgery, elective orthopaedics procedures and trauma and orthopaedic procedures. Some theatres were being refurbished at the time of our inspection.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had systems to help care for patients in need of additional support or specialist intervention. There were specialised outreach services to help manage deteriorating patients as well as a specialist team to support cardiac patients with learning disabilities.

The service had systems to help care for patients in need of additional support or specialist intervention. Before the start of a session the theatre team leader ensured that the theatre team brief took place and all relevant equipment was available for that sessions procedures. If equipment was not available or deemed clinically unsafe for use the surgeon was informed before surgery started. The equipment manager was notified at the earliest opportunity and a clinical incident completed.

The service provided a bariatric anaesthetic clinic in line with their bariatric enhanced recovery pathway. This was put in place to decrease intensive care unit bed usage by planning and delivering tailored care. The clinic implemented a bariatric drug chart and pre ordered medication for patients on their arrival to the ward.

Patients' needs and choices were identified and used to inform how services were improved and developed. There had been significant patient engagement in the re-design of the Urology Service Collaboration, working with the Royal Wolverhampton NHS Trust to deliver the Urology Area Network (UAN), in line with the national strategy set by the Getting It Right First Time (GIRFT) programme. This process included consultation with patient forums and appropriate challenge working alongside HealthWatch and both Walsall and Wolverhampton Health Oversight and Scrutiny Committees.

The GIRFT programme's National Specialty Report for Urology, was published in July 2018. A key recommendation of the report was that UANs should be established in order "to provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency". The national review of urology services led to the conclusion that organising urological care on a trust by trust basis was unsatisfactory, as only a few trusts could offer comprehensive urology services in isolation. This led to the recommendation that UANs be developed.

Managers monitored and took action to minimise missed appointments. We spoke to staff who were proactive in ensuring that patients attended for both physical and virtual appointments by calling them prior to attendance to ensure they attended.

Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day.

Staff had access to communication aids to help patients become partners in their care and treatment. Although we did not see them being used, leaflets and other information could be provided in different languages.

### Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. During our inspection, we observed nursing and medical staff interacting with patients and undertaking ward rounds. While they discussed their physical health needs and conditions, they also reviewed their mental health needs and made adjustments where necessary.

Wards were designed to meet the needs of patients living with dementia. There were named dementia link nurses on the surgical wards who provided additional advice on caring for patients living with the condition.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Examples of these were used in the surgical assessment unit. Staff were complimentary of the team that supported patients with a learning disability.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust wide enhanced care team provided staff for one-to-one observation also included activity co-ordinators who could work with patients to provide distraction activities and reduce the risk of falls.

The service had information leaflets available in languages spoken by the patients and local community. Posters used displayed the information relating to interpreter services in different languages. For example, in Punjabi, Urdu, Romanian and Polish. Leaflets were not printed in different languages or braille, but staff were on hand to explain information when required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus were very varied with a wide choice of meals. They met a variety of cultural and personal dietary preferences and were well aligned to meet the needs of local communities.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to appropriate translation services, and sign language interpreters when required. Staff had access to a telephone interpreter if they could not attend the ward at short notice. Staff told us they had not experienced any difficulties with accessing interpreters when they were needed.

Cancer services had introduced a dedicated code to classify cancer imaging requests from August 2022, alongside the introduction of faster diagnosis standard pathways and one-stop clinics for patients presenting with haematuria (blood in urine).

The trust recruited a family and carer co-ordinator and the role will involve advocacy and support for the unpaid carer, strengthening access to open visiting, mealtime support and will link in with Forward Carers Walsall.

### Access and flow

**Although people could not always access the service when they needed it, the trust was working hard to ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. Once admitted to hospital, patients' received the right care promptly.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. We understood that the COVID-19 pandemic had had significant effects on the service's ability to carry out surgery. Sixty one percent of patients were treated within 18 weeks which was among the lowest in the region with regional average of 68% and national average of 70%. Failure to achieve 18 weeks referral to treatment constitutional standards in the division of surgery was identified as a risk within the trust's risk register. Control measures had been put in place, staff held restoration and recovery meetings with oversight at executive level.

From June to July 2022 there was a 15% increase in the number of patients waiting over 52 weeks compared to 5% regional and 6% national trends. The proportion of the total waiting list that had waited 52+ weeks (3%) was lower than regional (9%) and national averages (6%). At the time of our inspection, the trust was ranked 9 out of 20 acute trusts in the Midlands for patients waiting in excess of 52 weeks for treatment.

The longest waiting lists were for surgery and trauma and orthopaedics. General surgery also had the most waits over 52 weeks with 11.5% of the waiting list waiting over a year.

The service carried out monthly clinical harm reviews on patients who waited longer than 104 days and worked in close collaboration with system partners.

The trust met the national requirement to have 0 patients waiting in excess of 104 weeks by April 2022. In the process, the trust provided mutual aid for 14 patients across two neighbouring NHS trusts. The trust remained on track with the national requirement to have 0 patients waiting in excess of 78 weeks by March 2023.

# Surgery

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The surgical division received 7,195 elective admissions and 9,752 emergency admissions from October 2021 to September 2022. Emergency admissions included those to the surgical ambulatory care unit where patients were seen for assessment.

The trust had performed well in ensuring surgery for those patients classified as needing treatment within a month (P2), with the trust consistently ensuring in excess of 70% of patients were waiting fewer than 30 days for this most urgent classification of elective surgery.

Patients' with the most urgent needs had their care and treatment prioritised. As of October 2022, 68.3% of patients were receiving treatment for their cancer within 62 days of referral, placing the trust at a national ranking of 40th and significantly ahead of the regional average (49.2%) and national average (60.5%).

The trust had made several investments to support the delivery of timely elective care:

- £1.64M/year investment to expand by 35 WTE theatre staff and 4.6 WTE consultant anaesthetists, approved by trust board in 2021/22.
- £761k/year investment in a joint urology collaboration between Walsall and Wolverhampton, that would in turn provide 600 new appointments, 600 follow up appointments, 1,512 diagnostic procedures and 406-day cases/year. An additional £76k had supported the introduction of a one-stop prostate biopsy clinic, based in outpatients.
- Refurbishment of 2 theatres in West Wing, delivered in 2021/22, without disruption to elective surgery. A further £9.1M refurbishment of 4 further theatres, anticipated for commencement in 2022/23.
- A £744k/year investment in the general surgery service, expanding the consultant workforce, providing additional elective clinics and diagnostic sessions.
- A £264k/year investment, introducing three additional trauma and orthopaedic consultants.

In addition, the trust provided a ring-fenced elective wing to the Hospital, providing dedicated elective beds, inclusive of an Enhanced Recovery Unit for seven elective operating theatres.

The trust had submitted an overarching plan for both 18-week RTT recovery and 78-week recovery to the Black Country and West Birmingham integrated care system (ICS). The plan and elective recovery pack were monitored both within the trust governance processes (accountable to the chief operating officer and to the performance and finance committee) and to the ICS elective care board. The trust was performing well with the provision of elective activity, with >100% of value weighted activity (when compared with 2019/20) being delivered consistently since August 2022.

During our inspection, staff and managers told us that they were seeing a rise in patients admitted both for and with COVID-19. The trust was starting to put in place arrangements to cope with this increase.

Managers and staff worked to make sure patients did not stay longer than they needed to. Across all surgical specialities length of stay was comparable to the national average.

Managers worked to minimise the number of surgical patients on non-surgical wards. Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. During our inspection, there were

three surgical patients on non-surgical wards. We reviewed their notes and the had been seen by the surgical team daily. Staff did not move patients between wards at night. The service moved patients only when there was a clear medical reason or in their best interest. Under the heightened infection control precautions due to the COVID-19 pandemic, ward moves were even more restricted.

Trauma and orthopaedic surgery activity was also very low during the pandemic and this had resulted in a large backlog of patients needing surgery. Again, theatre sessions in the independent health sector were being used to address the waiting lists.

Managers worked to keep the number of cancelled operations to a minimum. When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. The trust had not cancelled an operation due to the lack of access to an elective inpatient bed since March 2020.

Cancellations were monitored through weekly meetings and a root cause analysis conducted to understand the reason behind each cancellation. A total of 51 planned procedures were cancelled in August 2022 and 43 in September. The service monitored reasons for cancelled procedure and procedures were cancelled due to patients being unfit for surgery on the day, cancellation due to cases becoming more complex and lack of theatre time.

Managers monitored that patient moves between wards were kept to a minimum. There were regular meetings throughout the day where capacity and flow were discussed and issues escalated. The frequency of these and the seniority of the managers present was dependent on the level of pressure the trust was under. The surgical division recorded an average of 170 out of hours admissions from 10pm to 6am.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge planning usually started as part of the pre-operative assessment. Where required there was a multi-disciplinary approach and we saw good examples of this in the records.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The surgical division monitored patients declared medically stable for discharge daily and worked in conjunction with the intermediate care service within the community. Delays were managed via daily escalation meetings. There had been an average of three delays over the past 12 months. The division expanded therapist provision across surgical wards to expedite assessment and determine the appropriate discharge pathway for patients.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There were advice leaflets and posters on how to complain displayed prominently throughout the wards.

# Surgery

From 2021 to 2022, the surgical division received 116 formal complaints which was an increase when compared to 84 complaints received from 2020 to 2021. Examples of complaints received included poor communication regarding visiting, very basic updates on condition and miscommunication in relation to ward transfers.

During the same reporting period from 2021 to 2022, the service received 48 compliments for the division which were equally spread between the departments.

Staff understood the policy on complaints and knew how to handle them. There was information available to help them do so including signposting them to the patient advice and liaison service. Staff told us that they would always want patients to approach them directly so issues could be resolved quickly for the patient's benefit.

Managers investigated complaints and identified themes. Managers were able to give examples of recent complaints and were knowledgeable about themes and trends in their area.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw example complaints where patients had been kept informed and involved in their complaint and also an example where the duty of candour had been followed.

Staff could give examples of how they used patient feedback to improve daily practice.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good.

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

The service was led by a director of operations, divisional director and a divisional director of nursing. Clinical directors, matrons and care group managers within the surgical division were clearly knowledgeable about the services for which they were responsible and had the required qualifications and experience. They demonstrated integrity in their dealing with us by the honesty in talking about any problems with the service.

Most clinical directors/leads were consultants within surgical disciplines or anaesthetics and matrons had extensive experience in the areas they were leading. Care managers had experience in operations across hospitals. All staff told us they were confident in the leadership of the care groups.

Staff were positive about their leaders and co-workers and leaders spoke highly of their staff. Senior managers told us they were proud of how staff were working to recover surgical services.

Local nursing leaders were visible, supportive and approachable. Staff within the ward areas and theatres said they were familiar with the senior management team as they visited the surgical areas often and were approachable and provided support.

# Surgery

Staff said leaders at all levels were present on the wards, they were usually able to name them and talked positively of the support they gave.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them.**

The trust values were; respect, compassion, professionalism and teamwork. The values were displayed on notice boards.

The surgical division developed a "Vision for Outstanding" early in 2021. At the time of production, the document formed a series of objectives each care group within the division would complete. The division delivered monthly team briefs and the core of this brief adopted a "You Said. We Did" approach, with frequent updates against the original objectives.

All staff we spoke with knew what they were and felt they represented their own personal values. Staff demonstrated the values during our inspection, as they all showed compassion to patients, relatives/carers and each other; were professional; demonstrated high levels of teamwork and respect to others.

Staff had been involved in shaping the values of the trust. Staff had been consulted and were given the opportunity to put forward suggestions on what the trust values should be. The staff then voted on the values they felt were most applicable to the trust.

Staff understood and demonstrated the trust's vision and values and they felt the service adhered to the trust's aims. The trust's vision was 'caring for Walsall together' and was underpinned by five strategic objectives.

A nursing strategy 2019-2024 had been developed by involving patients and volunteers. This strategy was applicable to all registered nurses, care support workers and ward support staff. Staff gave very positive feedback about the strategy, for example, one nurse told us that "this is a good voice for all nurses".

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.**

A recent review highlighted cultural issues relating to the reporting of incidents by surgeons within the surgical division. Surgeons did not always report incidents and provided limited information to the division which resulted in a paucity of data available to the governance team and a lack of assurance around the quality of service. Staff we spoke with during our inspection said there has been a shift from this culture. All surgeons now openly report incidents.

Staff were overwhelmingly positive about how they felt supported, respected and valued by both their line managers and more senior staff. They gave examples of how they had been cared for and how they in turn had cared for one another while they gave support to other areas in the hospital and in some cases across the trust and in other hospitals.

Senior staff in theatres told us that they ran an open-door policy and that the most recent staff survey demonstrated an improvement in staff engagement. Junior staff said that the culture was good and that they were able to approach management and escalate concerns.

There was an openness in talking about where things had gone wrong and staff were comfortable discussing incidents and complaints, identifying what had gone wrong and how it was to be fixed. When things did wrong to the extent that a patient suffered harm, we saw that there was a supportive approach to finding out what went wrong, addressing the complaint and the "duty of candour" as required by the regulations was followed.

There was a real sense that staff were positive and proud to work in the division and for the trust and morale was high Staff told us that because staff were frequently moved from their usual ward to cover on other wards some of them found this stressful.

### Governance

**Governance processes were not always robust throughout the service. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

The governance process around monitoring of venous thromboembolism (VTE) assessments was not robust. The service reported 30 hospital acquired thrombosis (blood clots) from May 2021 to August 2022, three occurred in June, one in July and zero in August 2022. Hospital acquired thrombosis was reviewed by the divisional director and presented at monthly trust wide VTE meeting. There had been a recent change in process which now allowed VTE assessment to be done in the emergency department as part of the initial assessment. However, data reviewed did not always reflect the change in practice which demonstrated this change in practice had not been well embedded.

A monthly meeting was held for each care group which was attended by the clinical director/lead, matron and care group manager. There was monthly consultant, matron, band seven nurse, medical advisory committee, clinical governance, care group meetings and board divisional quality meetings. We were told all the meetings were minuted and circulated to attendees. There were also weekly and daily safety huddles on wards and within theatres. Daily trauma meetings took place which were attended by consultants and middle grade doctors.

The surgical division held monthly quality board meetings. Attendees included the divisional director, performance manager, decontamination manager, matrons, care group managers, clinical directors, patient safety manager and deputy director of operations. We reviewed minutes from the July 2022 divisional board meeting which showed the organisation took concerns very seriously and were working to understand the root causes and respond. They also clearly recognised the impact on staffing and ultimately performance and the quality of patient care.

Clinical governance meetings were held for the theatres, anaesthetics and critical care (TACC) care group. We were told they took place monthly. Items on the agenda included but were not limited to risk, staffing, falls, audits and finance. Top divisional risks and risks requiring escalating to the corporate risk register were discussed at divisional performance review and taken to risk management executive.

Safety huddles were held twice a day. During the safety huddle the nurses in charge of the ward provided updates to staff on new or changes to risks within the surgical division and on the ward.

All ward areas had WhatsApp team meeting groups which had been introduced due to Covid 19 restrictions. Documents were added to the group for all members to read and no patient or staff identifiable material was shared.

The service invited two members of the Association for Perioperative Practice (AfPP) to undertake a peer review of theatres in February 2022 to identify where practices were in line or deviating from the AfPP standards and

recommendations for safe perioperative practice (2016). They found staffing establishment within the operating theatres did not meet the minimum standard of AfPP staffing for patients in the perioperative setting. Following this review, a business case was submitted and approved to increase the establishment of operating theatre staff and anaesthetists.

The service had service level agreements (SLA) with third party providers. There were SLAs with local acute trusts to provide certain services including head and neck, ophthalmology, maxillofacial and rheumatology. The consultants from the local acute trusts attended Walsall Healthcare NHS trust to provide the services.

Surgical services at Walsall Healthcare NHS Trust led on the 'waiting list prioritisation' workstream. The trust is currently evaluating the effectiveness of the Copeland Clinical Artificial Intelligence Tool which utilises nonclinical factors such as sex, ethnicity and deprivation as part of a peer-review predictive model for mortality and morbidity following elective surgery.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, robust processes to monitor post-operative complications were not in place.**

There was no robust process in place to monitor return to theatres. Return to theatres was captured through incident forms. Staff reported unplanned return to theatre as incidents. They included the level of harm which informed the extent to which it was investigated in line with the trust's incident management policy. Where an incident required a systematic review of revisions, post-operative complications and returns to theatre, staff requested data as part of the incident investigation. The trust carried out 6813 elective and 3942 emergency procedures from October 2021 to September 2022. They had a total of 25 (0.37) elective and 17 (0.43) emergency procedures with required a revision.

The trust acknowledged there was work to do to build on the current tool to improve the systematic monitoring of post-operative complications and was looking to purchase a surveillance tool which offered statistical process charts to monitor any concerning trends, acting as an early identifier of training needs or management intervention.

The surgical division underwent a trauma and orthopaedic cluster review as there appeared to be a significant number of cases where the technique of a surgeon had been questioned by Royal College of Surgeons review experts. There was previously a poor incident reporting culture and lack of engagement of the governance team with the division decreased the possibility of this cluster of cases being identified at an earlier point.

The surgical division had three core approaches to managing the escalation of concerns or issues. The elective care access policy covered approaches to the management of elective care pathways. Each care group provided a monthly escalation report to the divisional quality board. Mortality and morbidity reviews were discussed during care group quality meetings.

The service held risk registers at a divisional level which were aligned with the issues staff and managers raised with us on the inspection. Failure to adequately assess and record venous thromboembolism assessments was included in the risk register. They were in a suitable format and clearly described the issue, risk, mitigations, remedies and the current status of action plans. Leaders had an oversight of risk register and clinical audits to monitor performance. This included sickness, numbers of vacancies, monitoring audits and themes. Risks due staffing was monitored by senior leaders to manage wards with safety.

# Surgery

Each service line within the surgical division kept their own risk register which fed into the surgical division risk register. The surgical division risk register held 146 risks assigned risks which included; departmental, care group, divisional and corporate risks.

Following the identification of the Westwing theatres as joint highest risk on the divisional risk register, plans for its refurbishment had been made to mitigate risk and ensure a safe operating environment for outpatients to ensure air handling units were compliant with Hospital Building Note (HBN) standards. At the time of our inspection, the service had refurbished two Westwing theatres and had plans in place to commence the refurbishment of four further theatres by March 2023.

A neighbouring trust managed pathology service under the banner of Black Country Pathology Service. Leaders reported significant delays in histology and diagnostics reporting impacts on the planning of patients' treatment plan and performance. There was a risk of patients deteriorating due to excessive waiting times. Staff escalated pathology delays weekly and as a result of oversight and scrutiny from the trust's cancer board, a recovery plan had been proposed and was to be considered at the trust's October board meeting. This was included in the trust's risk register.

We discussed systems that the service had in place for assuring safety during operations. We were told that the service had recognised that these needed improving as a result of never events that had taken place. Senior managers were familiar with these incidents and spoke confidently about their causes and the measures taken to prevent a repeat. For example, there had been a recent change in practice in theatres as a result of a recent never event.

The trust had an emergency preparedness and business continuity plan for business interruptions and special arrangements to allow the service to continue, in the event of major or critical incidents, including IT system failure. In addition, the trust had an emergency planning, resilience and response lead.

During our inspection, the trust was becoming increasingly pressured from an emerging COVID-19 wave as well as other respiratory viruses and flu. There was a coordinated response across the site as managers worked to reintroduce measures such as the enhanced wearing of masks.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.**

Information technology systems were used to monitor and improve patient care. The service had suitable clinical and managerial information systems to provide information for patient care, and both day to day and strategic management.

The arrangements for ensuring the confidentiality of identifiable data was in line with data security standards. Nursing and medical staff received training on information governance as part of their mandatory training and compliance rate was at 90.2%.

Staff had their own trust email account and received regular updates on training courses they could attend and could view whether their mandatory training was due or had expired. Staff had access to a personal electronic personal development page on the trust's intranet, where they could access training and review their personal performance records. They could also access policies, practices and guidance using the intranet.

Service performance measures were reported and monitored. Managers and senior staff had access to these reports and relevant and appropriate service performance information.

The surgical division used dashboards to monitor performance information for all services. Performance data included referral to treatment time performance, cancer target performance and "did not attend" rates. Information relating to incidents, falls, admissions/discharges, medicines errors, infection prevention and control, staffing, complaints and surgery cancellations were being reviewed monthly by the service leads.

The service provided a trust website for general surgery. This included the range of general and sub speciality surgical procedures offered including bariatric surgery, breast care, colorectal surgery and their pelvic floor services. The website included the services hours of operation, contact information and how to access the service.

Information systems were integrated and secure. The trust had implemented the policy for General Data Protection Regulation 2016 (GDPR) and the policy was available on their website.

Staff had been trained in the accessible information standards (AIS) as part of the Equality Diversity and Inclusion (EDI) training delivered by the senior EDI lead. Staff promoted the use of the accessibility standard through the use of the communication card.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.**

The trust encouraged patients and families on ward areas and theatres to complete the friends and family test. The trust web page displayed feedback from the Friends and Family Test.

A Macmillan hub was available to support patients who had cancer or a life limiting condition to promote their health and wellbeing.

The trust implemented initiatives to ensure staff were actively engaged. On all surgical wards there were notice boards communicating information in an accessible way. The boards were used to communicate positive information, audit results and other key messages. For example, we saw audit results displayed in theatres. Staff were sent a weekly and monthly newsletter by email.

The trust effectively engaged with its staff and the public, kept people informed and listened to people's views. Surgical wards and operating theatres held team meetings and provided relevant updates about the department, the division and the wider trust. A staff huddle took place at the beginning of each day for sharing and learning purposes. Staff spoke positively of being involved in decisions and new ways of working.

The trust had a health inequality steering group which focused on several projects including surgical pre-optimisation to provide greater equity in both access and ultimately outcomes for patients within the Borough.

The trust implemented initiatives to ensure staff were actively engaged. On all surgical wards there were notice boards communicating information in an accessible way. The boards were used to communicate positive information, audit results and other key messages. Staff were sent a weekly and monthly newsletter by email.

Staff engaged in drop-in sessions with the Chief Executive Officer and told us the visibility of the executive leadership team on ward areas had been positive for staff morale.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.**

The service had put many innovative projects in place to improve the service for patients. The intensive care and anaesthetics department had also been central to developments, including:

- The introduction of a ring-fenced elective theatre suite supported by a ring-fenced post-operative surgical ward, supported by an enhanced recovery unit.
- Improvements in outcomes for patients as reported by the Intensive Care National Audit & Research Centre (ICNARC), National Emergency Laparotomy Audit (NELA) and National Hip Fracture Database (NHFD)
- A dedicated Sepsis Response Team, working 7 days per week

The trust maintained a ring-fenced elective wing to the hospital, protecting the provision of elective surgery without disruption since the emergence of the covid-19 pandemic. The elective wing included an enhanced recovery unit which enabled the trust to deliver nationally upper quartile utilisation.

Staff participated in local and national research. The division had published a host of papers in the British Medical Journal, Journal of Anaesthesia and the British Journal of Surgery on the impact of COVID-19 on surgical outcomes. In addition, a novel study was published in the Annals of Surgery taking a collaborative perspective on whether surgical training was prepared for another wave of COVID-19.

The trauma and orthopaedic department did a presentation at the American Academy of Orthopaedic Surgeons identifying pre-op predictors of successful arthroplasty.

All nursing staff spoke positively about the trust's ongoing nursing strategy 2019-2024 and how the nurses and patients were involved in shaping the strategy through a variety of open discussions.

The trust were expected to be announced as receiving the MAKO Robot in October 2022 which will make them the first District General Hospitals to introduce robotic-assisted arthroplasty. The trust had also been accepted by National Institute for Health and Care to Robotic arthroplasty which is a clinical and cost effectiveness randomised controlled trial.

The service received a clinical audit award from the healthcare quality improvement partnership for work on the trust's neck of femur (NOF) pathway. This was an improvement as the trust had recently been a (NOF) outlier.

The trust had taken an innovative approach to undertake varicose vein sclerotherapy under local anaesthetic in an outpatient setting. The surgical division contributed 78 projects to the latest quality improvement annual awards. The winning project came from within surgery, based on improving prompt mobilisation post femur fracture.

The division introduced the Copeland Clinical Artificial Intelligence tool providing elective surgical morbidity and mortality both now as a result of delayed treatment. The tool also provides clinicians with decision support with the prioritisation of surgery, as per Royal College of Surgeons guidance.

# Services for children and young people

Good

## Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

### Mandatory training

**The service provided mandatory training in key skills to all staff and most staff had completed it.**

Nursing staff received and kept up to date with their mandatory training. Staff were knowledgeable about the training they received. For example, staff members told us they had completed training face to face and online on how to move and handle patients safely. The trusts overall compliance for mandatory training was 87%. Children's services were working towards meeting the trust's target of 90% by end of October 2022. Neonatal compliance with mandatory training was 90%.

Mandatory training included, fire safety, health and safety, equality and diversity and human rights, safeguarding level 3, paediatric intermediate life support, European Paediatric Advanced Life Support, information and governance, infection, and prevention control. The care groups had set a target to achieve 90% compliance by the end of October 2022 across all children services. Training statistic had improved, although some data had not pulled through the trust system.

All staff, including clinical support staff, were required to complete mandatory level 3 safeguarding children training, which exceeded the minimum requirements of the Intercollegiate document - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019). The trust had low compliance during COVID-19 however, this had consistently improved and had almost reached the trust's target of 90%. The trust encouraged training and development and monitored compliance rates during governance meetings.

Medical staff received and kept up to date with their mandatory training. Medical staff achieved mandatory training compliance of 100% for consultants and 96% for non-consultants. The trust planned to achieve 100% by the end of November 2022. Compliance targets were set by the care group to improve training.

Fifty per cent of doctors had completed level 2 children's safeguarding training. We saw planned inductions and improvement to achieve the trust target.

The mandatory training was comprehensive. Staff on wards completed safeguarding training, dementia awareness and mental capacity training and gave examples for some of the learning that had taken place.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. We saw staff had completed suicide preventiontraining which included completing risk assessments within patient records during admission to the ward. Staff understood the importance of completing records. However, this was not always consistently completed. Service leads reminded staff, through communication, to improve.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were sent a reminder to complete training when it was due by email and via supervision.

### Safeguarding

**Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Nursing staff received training specific for their role on how to recognise and report abuse. The nursing staff received safeguarding children's level 3 training as minimum. Compliance for September 2022 for level 1 and 2 Childrens safeguarding was 100% and level 3 was 82%. This did not meet the trust target but had improved since June 2022. Staff were working to improve this by end of October 2022.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff were trained and knew how to recognise abuse and escalate any concerns or signs in line with the trust safeguarding policies and processes. Consultants completed safeguarding children level 3. As of September 2022, overall compliance was 96%.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff on ward 21 told us, if they had witnessed any bruises or any intimidating behaviour from a parent towards a child, they would raise this immediately for the safety of the child.

Children admitted to the paediatric assessment unit (PAU) and ward 21 were cared for by staff. However, staff did not engage in safeguarding supervision. Supervision was provided by the trust safeguarding team and was accessible to all staff. Staff availability to engage in safeguarding supervision was impacted by staffing difficulties due post COVID-19. The safeguarding lead was keen to improve services and supervision.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff understood how to report abuse and were aware of the escalation processes of referral.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The staff told us if they had a concern, they would make a referral to the local authority in line with trusts processes. Staff members were able to ask for advice from seniors' leaders and colleagues if they had a concern with a child's welfare.

Staff followed safe procedures for children visiting the ward. All staff on all wards monitored when parents and families were visiting. Staff could visually see on an intercom screen when a visitor buzzed to enter the wards, and the staff member verified which patient they were visiting. Staff were familiar with parents and families who were visiting. The staff used swipe cards to enter wards. The security was managed safely on all wards. The staff knew how to escalate concerns if cameras were not working.

### Cleanliness, infection control and hygiene

**The service-controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves, and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained

# Services for children and young people

We inspected ward 21, 28, PAU and outpatients the areas were visibly clean this included patient bays, bathrooms, and playrooms. We spoke to the housekeeping team who consistently worked on the ward and was aware of their responsibilities. The staff told us it was important to keep areas for patients clean for a safe and infectious free environment.

The service performed well for cleanliness. All wards were monitored by an infection control lead and scored 87% overall. This included areas of the environment, sharps, personal protective equipment, linen, waste, hand hygiene and isolation. The ward managers shared environmental audits with staff for improvements during meetings.

Children services reported no infections, C difficile or any blood stream infections between June and August 2022.

We looked at cleaning records during inspection, cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. We saw staff wearing personal protected equipment (PPE) during care and intervention. Staff wore PPE when entering high risk areas where there may be a patient with a transmissible infection. We saw signs for infection control and prevention on doors where patients with infection were cared for.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaned equipment after use and labelled equipment to show when it was last cleaned.

We saw clean toilets and hand washing facilities across all bays and wards.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Children, young people, and their families could reach call bells and staff responded quickly when called. Parents told us nurses always responded when a child required attention from a member staff. For example, one parent told us, their child's sugar levels became low, and nurses brought some snacks quickly to maintain their sugar levels. We observed staff visible on the wards and talking to parents and children when attention or assistance was required.

The design of the environment followed national guidance. Wards were designed specifically to meet the needs of children and young people. The wards were spacious and with facilities for children like a sensory room, playroom, and outdoor play area. The areas were well maintained and encouraged to be used by the staff. Staff told us, there was a further plan to improve areas for children.

However, the children's outpatients required some improvements to the environment to meet the needs for children and young people. Nurses told us this area had changed during the pandemic to comply with infection control guidance and staff had removed toys and magazine for infection prevention and control purposes. The department had not yet returned to how it was pre-pandemic.

The hospital was building a new paediatric assessment unit adjacent to the emergency department. This was due to open in early 2023. Senior leaders told us this would be a better facility for children, young people and parents to support children when they came to hospital and provide an appropriate environment for children to be assessed.

Staff carried out daily safety checks of specialist equipment. Equipment was checked regularly. A monthly environmental audit for equipment and infection prevention and control scored 95% overall in June 2022. We checked equipment such as blood pressure machines and computers for portal appliance testing. All were compliant except one blood pressure machine that had expired in June 2022. We raised this with staff on the ward. Ward staff were aware of checking equipment before use and escalating any concerns for repair or safety.

The service had enough suitable equipment to help them to safely care for children and young people. The staff informed us they had enough equipment for use, they had slide sheets, hoists, bed pan washers and bathing facilities for children who needed them.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each child and young person and removed or minimised risks. However not all staff were trained to act quickly with children and young people at risk of deterioration.**

Theatre staff in West Wing had a dedicated bay for children in the theatre recovery area. This was in line with the Royal College of Anaesthesia (2022) guidelines which states that; 'Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a strong solution'. Control measures such as the use of screens and curtains, separate paediatric airway trolleys and paediatric immediate life support competencies were incorporated into the departmental training plan. Refurbishment of the theatre complex was to commence in 2023 and the new layout was to include a separate paediatric recovery area.

Not all staff in theatre had received paediatric immediate life support (PILS) or European paediatric advanced life support (EPALS) training. We reviewed PILS and EPALS training figures provided by the trust following our inspection that showed, eight members of staff were either PILS or EPALS trained, of these, seven were competent to work in the recovery area. The trust told us, one member of staff trained in either PILS or EPALS would be on duty in the recovery area should a paediatric patient be present. A further 24 staff had been booked to attend PILS or EPALS training on one of three dates between 21 November 2022 and 23 February 2023.

Anaesthetists scheduled for paediatric theatre lists were trained in paediatric emergency training and remained with the patient until the patient had been extubated (removal of the endotracheal tube from the lungs) and the patient was stable. In addition, the anaesthetist remained in the theatre complex until all paediatric patients had returned to the ward.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. All staff knew how to escalate a deteriorating child and used the Paediatric Early Warning Score (PEWS) to identify patients whose condition was deteriorating. Records demonstrated evidence of appropriate escalations and the documentation made specific reference for a consultant review.

Junior doctors and nursing staff were knowledgeable and understood patient risk. All staff undertook observations using PEWS. However, within the seven records we reviewed some observations were not always recorded. If the electronic system identified that staff did not complete a full set of observations a communication was sent to the senior nursing team. Further communication was sent out to remind staff all observations should be completed and if unable to do so, this should be documented in the patient documentation and escalated to the nurse in charge. The staff followed the escalation pathway if a child was unwell and contacted a consultant.

# Services for children and young people

A review was carried out locally by nurses to ensure that any escalation made because of a change in PEWS, or an escalation of concern from staff, appropriate actions were taken. Nurses told us they were able to contact a consultant quickly to respond to a child deterioration.

Following our inspection, we reviewed PEWS audits for the reporting period August to November 2022. The trust target was maintained throughout this period (90% or above). Action(s) taken as a result of audit results being below trust target included:

- Senior nurse led campaign for patient observation timeliness.
- Focussed discussions with teams in safety huddles and staff meetings.
- Focus on PEWS and audit quality in senior nurse meetings with a planned paediatric audit tool review in January 2023 when introducing the new senior nursing leadership team to all elements of audit / quality / patient safety.
- Ensure the continued use of both local PEWS audit tool and the trust wide audit tool available on the quality inspection app and platform for health and care settings.

An escalation policy and procedure was in place to support staff in recognising and caring for a seriously unwell child. Clinical Staff were aware of the escalation policy and procedure.

All staff received training in identifying a deteriorating patient with sepsis. Training was delivered with a focus on ensuring time critical interventions were implemented.

Staff completed risk assessments for each child and young person on admission using a recognised tool, and reviewed this regularly, including after any incident. Assessments were completed on arrival at PAU and ward 21. These included vital signs of temperature, heart and pulse rate, neurological status, urine, bowel and pain assessment. Medical staff and nurses adapted the frequency of clinical observations depending on the child's condition.

Staff knew about and dealt with any specific risk issues. Staff were aware of how to deal with specific risks, such as sepsis. Paediatrics had implemented the Paediatric Sepsis Six trigger tools.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). The children's services had seven-day access to Child and Adolescent Mental Health Services (CAMHS). CAMHS would attend the hospital to assess any patient that had presented in crisis. Referral was made directly to CAMHS via email and telephone call. A referral was accepted between the times of 8am and 6pm. The children's teams could access support out of working hours for any advice. The trust had appointed a Mental Health lead for Children and Young People to support services to develop and improve.

The trust was registered with three external nursing agencies, specialising in mental health, to provide emergency cover when required. The ward staff and on call managers had utilised this out of hours and continued to access support when required. A designated clinical mental health lead oversaw children services.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Staff used a STORM (skills training on risk management) a self–harm risk assessment and mitigation tool that included safety and care planning for front line staff in line with trusts policy. We saw 10 risk assessments completed, however, some lacked detailed information. The trust leadership had ongoing plans to improve record keeping overall. The trust recognised gaps and communication reminders were cascaded to staff.

# Services for children and young people

For the reporting period December 2021 to November 2022, there had been seven patients admitted to the service who required transfer to a mental health (MH) setting. During this period, the average length of time the patient was in the acute setting before being transferred to MH services was 17 days.

Actions taken to mitigate risk and to ensure a safe and appropriate outcome for the patient included:

- Individualised risk Assessment and care planning
- Ligature low risk estate
- One to one supervision by a clinical support worker (CSW) (internal team of mental health CSW's) or agency registered mental health nurse (RMN) via agreed pathway with CAMHS and Commissioning leads.
- Use of SBAR (Situation-Background-Assessment-Recommendation) tool that focused on mental health and well bring assessment and handover of information and risk.

In addition, processes were in place to ensure a safe and appropriate outcome for the patient and included:

- Early discussions with the trust's mental health team and the designated CYP mental health lead nurse within that team to ensure early and clear communication and assessment of risk.
- Clinical nurse specialist for CYP in place for support, training and escalation of concern.
- Early discussions with the mental health trust to discuss assessment, reviews, care planning and risk assessment sharing.
- Escalation to executive team and safeguarding team via the divisional director of nursing and/or matron(s) to ensure external communication and escalation of risk to partner agencies (including the Integrated Care Board (ICB) and NHS England).

Staff shared key information to keep children, young people, and their families safe when handing over their care to others. The team communicated with leads within the community and communicated collaboratively and effectively within multi-disciplinary teams.

Shift changes and handovers included all necessary key information to keep children and young people safe. Key information was shared with the team during handover, this included concerns of the child's health. For example, a child was admitted to ward 21 from emergency department with hypoglycaemia.

### Nurse staffing

**The service had enough nursing staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service had enough nursing and support staff to keep children and young people safe. The paediatric assessment unit (PAU) was staffed with two registered nurses and one clinical support worker and additional staff worked on wards, such as housekeeping, play leads and assistants. On some wards there had been periods where agency staff had been used and staff were deployed from other wards due to sickness and absences, these included nursing staff. The service had an action plan in place to address staffing issues this included, a robust recruitment plan. Staff told us that staffing levels had improved, and consistency was getting better. Senior nurses stepped in to cover clinical shifts when there was a need.

# Services for children and young people

Ward 21 (acute paediatric ward) daily staffing levels consisted of four registered nurses and two clinical support workers, one of which was the designated mental health nurse.

The neonatal ward had six staff per shift. This consisted of a nurse in charge, two qualified in the speciality, registered nurses and auxiliary nurses. This was in accordance with British Association of Perinatal Medicine (BAPM) recommendations. This was monitored by assessing patient acuity and capacity daily. If additional skilled staff were required, matrons stepped in to cover clinical shifts.

Neonatal nursing staff reported no direct concerns. Recruitment in neonates had been positive. The neonatal ward had a number of nursing staff on maternity leave and absences. Backfill was provided by agency staff, bank support and matrons. Managers made sure all bank and agency staff had a full induction and understood the service.

No negative impact or patient harm had occurred due to low staffing levels. The backfill provided ensured that nurses could continue developing the service and attend projects, such as the family Integrated Care Nurse and Baby Friendly Initiative.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The wards displayed a safety performance board. We looked at other months and the wards maintained safe staffing across all areas. Leaders were continuously reviewing staffing levels to ensure safety.

Ward managers could adjust staffing levels daily according to the needs of children and young people. Managers assessed staffing levels across all areas of children services and deployed staff from other wards if required.

The service was reducing their vacancy rates. Childrens services continued with ongoing recruitment. New starters were due to start in October and November 2022 with a full induction planned. The trust developed a programme for new inductions. The children services were awaiting business cases to be approved for further staffing. The trust looked at ways of implementing development for the staff in children's services due to recruitment challenges.

The turnover rates for paediatric children's unit and ward 21 was 11%, and the trust target was 10%.

Neonatal services had a reducing turnover rate amongst nursing staff at 6%. This was better than the trust target.

The service had reduced sickness rates over the last 6 months. The trust sickness rates reported a 7% average across all children services.

### Medical staffing

**The service had enough medical staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment.**

The service had enough medical staff to keep children and young people safe. Staff told us there were enough medical staff available on the wards, though some days felt busier than others. Handovers took place and were led by medical staff.

Nurses and junior doctors were able to access a paediatric consultant 24 hours a day, seven days a week. Parent of a child told us, following admission to a ward they were seen by a doctor as soon as they were admitted.

# Services for children and young people

Staff within outpatients told us there was a high increase in children's clinics following the pandemic. Doctors had been increased to the number of increased clinics; however, the nursing staff had not been increased. The trust had plans for ongoing recruitment across children services.

The medical staffing matched the planned number. We saw planned numbers of staffing displayed. The service had one consultant leave within the last 12 months. Two new consultants had started in September 2022. One consultant was recruited as part of the approved business case to support the new PAU.

### Records

**Staff kept records of children and young people's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, records were not consistently fully completed.**

Patient notes were not always comprehensive. However, all staff could access them easily.

We viewed 10 patient records across PAU, ward 21 and ward 28. Records were not always fully completed. Tools and templates were available for staff to use, to aid their assessments of children, however, there were some elements in records that were not completed in full. For example, some records failed to specify whether the child protection information system (CPIS) had been checked, others did not record ethnicity and importantly, some records we examined did not have all the safeguarding questions completed. There was a lack of flags and alerts on records to easily identify whether a child or young person had any protected characteristics, or whether they were looked after or subject to a child protection or child in need plan. In addition, the voice of the child was not effectively or consistently captured in some records.

Following our inspection, we reviewed documentation audits for the reporting period August to November 2022. The trust target was mostly maintained throughout this period (90% or above). Action(s) taken as a result of audit results being below trust target included:

- Discussion with teams in safety huddles and Staff meetings.
- Increase frequency to weekly audits to ensure focus on documentation standards
- Utilising education leads and cross covering of audit completion to ensure leads did not always complete their own areas audits.
- New matron to ensure feedback to staff on a monthly basis; bringing new ideas in terms of how to share not only audit results, but also give the narrative around their importance and why things are measured. (Aligning to professionalism, accountability, care quality and assurance).

When children and young people transferred to a new team, there were no delays in staff accessing their records. The staff on the wards were able to access records to ensure safety of children.

Records were stored securely. Records were always stored securely in a lockable cupboard on all wards. The staff on all wards were aware of keeping documents safe and secure.

### Medicines

**The service generally used systems and processes to safely prescribe, administer, record and store medicines. However, we did identify some storage issues on ward 21.**

Staff followed systems and processes to prescribe and administer medicines safely.

# Services for children and young people

We looked at 13 patient medicine records and saw that medicines had been prescribed, administered and recorded in line with trust policies and national guidance. Weights were recorded on all the charts seen which was important for calculating weight-based medicines prescribing in children and neonates. Allergies were highlighted and recorded on all medicine charts. The route of administration was recorded, including the reason for prescribing medicines.

A dedicated prescription chart specifically for the antibiotic gentamicin was available and brightly coloured in orange to ensure it stood out and was easily identifiable from all other medicine charts. This had been developed and designed by the clinical pharmacy team. Gentamicin requires careful monitoring and prescribing to ensure a safe and effective dose is administered.

Ward staff knew who to contact in pharmacy for advice on medicines. There was a dedicated clinical pharmacist led to support and advise staff.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people, and their carers about their medicines.

Staff monitored and reviewed the effects of medicines administered, which included regular reviews for antibiotic prescribing. Pharmacists reviewed, monitored and provided clinical advice on the best way to administer medicines. Advice was written onto the medicine charts as reminders.

Staff did not always store and managed all medicines and prescribing documents safely.

Medicines on the Neonatal Unit (NNU) and the PAU had neat and tidy medicine storage. Up-to-date audits were available to ensure safe and secure storage.

Ward 21 had one unlocked medicine cupboard due to a broken lock and were waiting for maintenance to repair. This was resolved during our inspection.

We found one liquid medicine in the medicine trolley on ward 21, which had passed its expiry date. This increased the risk of a medicine being administered with reduced effectiveness. Additionally, medicines were not always stored in their original containers. We found two loose ampoules of two different medicines stored next to each other in a medicine cupboard. This increased the risk of the incorrect medicine being picked and administered in error. A daily medicine checklist was undertaken, however, the storage issues found on ward 21 had not been identified by these.

Emergency medicines were available and stored in tamper proof trolleys or boxes, for example anaphylaxis boxes. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely.

The service ensured that medicines were stored at the recommended room or fridge temperatures.

There were appropriate systems in place for the safe disposal of medicines and destruction of controlled drugs.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services.

A full medicine history and medicines reconciliation was undertaken on admission to the hospital.

Staff learned from safety alerts and incidents to improve practice. There were robust systems in place for reporting incidents and for receiving and dealing with medicines safety alerts. The Medicine Safety Officer was involved in all medicine related incidents. For example, following a recent medicine incident a patient was sent home from a children's ward with insufficient supplies of medicines. This resulted in a change to practice on issuing and supplying medicines direct from the ward. The introduction of a TTO (to take out) register for pre-packed medicines was proving successful and was well liked by staff. It recorded a running stock balance of packs available and ensured low stocks were identified and replaced. It also ensured it was easy to track and trace medicines when they were handed out to patients.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff had told us how they reported an incident. They used an electronic system to report. Staff reported a good culture of reporting and incidents were shared through ward safety huddles and across divisional safety huddles. The trust actively investigated and followed them through in line with trust policy. Ward managers and leaders had an oversight of incidents within the children and young person's services.

Staff raised concerns and reported incidents and near misses in line with trust provider policy. Staff reported incidents and were flagged during meetings for staff to learn from. Leaders monitored incidents for themes and learning. This was shared amongst all staff.

There had been no never events within the children's and young people service over the last 12 months.

Managers shared learning from incidents with their staff and across the trust. We saw governance meeting minutes for July and August 2022. They noted how incidents and learning were shared with staff. The staff immediately picked up on incidents and actions were taken to improve.

Managers shared learning with their staff about never events that happened elsewhere. The trust worked in partnership with a local NHS trust to share learning. Leaders and staff told us this helped with learning from never events and networking and sharing practices with other colleagues at the same level. This benefited children's services at Manor Hospital. Staff were able to get advice from other colleagues who worked within the same role.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation when things went wrong. Staff understood and learned when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Senior leaders shared feedback with staff. Learning was part of regularly discussions in safety huddles and divisional governance meetings. Staff were encouraged to improve through training.

There was evidence that changes had been made as a result of feedback and patient voice was listened to through patient surveys, the 15-step challenge and engagement.

# Services for children and young people

Managers debriefed and supported staff after any serious incident. Incidents were discussed by ward managers and cascaded to the senior team. Staff took on board when areas required improvement. Staff told us they work hard to always improve when they got it wrong. The trust supported staff and staff were able to reach out to freedom to speak up guardians.

Managers acted in response to patient safety alerts within the deadline and monitored changes. Patient safety alerts were shared with all staff through safety huddles and monitored through clinical audits.

## Is the service well-led?

**Good** 

Our rating of well-led stayed the same We rated it as good

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

A divisional director for women's, children and clinical support was appointed in February 2022 to strengthen the leadership. Children services was supported by a divisional director of nursing and clinical director, clinical mental health lead and supporting clinical leaders. New leaders were developed within the service from ward manager to a divisional level. The trust encouraged staff and leaders to grow and be promoted within the trust. The staff informed us senior leaders were approachable and they were able to leaders if they had a concern or required any advice.

Leaders shared information and encouraged staff through meetings and newsletters to develop additional skills. Staff told there was a good structure of leadership across children services.

Leaders were aware of the divisional risks and were implementing mitigating actions. Staffing levels and recruitment were a challenge. A programme of recruitment of adult nurses was planned to commence for children services. The trust was encouraging new recruits to develop. A comprehensive induction pathway specific for children's services was planned, this included process, protocols, and detailed clinical pathways for children.

Staff working in the paediatric assessment unit (PAU) and ward 21 benefited from the support of a committed and proactive safeguarding children's team. The safeguarding children's team developed and delivered ongoing training and supervision.

The safeguarding children's team had implemented 'floor walks;' fulfilled multi-agency obligations at both operational and strategic levels through the multi-agency safeguarding hub (MASH) and the local safeguarding children partnership (LSCP) and had plans in place to strengthen the engagement of acute staff in safeguarding supervision. The 'floor walks' were valued by staff and provided an opportunity to access advice and guidance through face-to-face conversations, as and when required. Staffing challenges within the safeguarding team, however, had led to a temporary reduction from daily 'floor walks' to twice weekly.

# Services for children and young people

## Vision and Strategy

**The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The trust had a set of values developed with its staff, the values underpinned everything staff did and included Respect, Compassion, Professionalism and Teamwork. Staff knew and understood what the vision, values and strategy were and their role in achieving them.

Leaders had plans for their service which were aligned to the trust strategy. The children's services were continually improving and looked for ways to be different and stand out in the local population and among other trusts. The service was preparing for the opening of a new paediatric assessment unit (PAU) in early 2023. Leaders were looking forward to the new PAU and were motivating staff to embrace new ways of working. They told us it was going be an achievement and improvement for the local community. This would initiate a front door service to the local population within the area, an access point for children's services in Walsall where families, parents and children can be assessed and triaged at first point when entering the hospital.

Children services were working towards and preparing virtual wards which would be supported by a dedicated team of nurses led by a consultant. This was an extension of the hospital at home service and would assist in freeing up in-patient beds in preparation for winter. This would offer observational care following an assessment. Leaders prepared for the challenges ahead to meet the needs of children and young people.

## Culture

**Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff reported a good culture and felt valued by the leadership on all wards and across the trust. Staff members felt they were listened to and able to put views and suggestions forward during meetings to improve. Staff led with great passion and worked through challenges to meet the needs of patients and the local population. Wards planned activities for children which included for example, themes such as Chinese New Year, arts, crafts and mental health awareness days. Play leads and assistants encouraged celebrations of different cultures.

Staff working on wards felt they were listened to by the leadership team and the culture had improved. We observed a calm atmosphere and staff were seen working together to meet the needs of children. Staff told us if they had a concern, they would not hesitate to raise it. A recent engagement meeting had shared information across all children services and team building events had been held post pandemic.

Play leads and assistants told us they enjoyed working within the wards. Play leads and assistants had been involved in the development of areas to benefit children using the wards.

The outpatients' department had recently appointed a new matron. A nurse told us, areas were improving, however, the team were not always informed of clinics being listed. The team were previously involved in clinic discussions, but gradually this was getting better following the pandemic.

The divisional nurse director for children and young people shared learning across the team. The wards worked well together and looked for areas to improve.

# Services for children and young people

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

All staff and senior leaders were clear about their responsibilities and took accountability of their areas.

The head of nursing for quality monitored quality indicators to identify themes and trends. These were discussed at divisional governance meetings and enabled the service to improve. Outcomes from divisional governance meetings were shared with staff at ward and department level.

Quality indicators were monitored monthly through a performance dashboard and included, deteriorating patient and sepsis, environment, infection prevention and control, medicines management, nutrition and hydration, oral care, pain management and patient experience. For the reporting period, August to November 2022, the trust target was maintained throughout (90% or above).

To maintain focus on performance and sustaining good results, the service had taken the following actions:

- Discussion with teams in safety huddles and staff meetings.
- Utilising education leads and cross covering of audit completion to ensure leads did not always complete their own area audits.
- Matrons to ensure feedback was provided to staff on a monthly basis; bringing new ideas from previous practice in terms of how to share not only audit results, but also give the narrative around their importance and why things are measured. (Aligning to professionalism, accountability, care quality and assurance).

Ward and divisional safety huddles were in place to ensure there were regular discussions around for example, incidents, learning, patient safety alerts and risks.

Clinical audits were completed and managers identified themes and trends to make improvements. This was widely shared amongst children services. The service held a risk register to monitor any risks, this included for example, staffing and recruitment.

Challenges, improvements and proposals for change from the women and children division was shared at board level.

## Management of risk, issues, and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

Leaders used systems to manage performance effectively. They had oversight of the divisional risk register and clinical audits to monitor performance. The services main risks were sickness and staff vacancies.

Risks due to staffing was monitored regularly by senior leaders to ensure there were enough nursing staff to keep children, young people, and their families safe from avoidable harm.

A paediatric early warning score audit was completed weekly and monitored by the matron. Actions were taken to improve with electronic paediatric nursing quality indicators.

Children's services had safe processes and procedures in place for escalating paediatric social care and safeguarding concerns.

Performance was discussed during governance meetings. Staff were notified of any changes or new risks through meetings and newsletters. This included specific incidents, improving patient records or implementation of new risk assessment tools.

Leaders told us patient safety came first. Risks within children services were managed widely. Discussions openly took place during local safety huddles, and divisional governance meetings.

Leaders prepared for challenges and adverse events, for example the recent pandemic and winter pressures planning.

Children services had policies and systems in place. We saw a detailed escalation supervision policy and mental health act policy. Medical staff and nurses had clear guidance, when a child deteriorated and worked with multi agency teams

Leaders told us the quality of care was not compromised due to financial pressures and did not stop the service looking for ways to improve.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.**

The service had improved information management systems. managers told us they were more assured of the accuracy of the information and data they received.

Divisional and care group meetings reviewed all information about the service including staffing, incidents, trends in incidents such as falls and medicine errors, complaints and patient experience, audit findings and overall service performance.

Managers reviewed all information to give them an overall picture of the quality of care provided. For example, they reviewed incidents and complaints against staffing to identify if staffing shortages had been a causative factor. They were able to identify when staff required additional training for example in medicines management.

The trust had included a section in the divisional and care group meeting called the patients voice which included a summary of all patient feedback in the previous month including mystery patient and friends and family response. This enabled the service to see patients' feedback in a timely way, feedback was immediately shared with the wards and departments who also had access to the monthly information.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.**

# Services for children and young people

Staff engaged with parents and children, this included using local schools to review their service in order to identify any areas for improvement. The trust encouraged children surveys to be completed. We saw this displayed on boards with a QR code. The service used volunteers with specific skills to support children staying on wards and feedback was used to improve areas within children's services.

Patient experience leads told us feedback was shared actively with wards to improve and recognise and acknowledge good practice.

At ward level, visual departmental feedback results from June, July and August 2022 were collated by play specialists and reported into the patient experience group and the divisional director of nursing report. All areas of good practice were reported at ward level to drive improvements, for example areas included, food, drink and staffing.

The trust used a tool called the 15 Steps Challenge for patient feedback; this was initiated by listening to a specific child who was then involved in improving patient feedback. The 15 Steps Challenge explores different healthcare settings through the eyes of patients and relatives and supports staff to listen to patients and carers and understand the improvements that can be made.

Patient surveys scored in the top 20% of all trusts this had improved from 2018. In the children and young people's service, PAU received 91%, neonatal received 100% and ward 21 received 86% following feedback from patient surveys. The care group and departmental teams reviewed actions following in-patient surveys to further improve.

Patient feedback reports from March to August 2022, included mystery patient feedback,

Friends and Family Test, National Children and Young People's Survey, staff engagement and patient and carer engagement. The trust actively listened to little voices and young listeners and neonatal community outreach. The patient experience group reviewed feedback, such as visiting for families and siblings and prevention of infection control. Areas reflected on improvement and positive feedback such as patient voice to drive change.

Leaders cascaded information to staff across children services through a monthly newsletter to enable shared learning and areas for improvement this included, planning for winter pressures, new risk assessment tools and setting up a virtual ward.

The trust had appointed a specialist advisor for children's services in April 2022, to support improvement and embed positive change. The service had recognised additional support was required for specific improvements such as, recruitment, clinical training, and practice. The wards worked in collaboration across children services.

The special advisor reported that due to the challenge in nurses for children, the trust had appointed four new adult nurses to complete an external learning pathway as development. This initiative was going to be piloted in early February 2023 and was an opportunity for adult nurses to develop their skills in children's services.

Leaders recognised staff at all levels. The wards displayed an excellence board that recognised individual staff for their contribution within children's services.

**Learning, and continuous, improvement and innovation.**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement. Leaders encouraged innovation.**

# Services for children and young people

There were systems in place, across the service, to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Local schools and cadets were involved in reviewing children's services. Leaders told us it was important for children and the local population to be a part of positive change and being involved as individuals who use the service. Patient experience was actively encouraged in development of the 15-step challenge and "little listeners." Children were involved in improving the experience of patients.

Leaders encouraged innovation. Innovative working that the service was proud of included for example:

- Registered nurse (RN) adult recruitment in paediatrics which demonstrated a 'thinking outside the box' approach to the national nurse staffing crisis.
- Child and Adolescent Mental Health Services (CAMHS) collaborative working where the service had taken a multi-stream approach to ensure patient safety and staff confidence looking at; policy, environment, staffing, support, training, and multi-agency in-reach.
- Working closely with colleagues across the system in both mental health trusts, children's services, safeguarding, commissioners and the internal mental health team. This proactive approach had supported the development of a children and young person (CYP) plan to ensure the care that they received was supervised adequately by people who were trained to support and plan to meet their needs.
- The 'We Can Talk' project ensured paediatric staff were confident and competent to communicate with CYP in crisis. The project was designed to improve the knowledge, skills and confidence of any member of staff working with CYP.

The service was preparing for the opening of a new paediatric assessment unit (PAU) in early 2023.

Divisional leaders told us that children and adolescents were involved in speaking at different NHS platforms.

Leaders and staff told us "Every patient admitted brings a different challenge, and we learn from this and improve."

Staff had a good understanding of quality improvement. A paediatric virtual ward had been developed and planned over several months with a trained and designated team to oversee. This supported better collaborative working, particularly supporting the hospital at home service and complex patients to meet the needs of all children.

The trust had embraced quality improvement (QI) and had a well-established QI academy and training programme. Training was to be rolled out across the trust including, for staff in children's services.

| MEETING OF THE TRUST BOARD – 8TH FEBRUARY 2023 | | | |
|---|---|---|---|
| **Mental Health Update (6 monthly update)** | | | |
| **Report Author and Job Title:** | Jodie Kirby - Lead Nurse Mental Health & Gemma Powell – Mental Health Governance manager | **Responsible Director:** | Manjeet Shehmar – Chief Medical Officer |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☐ Discuss ☐ Inform ☒ Assure ☒ | | |
| **Assure** | • Improvement for mental health Act process within WHT<br>• Improvement of Mental Health patient care and treatment<br>• Learning from incidents | | |
| **Advise** | • Changes and improvement within WHT<br>• Updates of the Corporate Risk Register for mental health<br>• Incidents and themes<br>• Mental Health Act activity | | |
| **Alert** | • Any new risks or concerns relating to mental health<br>• Of Current known risks and update | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Corporate Risk register<br>• 2475 - MHA (has been downgraded and will step down from corporate risk register)<br>• 2581 - Internal CYP<br>• 2439 – Complex CAMHS<br>• 3002 – Complex adults | | |
| **Resource implications** | There are resource implications that are related to<br>• Agency/ bank costs to support and manage patients who require mental health 1:1 (support). trust wide.<br>• Cost to mental health bank whilst recruiting into vacant posts.<br>• Cost to MH budget to deliver IKON (restraint reduction network/ safe de-escalation and restraint training)<br>• Ongoing cost to the paediatric division who are supporting and managing mental health CAMHS patients - Paediatrics regularly require mental health qualified and CSW staff to support the complex patients on the ward area. | | |
| **Legal and/or Equality and Diversity implications** | Children and Young Persons Act 1933<br>Equality Act 2010<br>Equality Act 2010: Chapter 1 (protected characteristics) Chapter 2 (prohibited conduct) and Chapter 3 (services and public functions)<br>Human Rights Act 1998<br>Mental Capacity Act 2005<br>Mental Capacity Act Code of Practice<br>Mental Health Act 1983<br>Mental Health Act 2007 and Code of Practice | | |
| **Strategic Objectives** (highlight which Trust Strategic objective this report aims to support) | Safe, high-quality care ☒ | Care at home ☐ | |
| | Partners ☒ | Value colleagues ☒ | |
| | Resources ☒ | | |

# Mental Health Update

## 1. PURPOSE OF REPORT

The purpose of the reports is to show evidence of the current mental health risks, progress and actions. It will highlight the internal and external factors.

## 2. BACKGROUND

This report is a summary of current risks that are located on the corporate risk register for mental health. This paper aims to update and share the current changes and updates with the patient safety team.

**Risk 2475:**

This risk has now been stepped down from a corporate risk due to the risk score being reduced to a score of 5. The score has been reduced following the successful appointment of Mental Health Act administrators to both WHT and RWT who have worked collaboratively with teams across the organisation to ensure compliance with the Mental Health Act law, ensuring that the MHA process is embedded. Mental Health Act training continues to be delivered weekly to staff across the trust.

The Mental Health Act policy is in the final stages of ratification.
There has been evidence of a reduction in incidents relating to the MH Act and where incidents have occurred the team have been able to respond in a timely way to support and resolve any breaches of the MHA. Therefore, the outstanding risk relating to the wider Trust understanding of the MHA will be an ongoing action for the Divisional teams to ensure staff attend MH Act Training that is now available via ESR.

After successful completion of the Mental health working group and recruitment to all MH vacancies the corporate risk 2475 has successfully downgraded. The recruitment to MH staff has improved WHT understanding of mental health demands and quality of care delivered to MH patients.

## 3. DETAILS

**Corporate Risk register 2475** (internal) initial score was 25 (currently under review)

**July 2022 – Score reduced to 5**

- Completion of Mental Health Working group
- Recruitment to vacancies from the business case
- Mental Health Act policy in final stages of ratification.

**Corporate Risk Register – 2581** (internal) (Risk was merged with 2437 – December 2021)

**Corporate risk remains at a score of 20.**

Internal risk for patients awaiting Tier 4 hospital admission

WHT ability to support and manage any CYP awaiting a tier 4 admission. An increase in CYP in crisis within paediatrics which results in a failure to process and manage patient safety through the patient journey.

- Developing CAMHS services
- CAMHS service is day time only
- Lack of training for CYP staff that are supporting Mental Health patients in crisis.

To reduce the risk

- An informal working group has started to meet to develop an action plan. This meeting is to progress to a more formal group that escalates the MH Steering group and is led by the Paediatric Matron.
- To have an agreed SLA and clarity for services.
- Staff to attend mental health training and suicide prevention training.
- Rapid tranquilisation policy currently going through ratification

*We have successfully recruited to the CAMHS CNS post, and the post holder is proactively working with the division to develop policy, process, and guidance for CAMHS patients.*

**Corporate Risk register 2439 (external)**

**Corporate risk score remains at 20**

There is a national GAP for Tier 4 beds - this is an external service provided by NHS England.

- There is a nationally accepted risk to CYP in crisis owing to the lack of mental health service provision. The NHS Plan is looking to address this with improved funding to be made available however, whilst we wait to see the outcome of this the risk remains to the Paediatric unit; the lack of adequate service provision externally means we carry a high-level risk internally as a result of holding CYP who are in crisis.
- Nationally there are issues in accessing Tier 4 beds and locally we have a CAMHS service that is only available 8am-6pm.
- Overall, the risks are external to our service

**Mental Health Governance update :-**

**Incident Themes:** There were 268 MH related incidents reported between April-September 2022 with the top 3 cause groups being:

1. Non adherence to local policy (External partners)
2. Patient absconded
3. DTA breach

Chart 1: Top 3 incident themes

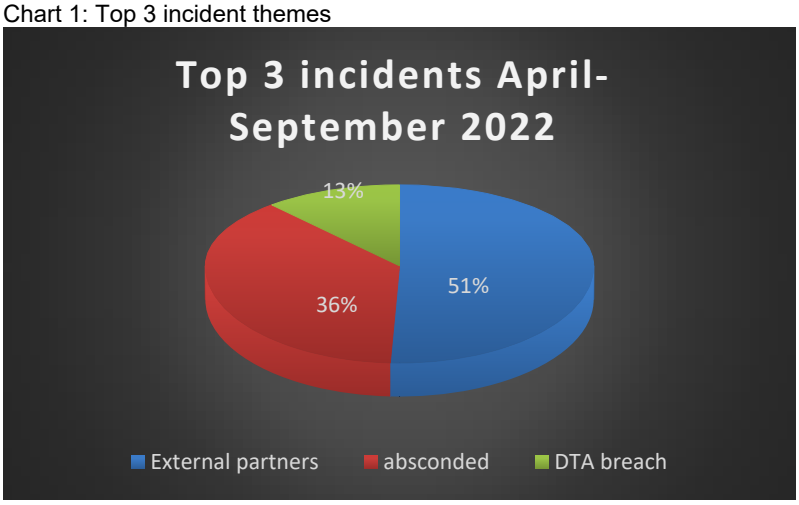
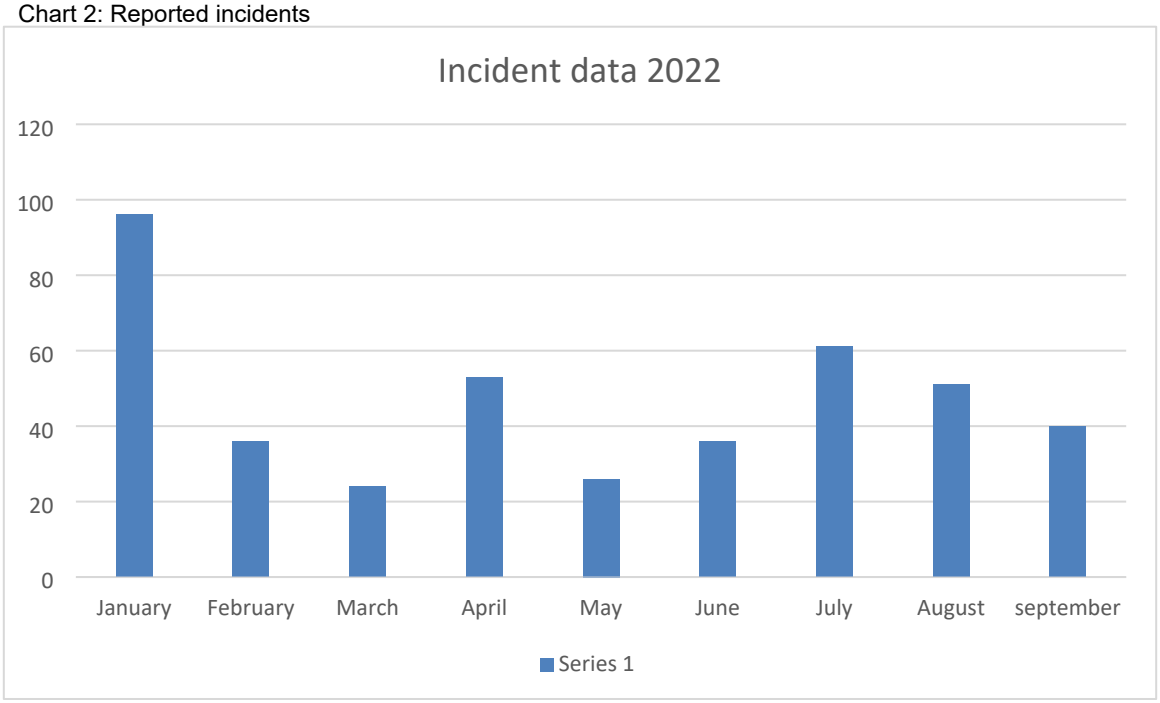


Chart 2: Reported incidents




The list below highlights the common themes each month that are raised to the MH team within WHT (the MH team respond swiftly and offer support/ guidance for the trust) : -

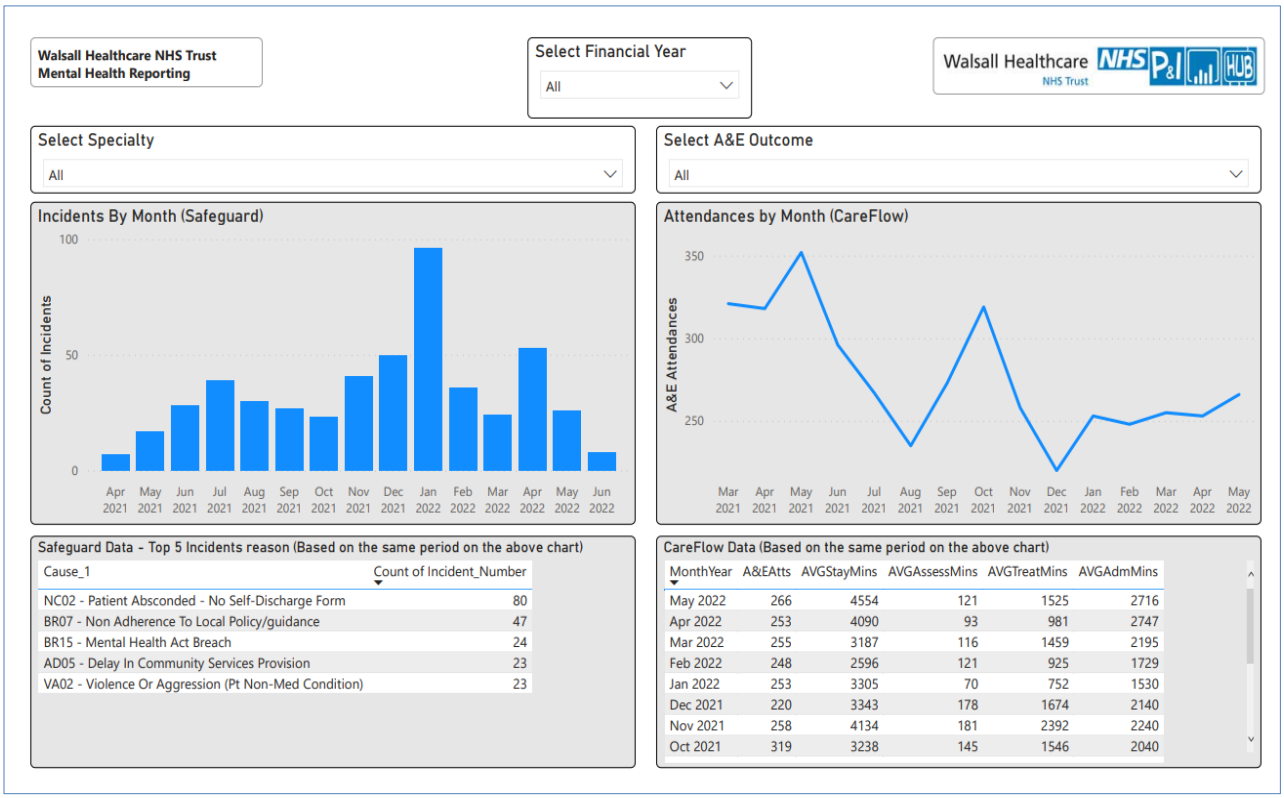
- Absconding patients (all areas)
- Absconding patients ED
- Lack of a streamlined service for external services for MHA process
- Challenges with completing section 5(2) MHA 1983
- Suboptimal attendance and training and meetings relating to QI.
- Police 136 process, access to MHA suite, and management of patients under section 136.
- Increase in section 136 attendances to ED
- Support children under section 136 suit as CAMHS currently do not offer any support to ED.
- Challenges to access the local 136 suite for CAMHS.
- Supporting patients and plans of care for Tier 4 admissions
- Supporting Paediatric division with the gaps in CAMHS provision
- Supporting WHT with gaps in CORE24 provision
- Supporting and escalating through appropriate routes
- Overuse of restraint/inappropriate restraint by security staff/ward staff
- Frequent admissions/HISU (High Intensity Service User)
- Direct admissions to the paediatric ward for patients who have no physical health cause.

The MH team at WHCT and RWT conducted an audit to further understand the issues and the findings are being worked through with partners in the Mental Health Trust.

**Mental Health Developments**

The Power BI hub was utilised to generate the MH data for patient flow and incidents to support an understanding of MH acuity and any future risks or workstreams that support improvements in patient care.

- Lists all Mental Health related incidents
- MH admissions for ED.




## Mental Health Act

## Equalities data:

The equalities data for those that were detained was as follows:

- Sex: 1 male and 7 female.
- Age: The average age was 30 years (12-80years).
- Ethnicity: detailed in the graph below for those detained to WMH

Chart 4: Ethnicity of detained patients

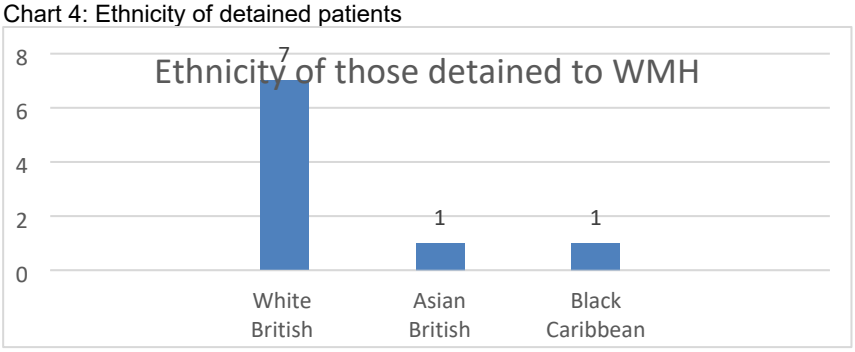
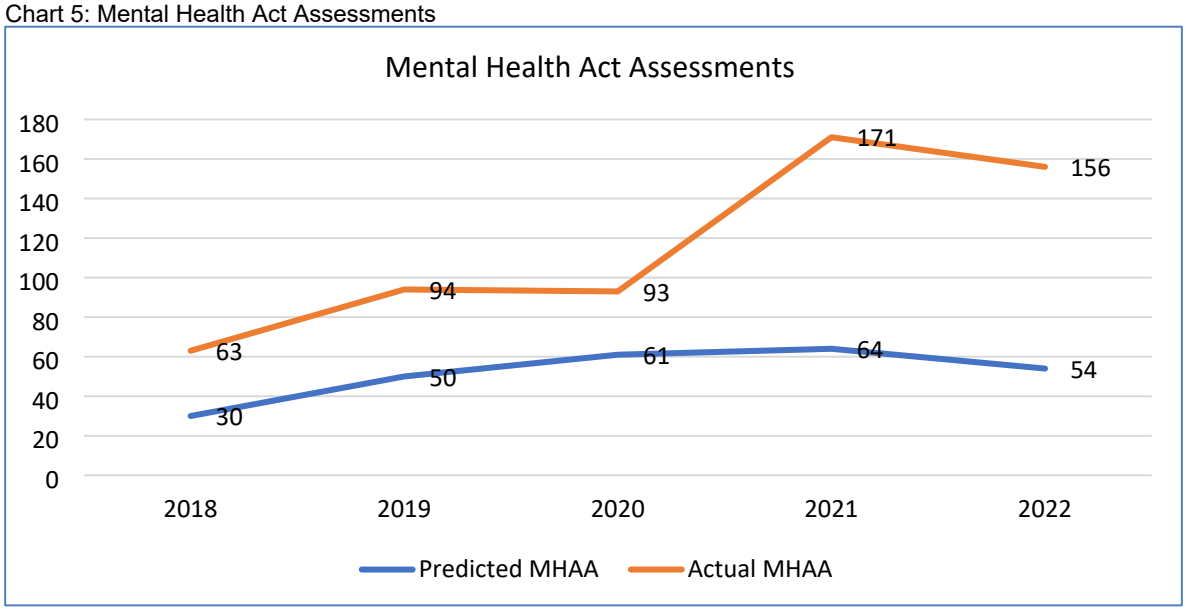


Chart 5: Mental Health Act Assessments

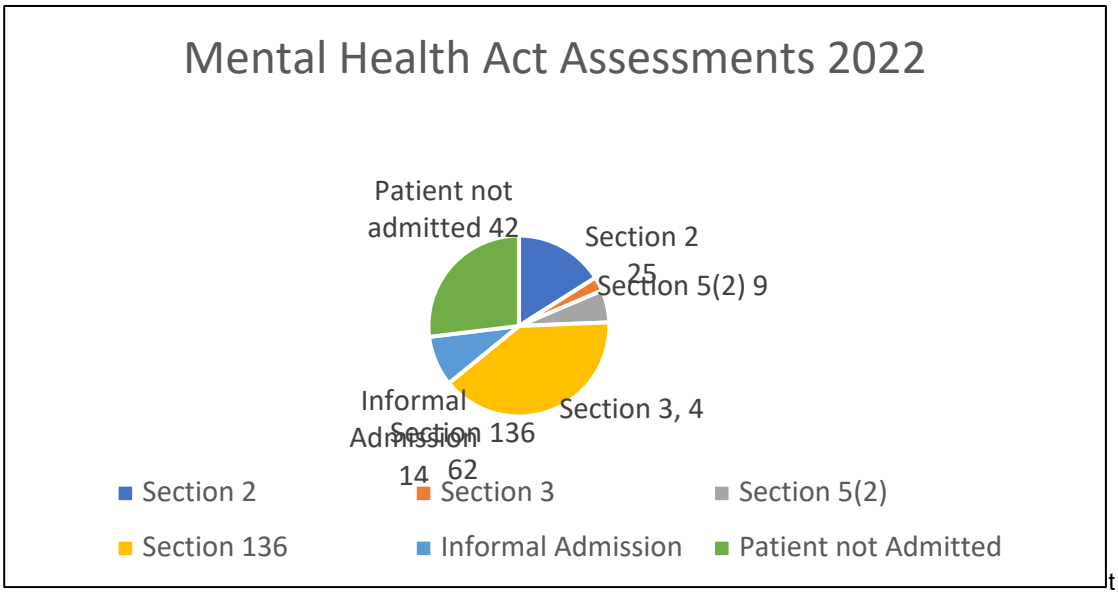



There have been 156 MHA assessments within WHT since January 2022 – October 2022.

- This graph shows the investment into MHA administrators has enabled WHT to have clear data for all mental health act assessments and outcomes for any patient assessed.

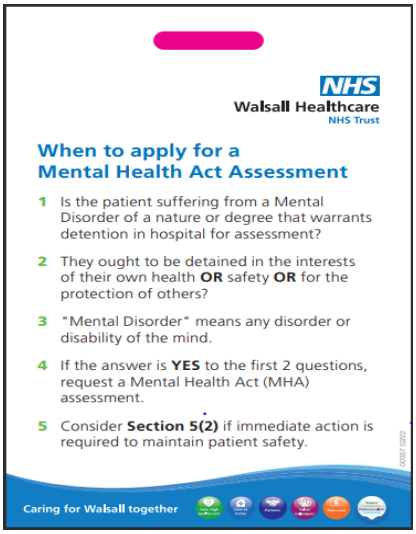
The Breakdown of assessments in 2022 are below :

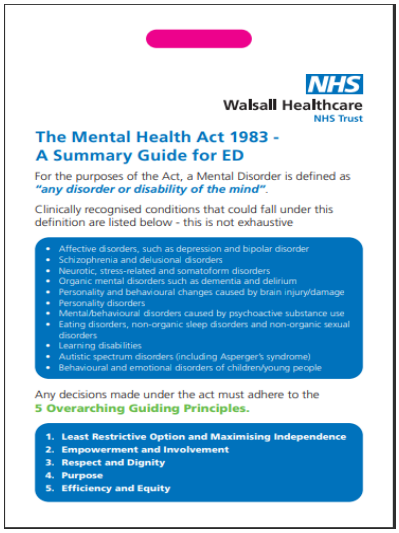
Chart 6: Mental Health Act Assessments 2022



## Mental Health Act - Staff cards:

The cards were handed out to nursing staff across the trust. We focused on Key areas to support the management of the MHA . The cards are a quick reference guide for staff for the mental health act.




## Mental Health Training:-

### IKON:

- Paediatrics :- 80% of paediatric workforce are trained in level 1 IKON for de-escalation and breakaway training.
- ED & AMU:- 50% of nursing workforce trained

Ikon training dates are available twice monthly to support staff accessing the training.

### Mental Health Act Training:

- Training is currently being delivered face to face by Teams. We are currently in the process of changing this to electronic training to make it more accessible for staff.

### Ligature Cutters:-

398 staff trained across WHT

- Training video is available on ESR

## Mental Health Team's project group

WHT mental health working group was completed in July 2022.

- All actions completed
- Evidence in practice that new process has been embedded

Project was successful.

*All working groups will feed into the Mental Health Steering Group.*

## 4. RECOMMENDATIONS for 2022/2023.

**Eating disorder updates and change in practice: -**
Hospital admissions for eating disorders increased by 84% in the last five years and there have been changes to the Royal College of Psychiatrists eating disorder guidelines. The launch for this guidance highlighted a noted increased in eating disorder deaths within acute trusts and the correlation between death and delays for refeeding in an emergency presentation to acute trusts.
The Trust will be starting a working group to review the policy, practice, and implementation for the MEED guidance.
WHT have started to see an increase in incidents relating to patients with an eating disorder.

***Future project work for the Mental Health Team:-***

| Project | Ward/ Area | Start date | Completion date |
|---|---|---|---|
| Eating disorder pathway and policy to support MEED guidance. | Trust wide | 29/9/22 | March 2023 |
| Children in Crisis working group, initial action plan agreed for the group | ED/Paediatrics | 05/10/22 | October 2022 |
| IKON – level 2 | Trust wide | On-going | On-going, to have level 2 training designed and commence roll out March 2022 |
| Review of MH training for Acute trust staff | Trust wide | On-going | TBC |
| “we can talk project” – development of CYP in crisis care plan in ED. | ED | May 2022 | October 2022 |
| Restrictive intervention policy | Trust wide | 10/11/2022 | April 2023 |
| | | | |

| MEETING OF THE TRUST BOARD – WEDNESDAY 8TH FEBRUARY 2023 | | | |
|---|---|---|---|
| **Medicines Management Report** | | | |
| **Report Author and Job Title:** | Gary Fletcher<br>Director of Pharmacy | **Responsible Director:** | Dr Manjeet Shehmar<br>Chief Medical Officer |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☐ Discuss ☒ Inform ☒ Assure ☒ | | |
| **Assure** | • It is through the Medicine Management Group that audit compliance is being monitored and escalated to Divisions where necessary<br>• Measures have been put in place to strengthen the effectiveness of medicines management through Divisional and Care Group engagement and the risk register<br>• Following Section 29A Notice in October 2023 measures have been put in place to address the issues raised in the Notice concerning medicines management.<br>• The Trust have responded back to the CQC as requested within the timeframe allocated with an update position regarding the Section 29A notice.<br>• Projects to support communication and education of staff are being set up which include E-learning, video training and face to face. | | |
| **Advise** | • The auditing of medicines management and prescribing quality is done locally on a weekly basis and is available on the intranet.<br>• Key information which underpins medicines management are available on the Medicines Management dashboard on the Trust intranet.<br>• Electronic drug storage units have been installed on wards 16 & 17 and are about to be rolled out within the new ED block.<br>• Electronic drug storage units have been purchased for refurbs on Ward 5/6, Wards 14&15, Maternity & Ward 24/25.The installation of electronic drug storage units will largely resolve compliance issues and further enhance drug security.<br>• The Trust is reviewing implementing an EPMA system and a project manager has been appointed to address the requirements for procurement, business case and timelines. In the meantime a review of the paper charts has been completed and is due for roll out in late January. | | |
| **Alert** | • The ward audit of medicines management continues to show gaps in compliance | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | The main risks identified are concerned with the level of compliance with the Medicine Policy which is managed through Corporate risk 2737 and associated Divisional and Care Group risks. | | |
| **Resource implications** | Resources will be required for purchase of further electronic drug storage units, an electronic prescribing system, clinical staff for | | |

| | | |
|---|---|---|
| | implementation and Controlled Drug management software, if supported in principle. Business cases to follow. | |
| **Legal and/or Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | |
| **Strategic Objectives** | Safe, high-quality care ☒ | Care at home ☐ |
| | Partners ☐ | Value colleagues ☐ |
| | Resources ☐ | |

# Medicines Management Report

## 1. PURPOSE OF REPORT

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

## 2. PHARMACY AND MEDICINES MANAGEMENT

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

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

- 4th November 2022 – deferred from October
- 30th November 2022
- December 2022 – no meeting

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

### Section 29A Notice

The Section 29A notice was served on 17th October 2022 following a CQC visit to MLTC in October, an executive led Medicines Management action plan group was set up on 26th October to monitor the action plan in response to the notice. The group meets on a weekly

basis. A response was provided to the CQC at the end of December 2022 in line with their requirements. The Trust is now collating the evidence requested from the CQC to show progress.

Following the appointment of a Specialist Advisor to support the action plan response, assurance was quickly provided that the patients identified in the Section 29A Notice had not come to any harm as a direct consequence of the issues raised by CQC.

The concerns raised by CQC in the Notice were (i) examples of unsafe prescribing – either illegible or not in accordance with Policy, (ii) medicines not available for patients such that doses were missed, (iii) patients weights not recorded where weight dependent drug doses are administered, (iv) poor diabetes management, (v) medicines available for administration were beyond the expiry date, and (vi) ambient temperature in the drug storage room on ward 1 was regularly out of range from June to October. The following actions were covered as part of the plan and CQC response:

1. A letter was sent out to all medical and nursing staff in November 2022 jointly signed by Chief Medical Officer, Director of Nursing and Director of Pharmacy. The letter set out the legal and professional obligation for all staff with regard to the safe handling, storage, prescribing and administration of medicines.
2. The process for date checking of medicines stored in ward areas was reviewed and clarified. Date checking is part of the top up process and records are kept of each time a ward is checked. In addition, a full sweep of the Trust for expired medicines was caried out on 9th November 2022, and 6 & 8th December 2022 by Pharmacy and all expired stocks identified were removed and destroyed. A repeat sweep will be completed in late January 2023. Weekly checks are also carried out in each area as part of the weekly matron's audit on Tendable.
3. The recording of patient's weights on the treatment chart is now part of a weekly medicines management checklist audit carried out in all clinical areas by the matrons. This data is captured on Tendable.
4. All ward areas were checked for correct ambient temperatures and where issues identified E&F provided temporary or permanent solutions. The temperature checks are also part of the weekly Tendable audit checklist and where issues are identified, escalated to E&F for resolution.
5. eLearning for Health prescribing module is now mandatory for all prescribers to complete – compliance is monitored via the Divisional structure. Compliance for the Division of MLTC is currently reported around 70%. The Division are validating the data to remove duplicates, forwarding training evidence and addressing individuals who have not completed the training by the end of January.
6. Ward stocklists have been reviewed and missed doses are audited on a weekly basis at part of Tendable which also requires evidence of what actions were taken to address the cause of the missed dose.
7. Pharmacist interventions are now collated and available as part of the medicines management dashboard on the Trust intranet. Interventions are where a pharmacist or a pharmacy technician have acted to correct errors, rationalise prescribing, advise on drug choice, optimise therapy, etc. Rarely is pharmacy advice not followed. Interventions demonstrate the value of the pharmacy ward service as the "safety net" for drug use and as such are a valuable source of near miss data to help drive learning and change. Supported by a pharmacist, medical and nursing staff are reviewing the

interventions data as part of the board round for the week so that any themes around prescribing can be highlighted, discussed and actioned if necessary.

In addition to the above, the following is also being reviewed/developed:

1. Treatment chart.

The Trust is an outlier with regard to still using paper prescription charts. It is recognised that many of the issues raised within the Section 29A Notice would be resolved by the implementation of an EPMA system. Such systems also incorporate a decision support function which directs safer prescribing and administration, and avoids all the risks around omission of details, errors or illegibility inherent in a paper system. The Trust will be working towards the implementation of an EPMA system at the earliest opportunity.
However, work has been undertaken to review and revise the current paper chart. A revised chat has been developed which will mitigate as far as possible the factors which lead to prescribing and administration errors and omissions. The new chart will also incorporate sufficient space for medicines reconciliation, pharmacy notes, antibiotic review/stop, recording of omitted doses, etc.
The new treatment chart will be subject to a pilot imminently and if the pilot is successful, a roll out across the Trust.

2. Medicine Policy review

It is recognised that as the Medicine Policy is a large single document it can often be difficult for users to refer to and find relevant information to guide their practice. The Specialist Advisor is leading on a review of the policy and it is envisaged that the ideal document would be to have a simplified overarching Policy document which sets out basic principles, but which is supported by a suite of procedures which describe specific legal and professional elements of medicines management. The intention being that the procedures are clearer, shorter and easier to refer to.
In order to highlight the key messages from the Medicine Policy, the Specialist Advisor has also developed posters for ward and clinical areas setting out the “Eight Rights” for medicines prescribing and administration, and a credit card sized prompt card for correct prescribing.

3. Medicines Management Group

The Specialist Advisor is also reviewing the terms of reference for the MMG to ensure that robust assurance and accountability is provided. This is still progressing and has been extended to include discussions with RWT to more fully align or amalgamate the MMG across the Group. The agenda has been reviewed to ensure that the appropriate levels of assurance are received from the MMG sub-groups.

4. MLTC Divisional Medicines Management Group

MLTC has set up a bi-weekly steering group for medicines to oversee actions and improvements for the Section 29A Notice. The group receives reports from each of the care groups within the Division to provide update and assurance on actions based on the weekly Tendable audits, Safeguard intervention data, PGDs, interventions and medicine related risks on the care group risk register.

As part of the wider review if Divisional governance structures, it is recommended that this is taken as the standard Divisional model for reporting and assurance from care groups, through Division, to MMG.

## Medicines Management Dashboard

A dashboard of key medicines management metrics has been set up on the Trust Intranet:

1. Weekly Audit Data (Tendable)

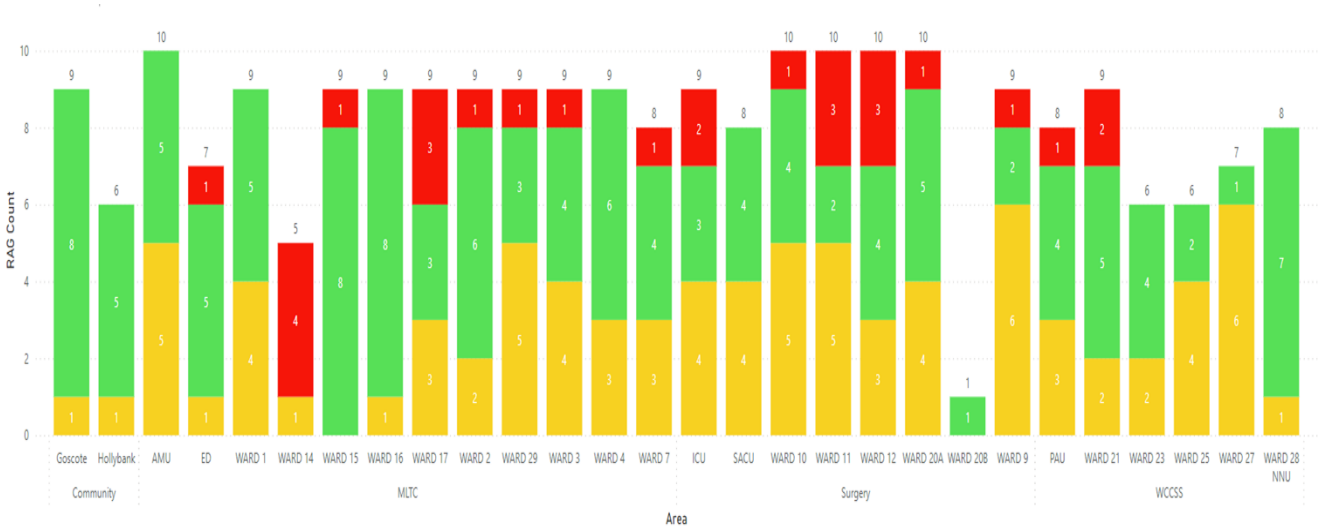
The ward weekly audits comprise 13 audit criteria which covers drug storage, patient identification, prescribing quality, recording of patient's weights, allergy recording, and CD record keeping. The audits are carried out by the matron or deputy and the result for each ward is discussed at the care group huddle. Data is presented below on a weekly basis with the overall scores for each criteria across the Trust.

| Week Commencing | Overall score | Medicine room / CD | Does patient have a wrist band insitu with appropriate allergy status | Patient prescription charts have details of patient name,date of birth and hospital number or NHS number? | Is allergy status documented on the prescription chart? | Is the nature of the allergy documented on the prescription chart? | If there has been an omission of a medication, has a code been used? | Is there evidence that action has been taken to address theomission, unless there is a valid clinical reason for theomission? | Is the patient's weight documented on the prescription chart? | Are all the medication names on the prescription chart written in block capitals? | Are all the medications prescribed on the prescription chart signed? | Are all the medications prescribed on the prescription chart signed with name printed in block capitals/or stamp used? | Are all the medications within their expiry date? (5 random medications checked) | Controlled drugs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 02 January 2023 | 90.11 | 93.56 | 95.84 | 98.01 | 99.19 | 71.30 | 91.62 | 84.33 | 63.75 | 76.60 | 98.85 | 70.26 | 100.00 | 93.91 |
| 26 December 2022 | 88.69 | 90.47 | 94.00 | 97.00 | 97.45 | 62.65 | 94.51 | 71.78 | 65.93 | 80.03 | 99.50 | 78.52 | 100.00 | 92.50 |
| 19 December 2022 | 88.18 | 88.37 | 96.99 | 99.62 | 95.48 | 68.36 | 88.39 | 90.74 | 60.80 | 74.57 | 99.62 | 68.33 | 100.00 | 95.34 |
| 12 December 2022 | 92.13 | 93.82 | 97.50 | 100.00 | 98.89 | 75.76 | 97.88 | 92.93 | 68.67 | 77.38 | 96.80 | 80.96 | 100.00 | 93.12 |
| 05 December 2022 | 90.33 | 92.94 | 92.06 | 99.09 | 100.00 | 73.48 | 96.67 | 95.93 | 66.04 | 69.67 | 98.64 | 68.67 | 98.10 | 93.26 |
| 28 November 2022 | 89.38 | 92.61 | 93.64 | 99.13 | 97.25 | 74.02 | 99.21 | 87.79 | 70.45 | 69.52 | 99.02 | 68.39 | 100.00 | 86.75 |
| 21 November 2022 | 89.23 | 92.83 | 97.73 | 97.02 | 97.20 | 64.66 | 94.45 | 89.41 | 67.78 | 64.83 | 98.31 | 58.22 | 100.00 | 92.00 |
| 14 November 2022 | 88.21 | 91.94 | 96.50 | 100.00 | 97.84 | 72.02 | 98.04 | 87.73 | 61.58 | 56.95 | 98.17 | 51.95 | 100.00 | 90.79 |
| 04 November 2022 | 87.32 | 90.80 | 90.00 | 96.34 | 96.89 | 63.96 | 99.00 | 75.75 | 66.66 | 64.68 | 98.05 | 56.62 | 98.33 | 91.67 |
| 31 October 2022 | 81.82 | 91.41 | 89.58 | 93.38 | 98.24 | 58.68 | 91.86 | 73.75 | 26.98 | 46.81 | 98.43 | 38.49 | 97.78 | |

Whilst the overall score shows a gradual improvement, and each criterion shows an improvement from the starting position on 31/10/2022, there are still some areas which require improvement. These are:

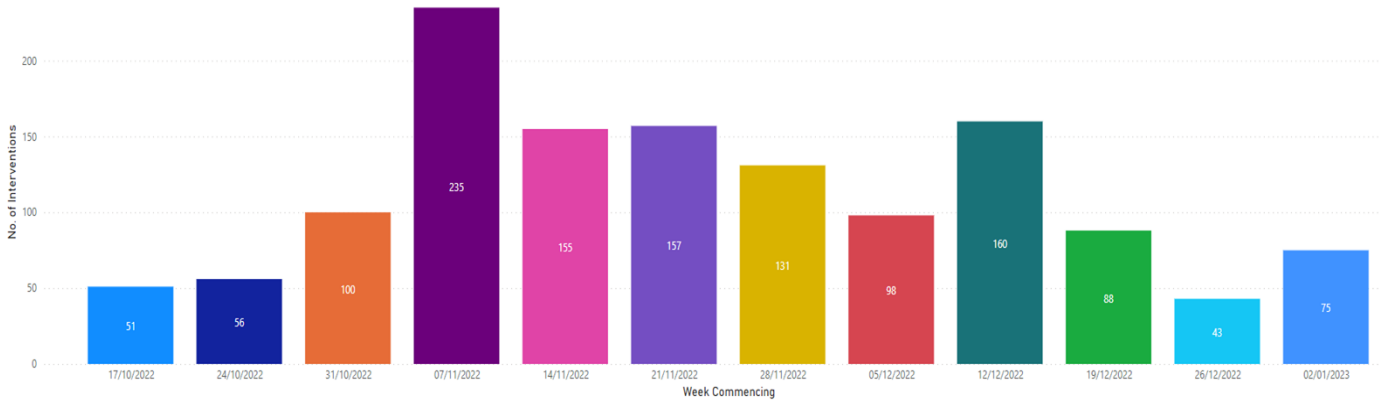
- The nature of the allergy recorded on the chart
- Evidence that action has been taken to address an omitted dose
- The patient's weight is recorded on the chart
- All medications are prescribed in block capitals
- All prescribed medication have prescribers name in block capitals or stamp

The table below sets out the occurrence of the overall RAG rating for each ward covered by the audit. The new paper drug chart will enable better documentation by providing space for block capitals and a name stamp.

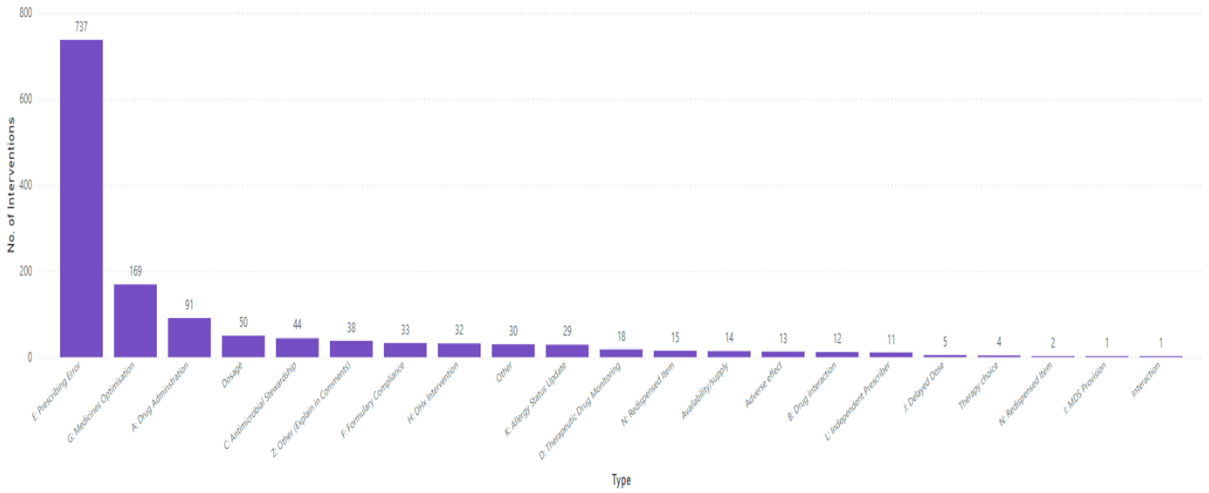



2. Pharmacist Interventions

The number of pharmacist interventions since 17/10/2022 is set out below. The interventions can be viewed as near misses and demonstrate the value of the clinical pharmacy service. The detail of each intervention is available on the dashboard and can be sorted by consultant. It is essential that teams review their intervention data on a regular basis and learn from common themes.

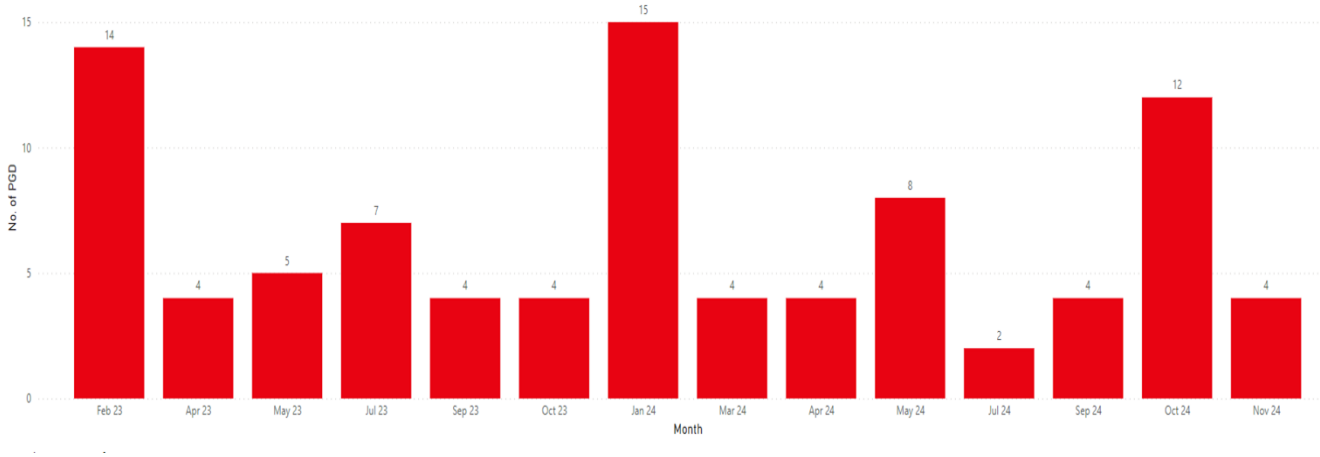



Below is a breakdown of the different categories of intervention. The most common is prescribing error – for example, this is where the clinical pharmacy team have picked up on an incorrect dose, or frequency, or where the prescription is incomplete.




3. Patient Group Direction

The PGD dashboard allows Divisions and Care Groups to review their PGD and to anticipate when a review is due. Currently there are 91 PGDs across the Trust and all are in date. The table below shows the schedule of expiry – there are 14 PGDs which will expire in February. The Care Groups are aware and are in the process of reviewing and updating.




The Medicines Management dashboard also includes information on:

- Formulary status of all drugs
- Ward stocklist for drugs for all locations
- Yellow card reporting for any adverse events
- Log in to Medusa Guidelines
- eBNF

The dashboard will be developed still further based on feedback from users.

## Risk Register

Risk 2737 has been placed on all Divisional and Care Group risk registers around the non-compliances to the Safe and Secure Handling of Medicines and Controlled drugs Audit. This has shown to improve local ownership of 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 evidence 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. The risks are reviewed at the Divisional Performance Reviews.

## Ward storage

As discussed above, wards are required to use the Tendable app to complete ward storage audits which provide evidence towards divisional care group medicines management risk. The information is available on a weekly basis on the Medicines Management dashboard and form the basis for discussion at care group and divisional safety huddles and Medicines Management Groups

## Further Developments

- Funding secured to purchase automated ward storage cabinets across Wards 14-17 and Ward 5 as part of the refurbishment programme. The projects also include swipe card access to drug storage areas, electronic temperature monitoring and air temperature control. this will allow for the above standards to be achieved consistently across these ward areas. The refurbishment of Wards 16 &17 has been completed and the Pyxis units are installed.
- 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 prepacked medication which has been an area of concern for this division. The installation is scheduled for February/March 2023
- The new build ED will include air temperature monitoring, swipe card access to drug areas and electronic drug storage units in four locations – ED, PAU, AMU and ED Resus. The Pxyis units are on-site and are being loaded and configured in ready for installation.
- A quote from BD has been obtained for the installation of BD pyxis units on the remaining inpatient areas. Options for a managed service are being explored between BD and finance. A business case will be developed.
- Pharmacy has installed an electronic cabinet for controlled drugs. This will enhance security within pharmacy and has allowed the audit trail to become paperless
- Pharmacy has begun some work with Corporate Quality Nurses – Rachel Tomkins and Kelly Saville – to set up workshops for nursing staff to focus on discussions around NMC professional accountability & responsibility, and legal aspects of practice and

medicines. Initially the work will focus on Divisions, but potentially will be expanded and become part of regular professional updates.

## 3. REGULATORY

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

## 4. RECOMMENDATIONS

TMC is to note that since the Section 29A Notice, a wide range of measures have been put in place to drive improvement in Medicines Management, particularly regarding storage of medicines and prescribing quality. The newly developed Medicines Management dashboard enables full transparency of data relating to medicines management. Whilst there are areas where further improvements are required, it is possible to evidence progress so far.
The above measures will also improve accountability, especially through the Divisional governance structures – the developing MLTC Medicines Management Group should become the model as the key MM group for each Division.

| MEETING OF THE PUBLIC TRUST BOARD<br>Wednesday 8th February 2023 | | | |
|---|---|---|---|
| WHT Safeguarding Update Report Q3 (Oct to Dec 2022) | | | |
| **Report Author and Job Title:** | Fiona Pickford<br>Head of Safeguarding | **Responsible Director:** | Lisa Carroll<br>Director of Nursing |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>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.<br>• Substantial work has been undertaken regarding the completion of actions outlined in the WHT Safeguarding Development Plan.<br>• The learning disability agenda within the Trust is being scoped via collaboration work across RWT and WHT. There is progress with flagging LD patients in case records.<br>• DoLS have remained buoyant due to the significant work undertaken by the safeguarding team during this period (due to ward support work)<br>• Safeguarding Children and Adult Training Level 3 compliance has increased slightly in Q3.<br>• Office space has now been found for the safeguarding team at Town Wharfe. | | |
| **Advise** | • Significant staff shortages (in the safeguarding children) have had an impact on contributing to some Walsall Partnership work during Q3, particularly with contributing to the MASH work. This has been included on the risk register.<br>• 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 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).<br>• A MCA/DoLS action plan has been developed to support the work around raising awareness of Mental Capacity Assessments.<br>• The Respect Audit process is being reviewed in Q4. | | |
| **Alert** | Safeguarding Training Level 3 (adults and children) compliance has shown a slight increase during this period, but 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 Q3 (Oct – Dec 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 Q3 report include:

- The Safeguarding DASHBOARD has been submitted monthly to the ICB following scrutiny at the Trust Safeguarding Group. Additional work has continued during Q3 to complete outstanding areas of reporting on the DASHBOARD template. This work continues.
- It is noted that during Q3 there has been an increase in compliance for both children and adult training (Level 3). Additional training sessions have been advertised and staff to non-compliance status. The overall safeguarding training programme is being reviewed in Q4.
- 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 during Q4 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 has now been found (at Town Wharfe) to provide the support for the team and to offer space for supervision.
- Safeguarding adult support is required for the community teams, this will be addressed following the induction of new members of staff in the adult service during Q3/4. To note that contact has now been made with respective leads in the community areas to progress this.
- WHT have attended all ICB and LA partnership meetings.
- The Walsall Local Authority Joint Targeted Area Inspection was undertaken in November 2022. The focus for this was the early intervention service offered to vulnerable young people and included a significant inspection of MASH. WHT participated in the inspection and ED, Maternity, 0-19 and bespoke services were visited. The outcome of the inspection was published in January 2023. The rating was that overall Walsall has good leadership, systems and processes in place. There will be an overall action plan created for the partnership to contribute to.
- Progress continues to be noted in completion of actions aligned to the Safeguarding Development Plan. There is further work to be progressed regarding the development of a safeguarding audit programme, policy completion and oversight of incidents. To note that the safeguarding team leads are now attending divisional governance meetings and this work will continue during Q4/Q1.

- WHT and Walsall Local Authority Adult Service Leads have met during Q3 to discuss the planned work for outstanding S42 cases. In 2023 there will be further planning arrangements to work together with key partners internally and externally 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 Q3 there were 3 child cases referred and 1 adult case. 3 places at external IMR training has been secured for WHT safeguarding team in Q4.
- During Q3, 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 throughout the past 6 months 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 Q3 was 110 similar to Q2 (112). The safeguarding adult team have provided robust ward support during this period which has clearly impacted on the number of applications being progressed.
- There was a total of 141 Adult Safeguarding referrals made in relation to Trust patients during Q3. Of the 141 referrals made, 54 were made by the Trust to the local authority (these are the referrals that the Trust Safeguarding Team are made aware of). West Midlands Ambulance Service were the biggest referrers. Themes were around unsafe discharge, pressure ulcers, medication errors, self-neglect and domestic abuse.
- the Safeguarding Adults Team have worked to support the Discharge Lounge with their work around unsafe discharge by developing and promoting a 7-minute briefing around Safeguarding & Safe Discharge as part of wider learning for the organisation.
- WHT and RWT are working in collaboration to respond to the LPS consultation. Key meetings locally and nationally have been attended to ensure the work is progressing within the Trust in line with expectations. Draft guidance (from central government) is still outstanding which confirms the LPS operating model.

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

This Q3 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.<br>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<br>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.<br>**Annual Submission** |
| **Q3 Update**:<br><br>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:<br>• 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.<br>• Safeguarding responsibilities are included in all staff job descriptions.<br>• A suite of safeguarding policies.<br>• Effective arrangements for engaging and working in partnership with other agencies.<br>• 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**

**Q3 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 has progressed between WHT and RWT. (**Appendix 1**).

- The domestic violence policy for the Trust has been updated and will be presented to the Trust Policy Group in Q4.
- A joint RWT/WHT 'managing allegations of trust' policy is currently being scoped for conclusion in Q1.
- The safeguarding team has expanded during Q3 to include the new Deputy Head of Safeguarding (commenced in post 3rd October 2022). The outstanding post cited within the previous business case (the Safeguarding Business Support Manager) is currently in recruitment stage and is expected to be finalised during Q4.
- During 2022, 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 over 92.46% by November). 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.
- WHT have worked with ICB and Walsall Partnership colleagues during Q3 in regard to reviewing attendance at key meetings (to ensure full commitment, attendance and participation). In November WHT supported Walsall Local Authority in the Joint Targeted Area Inspection (JTAI).

**Actions**:

- To complete to the recruitment of the business support manager in Q4.
- To work collaboratively with RWT to ensure all policies are updated by end of Q4.
- To ensure any actions from the JTAI are concluded.

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.

**Q3 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 (to develop additional eLearning and face to face delivery options) with both WHT and RWT 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.
- The safeguarding training compliance is reported monthly at the Trust Safeguarding Group (for each Division) and via the Safeguarding Dashboard presented to CQRM monthly which provides overall training compliance across the Trust.
- During Q3 Safeguarding Children Training Level 1 and 2 compliance was over 96.8% and 93.1% respectively. Level 3 compliance has improved slightly in December to 87.5%, up from 81.9% in October, this is most likely due to the additional advertisement of training sessions and with Divisional support. WHT training and development department have been contacted to assist with including the national e learning package to the current programme.
- During Q3 the compliance for Safeguarding Adult Level 1 and 2 training remained consistent with over 96% for Level 1 and 95% for Level 2. Level 3 training compliance has improved slightly in December to 80.34%, up from 78.5% in October. 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 93.2%. 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 personal training compliance has varied. Adult Level 4 training (2 x Named Nurses) is 50% with 1 staff member outstanding. Children level 4 training (5 x Named Nurses) is 80% with 1 staff member outstanding due to staff sickness and limited access to training regionally during this period. L4 training has been sought during Q4 for those staff outstanding.
- 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 in 2023. At the time of this report, no national updates have been received.
- Domestic Violence Training is included in both Adult and Children Safeguarding Level 3. Additional training has been offered during Q3 via the Walsall Partnership.
- The attendance at Prevent Training has been excellent during Q3 at over 97% predominantly.
- WHT Board children and adult training was delivered in November 2022. This now stands at 100% compliance.

**Actions**:

- Safeguarding Training compliance will continue to be monitored during Q4 and additional training dates will be provided as necessary to meet the needs of the Trust.
- The Safeguarding Training Programme will be reviewed in Q4.

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.

**Q3 Update:**

- During Q3, 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 Community Staff/midwives identified to receive safeguarding supervision within Q3** | **Q3 Compliance** |
|---|---|

| | |
|---|---|
| Health Visitors: **30** | 21 = **70%**<br>Exceptions 1 x Mat leave, 2 x cancelled, 3 x sick leave, 3 x supervisor on sick leave. |
| School Nurses: **36** | 19 = **53%**<br>Exceptions 1 x sick leave, 2 x cancelled, 14 x non-compliant – rebooked for Jan 23. |
| Community Midwives (Group): **30** | 27 = **90%**<br>Exceptions 3 x sick leave |

- Health Visitor and School Nurse supervision compliance has improved in Q3 for both Health visitors and School nurses. All practitioners that are outstanding have been prioritised and are scheduled to be seen in January 23.
- In Q3 the safeguarding children team have also provided group safeguarding children supervision to support staff working in the 0-19 Service.
- During Q3 practitioners in Paediatric Emergency Department, Community Children's Team and Acute Paediatrics have had access to the monthly safeguarding supervision sessions. These have been poorly attended, however in October there was improved attendance, which was due to changes to the date the supervision was facilitated.
- The safeguarding team (children and adult service) have also undertaken safeguarding floor walks which provides additional opportunistic case reflection and support and guidance.
- In December the 2 x band 7 (1.2 wte) safeguarding children supervisors from the 0-19 service were permanently transferred into the safeguarding team.
- Midwives have received a range of one to one, group supervision during the period and compliance has remained excellent.
- To note that 2 places have been agreed for community midwives to complete the NSPCC supervision training during 2023.

**Actions:**

- To monitor supervision compliance and ensure outstanding supervision is completed.
- To promote safeguarding children supervision across acute paediatrics.

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. |
| **Q3 Update**:<br>• During Q3, WHT have attended all respective safeguarding case review groups across the region. This covers work aligned to Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Learning Disability Reviews (LeDeR) and Domestic Homicide Reviews (DHR). The Deputy Head of Safeguarding attends the Walsall Practice Review Group (PRG).<br>• WHT have contributed to the chronologies, reports and participated in the multi agencies discussion following the deaths of 3 children in Q3. None of the deaths progressed to a Child Safeguarding Practice Review.<br>• There has been learning following the child deaths, which is monitored at the WHT internal CSPR/SAR/DHR/LeDeR Group. This Group continues to meet bi-monthly to review and update all actions aligned to the Organisation.<br>• Learning has been disseminated via training; supervision, 7-minute briefings and team operational meetings.<br>• One adult referral has been submitted to Walsall Practice Review Group during Q3 and is currently being scoped for a decision on whether it meets the criteria for a SAR.<br>• During Q3, 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.<br>• External IMR training has been sourced for WHT safeguarding service (3 places) to be undertaken during January 2023.<br><br>**Actions:**<br><br>• To work more closely with the Divisions following a Significant Incident and/or death of a child to ensure learning is disseminated.<br>• To undertake audits with the Services to aid assurance that learning is embedded and there has been a change in practice.<br>• For WHT to review their internal notification and quality assurance process in relation to escalation of new cases to ensure consistency with information coming in and out of the Trust.<br>• To ensure any case action plans are completed within timescale<br>• To attend Walsall Practice Review Group (PRG) and share findings with respective groups/divisions.<br>• To attend the WHT PRG meeting and ensure learning disseminated<br>• To 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. |
| **Q3 Update:**<br>During Q3 WHT has ensured that learning from all types of reviews has been disseminated Trust wide via:<br>• Trust brief<br>• Daily Dose<br>• 7 Minute briefings<br>• Bespoke/Training<br>• Specific targeting of professionals/wards<br>• Team operational meetings<br><br>Recommendations are also embedded within mandatory and bespoke safeguarding training.<br><br>Single agency action plans have also been discussed and updated at:<br><br>• The Trust Safeguarding Group during Q3<br>• Divisional Governance meetings (Safeguarding and Trust wide)<br>• Matrons and Heads of Nursing meeting<br>• Practice Review Group<br>• WHT internal CSPR/SAR/DHR Meeting (PRG)<br>• Operational Meetings (Safeguarding Children, CYPiC, Learning Disability and Safeguarding Adults)<br><br>Learning from reviews is also embedded within the safeguarding supervision process across the service.<br><br>The WHT internal practice review group have updated most of the actions that were outstanding and provided evidence accordingly.<br><br>**Actions:**<br><br>• To continue to communicate during Q4 information across the Trust in regard to new cases or actions. |
| 5. a. Health providers are required to provide evidence that staff are aware of the importance of listening to children, young people and adults with care and support needs.<br>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.<br><br>**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.

**Q3 Update:**

Safeguarding Adults Activity during Q3

- 110 DoLS applications were submitted during Q3 (Oct = 35, Nov = 25, Dec = 48) which remains the same as Q2. 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 Q3.
- No Prevent referrals have been made during Q3. This is not unexpected, as Walsall has a low level of activity.
- All Prevent returns (to NHSE) have been completed in required reporting timeframe. (Q3 report submitted in January 2023).
- There was a total of 141 Adult Safeguarding referrals made in relation to Trust patients during Q3. Of the 141 referrals made, 54 were made by the Trust to the local authority (these are the referrals that the Trust Safeguarding Team are made aware of). West Midlands Ambulance Service were the biggest referrers. Themes were around unsafe discharge, pressure ulcers, medication errors, self-neglect and domestic abuse.
- the Safeguarding Adults Team have worked to support the Discharge Lounge with their work around unsafe discharge by developing and promoting a 7-minute briefing around Safeguarding & Safe Discharge as part of wider learning for the organisation.
- During Q3, 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 has been drafted to support this work. Progress will be reported to the Trust Safeguarding Group. (Appendix 2)
- 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 scoped during January 2023.

- During Q3, the Learning Disability and Autism Lead (from RWT) has continued to provide support across both Trusts. 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 (for expansion to the LD team) will be prepared and presented to the Trust Safeguarding Group in Q4.

Safeguarding Children Activity during Q3

- During Q3, the safeguarding team staffing shortages continued due to sickness and vacancies. The staff shortages and the impact on Service delivery remains on the Trust Risk Register.
- During Q3 the safeguarding Children Team received 67 contacts (in Q2 59 contacts received) from practitioners requiring advice, support and guidance. Themes included children with mental health concerns; domestic abuse; escalation of cases and child deaths.
- During Q3 the Safeguarding Children Team supported staff with 25 statements for court. 11 (44%) of the statements were for the health visiting service.
- 131 MARAC cases were discussed in Q3 involving 213 children. This is a decrease when compared to Q2 data (141 MARAC cases were discussed in Q2 involving 246), which is because there was one less MARAC convened due to the Christmas period.
- MASH and Daily Domestic Abuse Triage remains a key part of the Safeguarding Children Team activity. During Q3, the activity for undertaking MASH checks and strategy meetings remained consistently high. There was a total of 2331 MASH checks, compared to 2106 completed in Q2.
- In Q3 1592 Amber checks were completed compared to 1477 Amber checks completed in Q2. This is a rise of 7.79%.
- There was also a rise in the number of Red checks completed and strategy meetings that the named nurse attended. There were 493 children records reviewed for the completion of Red checks completed compared to 367 in Q2. This is a rise of 34.3%.
- During Q3 the Named Nurse attended all MASH strategy meetings invited to, there were 63. In Q2 there were 49 Strategy meetings. This is a rise of 28.57%.
- In October the safeguarding Children Team had challenges completing the Amber checks within timescales (one day). The possible reasons for the outstanding checks include the previous rise in Amber checks; inadequate staff resource in the MASH; increase in Red checks and strategy meeting (when NN in MASH is completing Red checks and/or in attendance at MASH Strategy discussions this reduces the number of Amber checks that can be completed). Additional staffing was required to complete the outstanding checks in November.
- It is noted that the Team successfully recruited and inducted 3 x 1wte administrators to support the work in the team.

- The Safeguarding Children Team have continued to provide support via face to face 'floor walks' to Ward 21, ED, Maternity and Fracture Clinic although less frequently than in Q2 due to staffing shortages. Extended support to other areas will be scoped during 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.

**Actions**:

- 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 monitor 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.

**Q3 Update:**

- Throughout Q3, the safeguarding development plan has been presented at the Trust Safeguarding Group for monitoring and oversight. (**Appendix 3**). The work has progressed significantly in relation to concerns previous concerns raised in 2021. The safeguarding development plan now forms part of the normal reporting process through the Safeguarding Group and continues to provide assurance to the ICB and Local Authority.
- The safeguarding team leads attend all WHT Divisional Governance meetings to support and provide oversight of risks that are discussed.
- During Q3, 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 2023.
- In Q3, in preparation for transition to Liberty Protection Safeguards (LPS) the safeguarding adult team have worked collaboratively with RWT and ICB. The focus on MCA and DoLS will continue during 2023. The Trust is attending local and regional collaborative meetings to ensure there is up to date focus on the subject.
- WHT have drafted an action plan following the recent publication of 'Changing our Lives' report for LD and Autism service which looked at what health

providers offer against a set of measures. (**Appendix 4**). The action plan will be reviewed and progressed during 2023.

**Actions:**

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

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

**Q3 Update:**

- During 2022, the WHT Safeguarding Team commenced collaborative work with RWT regarding the response to the LPS national report.
- The joint targeted area inspection (JTAI) of the multi-agency response to the identification of initial need and risk in Walsall took place in November. It was carried out by Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). WHT, Walsall Council, Education, West Midlands Police and local NHS services were the main partnership contributors to this inspection. The inspection looked at areas where children 'at risk' may become known to the authorities such as the Emergency Department at Walsall Hospital, the West Midlands Police Control Room and the multi-agency safeguarding hub (MASH). WHT participated fully in the inspection.
- The outcome of the JTAI was published in January 2023. The key findings described children who need help and protection in Walsall receive a coordinated and effective multi agency response, are supported by a comprehensive multi-agency early help offer which gives them access to a range of support and services, when they need it. The report concluded that there is strong and stable leadership across a range of partner organisations which enables the right help to be provided to children and young people at the right time. There will be an action plan developed by the Walsall Partnership following the inspection, and WHT will be cooperating with any relevant health actions.
- WHT will be working with Walsall Local Authority and ICB in response to the national report following the death of children Arthur and Star.
- WHT are awaiting guidance on the Oliver McGowan learning disability training requirements for the Trust (expected Q4).

**Action:**

- To attend partnership meetings in response to the outcome of the JTAI
- To attend relevant ICB meetings in response to the publication of the report into the death of children Arthur and Star.

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) |
|---|

**Q3 Update:**

- During Q3 WHT reviewed attendance at all key Walsall Partnership meetings and presented the report to WSP and ICB
- During Q3 the Safeguarding team have attended all requested partnership and safeguarding meetings with Walsall Local Authority (LA), ICB and all care planning operational meetings. This includes MARAC and Practice Review Group (PRG)
- A combined partnership feedback form is now presented to the Trust Safeguarding Group monthly (from December 2022).
- WHT have submitted the completed ICB Dashboard monthly. All exceptions are discussed at the Trust Safeguarding Group (attendance from ICB noted)
- WHT do not attend MAPPA meetings currently.

**Actions:**

- To report on partnership meetings at the Trust Safeguarding Group.
- To ensure information is provided to the Partnership for key groups as discussed within the meetings.

## 3. RECOMMENDATIONS

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

Walsall Healthcare NHS
NHS Trust

# Safeguarding Service

## Safeguarding Policy Document – updated December 2022

| No. | Name of Policy | Approval Date | Review Date | Commence Review (3 months prior to review date) | Lead Practitioner | Notes/Progress |
|---|---|---|---|---|---|---|
| 1 | Prevent Policy - OP110<br><br>V2 March 2021 | 26.04.22 | April 2025 | January 2024 | JL | 26.04.22 – Policy is now on the intranet. |
| 2 | Female Genital Mutilation Policy (FGM)<br><br>V2 April 2022 | | December 2023 | September 2023 | TT | **06.01.23 – Two policies identified are being reviewed and updated into one policy, once completed will be submitted to February policy group.**<br><br>08.12.20 – Two policy's available on the intranet in date. Policies to be reviewed and updated then submitted to policy group Jan 23. |
| 3 | Domestic Abuse Policy<br><br>V2<br>Under review: October 2022 | | | | SS | **06.01.23 – sent to the safeguarding team for comments to be submitted to policy group next week following amendments for February Policy Group.**<br><br>13.12.22 – will be submitted to policy group end of Dec 22. |
| 4 | Safeguarding Children Supervision Policy<br><br>Under Review to combine adult and children's under 'Think Family' Supervision Policy 2022 | | October 2022 | | DF/JJ | **06.01.23 – under review to include children and adults following formalised approach being agreed in acute wards as part of safeguarding supervision research. Aim for April policy group.**<br><br>13.12.22 – under review to include formalised sessions for acute services following JTAI inspection |

| | | | | | | |
|---|---|---|---|---|---|---|
| 5 | Safeguarding Adults Supervision Policy<br><br>Under Review to combine adult and children's under 'Think Family' Supervision Policy 2022 | | April 2023 | January 2023 | DF/JJ | **06.01.23 – under review to include children and adults following formalised approach being agreed in acute wards as part of safeguarding supervision research. Aim for April policy group.**<br><br>13.12.22 – under review to include formalised sessions for acute services following JTAI inspection |
| 6 | Safeguarding Adults at Risk Policy<br><br>Under Review to combine adult and children's under 'Think Family' Safeguarding Policy 2022 | | April 2023 | January 2023 | JL/LR | **06.01.23 – work commenced to combine adults and children policy 'Think Family' approach. Aim to complete by end for March for policy group April 2023.**<br><br>13/12/22 – policy being reviewed |
| 7 | Safeguarding Children Policy<br><br>Under Review to combine adult and children's under 'Think Family' Safeguarding Policy 2022 | | April 2023 | January 2023 | DR | **06.01.23 – work commenced to combine adults and children policy 'Think Family' approach. Aim to complete by end for March for policy group April 2023.**<br><br>09/12/22 – policy being reviewed |
| 8 | Managing Allegations Against Staff | | December 2022 | September 2022 | FP | **06.01.23 – Policy allocated to be reviewed as Joint policy with RWT.**<br><br>09/12/22 – currently being reviewed. |
| 9 | Deprivation of Liberty Safeguards (DoLS) Policy | | | | MIn/JL | **06.01.23 – Policy found and submitted to policy group for Jan 23 advised requires further amendments prior to approval.**<br><br>09/12/22 – policy to be reviewed and submitted to policy group Jan 2022 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | 26/10/22 Maggie or team to locate policy and review to submit to policy group? Nov 2022 |
| 10 | Mental Capacity Act Policy<br><br>For ratification Jan 2023 | 20.12.22 | November 2026 | September 26 | JL | **06.01.23 – Policy approved at policy group panel 20.12.22.**<br><br>09/12/2022 – submitted to policy group in Nov 22 circulated to EIA, Library and Lisa Carroll for final sign off. References updated at library's request. |
| 11 | VIP / Celebrity Visitors to the Trust | | | June 2022 | | **06.01.23 – For review by HR.** |

**MCA/DoLS Action Plan 2022 – 2023 – *Draft Plan***

| | Action | How will this be achieved? | How will this be evidenced? | When will this be achieved and what progress of the action plan? | Staff Responsible | Rag Status |
|---|---|---|---|---|---|---|
| 1. | Promote MCA/DoLs through Trust Comms. | a) Complete a 7-minute briefing to be promoted to all trust staff. | Through communication newsletter, via safeguarding intranet site, and promoted on floor walks. | On-going with continual evaluation and review impact from 24/10/22.<br><br>a. 7-minute briefing on MCA/DoLs completed previously. Document reviewed and updated – 2.11.22 Promoted on floor walks and sent to ward managers - 2.11.22 | WHT Safeguarding Adults Team | |
| 2. | To review the clinical areas requiring support with MCA and DoLS applications.<br><br>All other WHT sites will continue to | b) To ensure WHT sites have regular contact and access to support via drop-in sessions and floor walks by the Trust Safeguarding Team.<br>c) To monitor MCA assessments and | To review the MCA/DoLs policy amending the policy in line with legislative changes and outcomes of audits.<br><br>MCA flowcharts to be produced and sent out | On-going evaluation from 24/10/22<br><br>b. Daily floor walks conducted by Safeguarding Adults Team. Wards/Depts have named Safeguarding Adult Team member allocated (Clusters).<br><br>c. The monitoring of MCA assessments & DoLS applications will continue to be monitored daily by the Safeguarding Adult Team. | Safeguarding Team with support from matrons | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | receive onsite support. | DoLS applications on the inpatient wards over the next few months. Identify additional areas to target.<br>d) To complete a small-scale survey next week and repeat in 2 months, focussing on MCA assessments, completed at Manor Hospital.<br>e) To offer additional MCA / DoLS training across the Trust including bespoke sessions on wards/departments. | to WHT sites to be placed on nursing stations as aide memoir.<br><br>To ensure wards document MCA assessments and reviews.<br><br>Quality whiteboard on wards to log numbers with MCA/DoLs and discuss during each handover.<br><br>To evidence advice given to all WHT sites on the safeguarding database.<br><br>An informal audit to capture clinical areas that require additional support with completing MCA/DoLS applications, review, | Any gaps/themes will be identified through the monthly DoIS audit (i.e. no of DoLS applications by ward). MCA Flowchart to be sent electronically to ward managers and existing Safeguarding Champions.<br><br>d. Small scale survey completed on 9 wards between 24th – 31st October. Survey to be revisited week beginning 12th December 2022.<br>**Update: 06.01.23** Survey due on 12.01.22 postponed to commence week beginning 23.01.23<br><br>Patient Flow Meeting 01.11.22 re: new electronic whiteboard. Safeguarding symbol to be added (green dot) includes MCA/DoLS.<br><br>e. Offer of MCA/DoLS training session for PEF's 02.11.22 – date/time to be confirmed.<br>**Update: 07.12.22** – remains in progress due to training session needing to reflect Wolverhampton & Walsall processes.<br>**Update: 06.01.23** – training session slides updated to reflect both WHT and RWT processes. | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | and report to relevant groups regularly.<br><br>Monitor and evaluate the effectiveness of MCA training e-learning and face-to-face compliance. | MCA & DoLS will continue to be included in level 3 Safeguarding Adults Training.<br>Safeguarding Champions 12-month programme to be refreshed and to include session on DoLS and MCA.<br>Additional support to AMU Safeguarding Champions began in October 2022 which includes session on MCA & DoLS.<br><br>Plan for additional MCA/Dols training for Wards/Depts to be developed once survey results are collated (see 2 D).<br>There has been some adhoc MCA/DoLs training on the wards.<br><br>We don't have specific MCA e-learning currently.<br><br>**Update: 07.12.22** Meeting arranged with Dr Huda Mahmoud, who is the Simulation Lead & Shedene Bogle on 12.12.22 re: bespoke module for MCA - using virtual reality.<br>**Update: 06.01.23** – introductory meeting took place. Awaiting further feedback on whether funding is available to pursue this option. | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. | To create an MCA / DoLS prompt sheet (flowchart) for inpatient areas where potential MCA / DoLS are identified, including how to document and report. | a) To review the current document in place to support staff with identifying MCA/ DoLS.<br>b) Develop flowcharts for staff.<br>c) To pilot draft flowchart as intervention following MCA Audit. | To share draft flowchart with safeguarding team colleagues, and ward staff for feedback.<br><br>To promote increased awareness and generate conversations. | December 2022<br><br>a) All wards/Depts currently have green DolS folders, these are currently being refreshed.<br>b) Draft flowcharts have been developed for staff which have been shared with the safeguarding team for comment admin support will then be sought for final published document before c) being shared with wards/Depts.<br>(Flowcharts also include process post initial DoLS application).<br>**Update:** | Safeguarding Adults Team | |
| 4. | Review MCA/DoLs Policy. | a) MCA Lead to develop and review MCA/DoLS Policy in Q3<br>b) To share the draft with the safeguarding team, leads, and Trust Group members and make changes following recommendations.<br>c) Safeguarding team to plan the launch of and implementation | The Policy will be agreed by WHT internal processes and be available on the Trust Website. | January 2023<br><br>a. Named Trust MCA/DoLS Lead identified.<br>b. Current Trust Mental Capacity Act (2005) Policy v.4 was last updated in July 2018 and required review in 2021. Enquiries made with regards to whether policy has been reviewed and is awaiting ratification – 02.11.12<br>c. launch plan to be developed once revised policy has been ratified.<br>d. Trust Safeguarding Team attended the Regional LPS Meeting on 01.11.12 - key highlights to be fed back at Safeguarding Adults | MCA DoLs Lead and Safeguarding Lead | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | of the policy once ratified to embed in practice.<br>d) To prepare for the impending changes of LPS legislation (awaiting practice guidance Q3/Q4) | | Team Meeting and Trust Safeguarding Committee.<br>**Update 07.12.22 –** final changes made to MCA Policy. To be presented on 20.12.22 at PMCG meeting for sign off.<br>**Update: 06.01.23 –** MCA Policy presented to PMCG on 20.12.22 Policy agreed by Executive Lead, final stage will be for sign off by Trust Board. | | |
| 5. | MCA/DoLS Promotion<br><br>The team will promote MCA/DoLS utilising available resources. | a) Safeguarding Team to promote MCA/DoLs by utilising relevant resources (pens, aide memoir templates or posters) daily whilst undertaking floor walk.<br>b) Safeguarding Team to monitor feedback | Resources will be promoted and be available for staff in all clinical areas.<br><br>To promote awareness and provide opportunity for feedback | **On-going from October 2022**<br>a. Safeguarding Adults Week takes place Mon 21st November – Sunday 27th November 2022. The Safeguarding Team have a plan for the week to include a different safeguarding topic to be promoted each day - MCA & Dols is one topic. The plan includes promotion through Comms and visits to the wards and depts by the team. Goody bags for each ward. Stall in atrium/Costa. Quotes have been sought from 3 suppliers for banner pens (01.11.22). Safeguarding Admin to order pens through procurement 4.11.22) Further supply of | MCA and DoLs Lead | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | MCA & DoLS credit cards to be purchased for dissemination.<br>**b.** Feedback from staff to be captured through safeguarding team consultation forms.<br>**c.** **Update 09.01.23** Safeguarding Adults Team stall held in hospital atrium on 23.11.22 which provided an opportunity for staff to talk to the safeguarding team and for the team to promote awareness around MCA & DoLS. | | |
| 6. | Safeguarding Team to undertake a survey of staff's current awareness of Mental Capacity Assessments and monitor the progress of improvement. | a) During floor walk safeguarding team to complete a short survey with staff to monitor current understanding.<br>b) Promote MCA to areas identified requiring more support and monitor impact.<br>c) Dip sample random records during floor walks to ensure | Initial data to be collated and report complied.<br>Audit results to be presented to the Trust Safeguarding Group.<br><br>Re-audit 6 months post implementation of interventions. | Commencing October 2022<br><br>a. (See also 2d) Verbal report of initial preliminary findings from 24/10/22 shared with F. Pickford<br>b. See 2c<br>c. Continuation of daily floor walks by the safeguarding team which include daily patient record checks of MCA and DoLS applications.<br>d. Trust Safeguarding Team sought permission from ward nurses in charge on the day that the initial survey was undertaken. | Safeguarding Adult Team | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | increased compliance with MCA.<br>d) Ward Matrons/key staff to be notified of the survey.<br>e) Data analysis to be recorded on spreadsheet.<br>f) Outcome of results to be included within the implementation plan. | | Survey feedback will be shared with ward matrons and key staff.<br>e. Safeguarding Admin to collate onto spreadsheet/report 01.11.22<br>f. Final report to be compiled by January 2023 and shared with Trust Safeguarding Group.<br>**Update 09.01.23** – Repeat mid scope/survey due to be conducted week commencing 12.12.22 was delayed due to winter pressures and other audits taking place (ReSPECT and DolS) however plan if this to take place week commencing **23.01.23** | | |
| 7. | To promote safeguarding team support and MCA during floor walks | a) Develop a 7-minute briefing for the safeguarding team to promote during floor walks.<br>b) Provide the safeguarding team duty | Post-floor walk evaluation to be undertaken any patient specific advice given to be documented as per Safeguarding Policy. | On-going from October 2022.<br>a. See 1a, 5a and 5b<br>b. Laminated contact information sheets to be handed out by Safeguarding Team to wards and depts (where applicable). Update contact details on Trust intranet and internet – awaiting access as of 02.11.22 | Safeguarding Adult Team | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | telephone number and role of the safeguarding team. | | **Update 07.12.22**: 7b now completed. | | |
| 8. | To review current MCA/DoLS E-learning package to ensure it meets the needs of staff undertaking MCA/DoLs assessments. | a) The current training package will be reviewed by the Safeguarding Adults training lead.<br>b) A video recording of an MCA/DoLS assessment to be developed to support staff.<br>c) Training lead to assess the impact of e-learning and face-to-face learning to ensure it meets the learning outcome. | Video recording to be discussed at the with Safeguarding Governance Meeting | March 2023<br>a. Please see 2e<br>b. Team to email trust Comms to clarify if it would be possible to film a short session and if so if this could be placed on the intranet for staff to view.<br>c. Please see 2 e | Named Nurse Safeguarding Adults | |
| 9. | To improve the quality of Mental Capacity Assessments and Deprivation of Liberty Safeguard applications | a) To video record the process of completing a Mental Capacity Assessment, and | Commence process and database to capture number of MCA/DoLs assessments completed and reviewed. | Commence October 2022<br>a. Please see 8b<br>b. Please see 8b<br>c. Please see 8b<br>d. MCA /DoLS assessments are monitored and reported on | Named Nurse Safeguarding Adult (MCA and DoLS Lead). Safeguarding Adult Lead. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Deprivation of Liberty Safeguard<br>b) To video record the process of the Best Interest Meeting.<br>c) Promote the availability for videos on the safeguarding intranet page for staff to access.<br>d) Monitor impact of MCA/DoLs assessments following training sessions. | Commence process to assess the quality of MCA/DoLs assessments. | monthly through the Safeguarding Committee. | | |
| 10. | Local Safeguarding Champions in each clinical area to be identified to include promote the work of MCA and DoLS within the wider safeguarding champions role. | a) Clinical areas to be asked for expressions of interest or for staff to be nominated by the Senior Nurse for the clinical area.<br>b) Bespoke safeguarding training package to be delivered to | To compile a database of safeguarding champions.<br>Action log of meetings to be maintained.<br>Evaluation of training to be undertaken. | a. Safeguarding champions programme began in October 2022 with identified staff from AMU (7), 5-week training programme.<br>b. Wider safeguarding champions programme to be extended to community and re-instigation of programme for existing Safeguarding Champions (33 across the Trust currently).<br>c. Safeguarding Champions received Safeguarding Supervision Training in 2021. | Named Nurse Safeguarding Adult (MCA and DoLS Lead).<br>Safeguarding Administration | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | champions, so this information can be disseminated across the Trust.<br>c) Safeguarding supervision for safeguarding champions.<br>d) To consider a name change to safeguarding advocates and learning supporters to promote patient-centred decision-making. | | Plan for Safeguarding group supervision to be provided for Safeguarding Champions as part of the planned programme for 2023.<br>e. For further discussion and review<br>**Update 07.12.22 –** Safeguarding admin seeking confirmation of venues for champions sessions.<br>**Update: 09.01.23**<br>Venues and dates confirmed for safeguarding Champions for the new financial year. Task and finish group set up by safeguarding leads to plan ahead. Session planning will also include planning for champions safeguarding supervision. Further work to be carried out with regards to recruiting champions from community services. Jan – March 2023. | | |
| 11. | Safeguarding Team to undertake a formal review of staff compliance with Mental Capacity Assessments | a) Dip sample patient records from all inpatient wards.<br>b) Ward Matrons to be notified via email of formal audit. | Audit results to be presented to Trust Safeguarding Group. Action plan to be implemented following outcome of findings. | Commencing March 2023<br>Report compiled by April 2023<br>Report findings to TSG to be confirmed in 2023.<br>a. Ongoing as part of MCA/Dol's monthly audit | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | c) Data selection to be recorded on spreadsheet.<br>d) Interventions to be implemented March 2023. | Re-audit 6 months post implementation of interventions. | b. Audit to be feedback to Safeguarding Committee for dissemination<br>c. Data recorded on monthly table and shared | | |

Walsall Healthcare NHS
NHS Trust

# Safeguarding *Assurance Progress* Plan – January 2023

| | Issue | Action required | Timescale & Identified Lead | Progress Update | Evidence/RAG rating |
|---|---|---|---|---|---|
| 1 | **Safeguarding Service & Team Resource** | To carry out a review of the current resources within the Safeguarding Team (Adults, Children and LAC) to ensure there is the capacity to promote good professional practice, support the local safeguarding system and processes, provide advice and expertise for fellow professionals, and ensure safeguarding supervision and training is in place. | **January 2023**<br><br>(To conclude recruitment process)<br><br>Head of Safeguarding | **05.01.23**<br>**The Business Support Manager Band 5 post to be readvertised. NNSC Band 7 posts x 2wte currently in recruitment progress.**<br><br>**08.11.22**<br>Deputy Head of Safeguarding has commenced in post on Monday 3rd October.<br>Band 5 Business Support manager post now in recruitment stage (November 2022). Date for interview tbc.<br>2 Band 7 posts in Safeguarding Children Team out for advert/recruitment.<br>Team office space at WMH escalated to COO. Awaiting confirmed allocated area by November. | **In process**<br><br>Evidence: (*Minutes with Outcome of finance meeting January 2022*)<br><br>Staff in post |
| 2 | **Safeguarding Supervision Process (Adults & Children)** | **a)** Safeguarding Team to develop a Specific Safeguarding Supervision Policy (Children and Adult Policy) | **January 2023**<br><br>Head of Safeguarding and Team Leads | **05.01.23**<br>**Supervision Policy modifications in progress.** | **In process**<br><br>Evidence: (*Copy of Supervision Policy*) |
| **3.** | **Safeguarding and SUI Processes within WHT** | SG attendance at SUI – Falls, PU meeting<br>Provide safeguarding oversight on safeguarding incidents as appropriate. | **Dec 22**<br><br>Director of Nursing | **05.01.23 COMPLETED**<br>**Safeguarding team are cited on current incidents and attend Divisional Meetings. Further work with governance and quality team to review the incident management process which includes safeguarding incidents/quality/patient experience and** | |

| | Issue | Action required | Timescale & Identified Lead | Progress Update | Evidence/RAG rating |
|---|---|---|---|---|---|
| | | | | **complaints. New action to be created within plan.**<br>**8.11.22**<br>Safeguarding Leads are now included at Divisional risk meetings. HoS and DHoS to monitor until end of December 2022, and will confirm (with Divisions) who is attending for oversight of SUIs and Serious Incident/risks in 2023.<br>**Action: to update the TSoG in January 2023** | |
| **4** | **Safeguarding Audit:**<br><br>**Child Protection Information System (**CPIS)<br>To ensure that this process is embedded across the Trust. | • Current CP-IS SOP requires improvement<br>• Current SG Children Policy needs to be updated to reflect CP-IS.<br>• Audit to be undertaken to ensure practitioners are using CP-IS during Q3/4. | **April 23**<br><br>Head of Safeguarding | **09.12.22**<br>**Date to be confirmed.**<br>**Awaiting dip sampling of records – date cancelled due to sickness within SG Children Team. Plan to complete in Q4 22/23.** | **In process**<br><br>Evidence:<br>*Audit findings & action plan*. |
| **5** | **Safeguarding Training Programme to be reviewed. (October 2022)**<br><br>**Reduced compliance noted in Q2**<br>**The Children and Adult Training Package currently requires reviewing and refreshing.** | • Safeguarding Service to review delivery options available – meeting to be set up in October (SG Leads)<br>• WHT to offer more training dates whilst the review is in place<br>• For WHT to email directly all staff who are outstanding with their training | **April 23**<br><br>Head of Safeguarding | **09.12.22**<br>**Elearning options escalated. Review of overall training programme (with RWT) to commence in Q4. Task and Finish Group to meet to look at the intercollegiate guidance.**<br><br>**06.10.22**<br>Staff have been emailed directly with dates of forthcoming training dates. | **In process** |
| 6 | **Learning Disability Service Within WHT**<br>confirmation of role of LD service within Trust, and review of LD Strategy/Standards**.** | To review the current model of service provided by LD team (via BCHT) to include posts, training, autism & LD Strategy. | **April 23**<br><br>Head of Safeguarding | **05.01.23**<br>**Progress within the Trust in regard to flagging records and provision of resources.**<br><br>**09.12.22/ 06.10.22** | **In process** |

| | Issue | Action required | Timescale & Identified Lead | Progress Update | Evidence/RAG rating |
|---|---|---|---|---|---|
| | Gap analysis to be undertaken to establish areas for escalation/improvement. | • Additional resource required during scoping of service (from May 2022) | | Meeting convened with BCPFT October to confirm funding arrangements. Referred to WHT and BCPFT contract/HR service.<br>EW is preparing a series of resources that can be used by staff (updating logo on documents to reflect RWT/WHT)<br>Olivery McGowan Training planned for roll out (potentially) November 2022. To be scoped for implementation and to confirm package. EW to update TSoG in December.<br>**07.09.22/05.08.22 Update:**<br>Report prepared and presented to Trust Group in July 22. Further work in place to scope the commissioning aspect of the service from CCG/LA. Anticipated business case/service scope to be drafted by end of Q3/Q4. Included in SG Annual Report and discussed briefly at Trust Board on 3rd August 22.<br>**06.05.22 Update:**<br>EW (LD Team Lead Band 7 from RWT) working at WHT from May 22 for 2 days per week on site to scope service with LD nurses from BCPFT. Focus will be on standards, strategy, team & flagging. Role to support the LeDeR process. Report on progress Q2.<br>**11.4.22 Update**<br>Service discussion in progress. For update to Trust Group in May<br>1.2.22 Update:<br>HOS to meet with BCPFT LD Community Lead to clarify KPI's and service spec.<br>**23.12.21 update:**<br>HoS to meet with the LD nursing team to discuss the service and achievements towards any identified KPi's. WHT have enrolled on NHSI | |

| | Issue | Action required | Timescale & Identified Lead | Progress Update | Evidence/RAG rating |
|---|---|---|---|---|---|
| | | | | Improvement Standards with an end date for Feb 2022. Data regarding processes currently being collated by service leads within the Trust. LD nurses supporting with service user feedback questionnaires (requirement is 100), link for staff to complete on line staff version has been circulated.<br>**22.10.21 update**<br>BCHCT have appointed into the 0.5wte vacancy. Current provision therefore 1.0WTE<br>Trust has supported BCHCT re- 'changing our lives 'audit. Will await final report. Audit was commissioned by Black Country and west Birmingham CCG.<br>Trust has enrolled on NHSI LD and autism improvement standards self-assessment process. Communication plan to be developed to ensure staff aware of the Trust participation. Audit supporting the process<br>**12.10.21 Update:**<br>LD service provision discussed at WHT Board 7.10.21. Service to be scoped and paper to go to Board in March 2022.<br>**10.09.21 Update:**<br>Initial scope of current LD provision for WHT (from BCHFT) has identified gaps – (limited resourcing and subsequent oversight of LD patients within the Trust). For further review with WHT Chief Nurse in Q3.<br>**05.08.21 Update**:<br>Full review of LD service and provision to commence September 2021. Initial meeting with LD lead from BCHFT arranged 31.8.21. | |
| **7** | **Safeguarding Policy Work from 2022** | Review of all related WHT safeguarding policies to ensure: | ***Review Dec 22*** | **05.01.23** | **In process** |

| | Issue | Action required | Timescale & Identified Lead | Progress Update | Evidence/RAG rating |
|---|---|---|---|---|---|
| | | • Updated<br>• Relevant<br>• That any outstanding policies are written | Head of Safeguarding | **Policy work in progress. SG attendance noted at Trust Policy Group and request to consider all key policies which may require safeguarding oversight recommended.**<br><br>**09.12.22**<br>**Present current policy position at Trust Group**<br>**07.08.22/05.08.22**<br>Review progress and update on a monthly basis At Trust SG Group<br>**08.07.22 Up0date**:<br>**06.05.2022 Update**:<br>SG Policy tracker to be drafted and presented at Trust Group in June/July 2022. Policy leads to be confirmed for updating respective documents that are outstanding. Support from RWT and WHT staff to ensure this work is completed. | |
| 8 | **May 2022**<br>**Liberty Protection Safeguards known as LPS (from Oct 2023 tbc)**<br><br>WHT to be fully prepared for the forthcoming changes within legislation and implications for practice | Review of national (and local) documentation around the intended introduction of LPS and the impact and implications for WHT.<br><br>• There should be WHT attendance at relevant national and local LPS events.<br>• WHT to attend the Black Country STP LPS Group and feedback to SG Group<br>• Identify a Trust 'Lead' for LPS<br>• Set up a Trust Group with relevant stakeholders to support this work | **April 23**<br><br>SG Adult Lead | **05.01.23**<br>**NHSE/I and Providers forum 19.1.23 noted. WHT attending for update on process/progress. WHT LPS Draft Plan to be developed thereafter. WHT IT Lead attending meeting to establish future needs. MCA/DoLS action plan in place.**<br><br>**09.12.22**<br>**MCA & DoLS action plan produced to review over next 12 months. (separate item at TSoG)**<br>**06.10.22 Update:**<br>**LPS Draft Plan to be produced and presented to TSoG end of Q3.**<br>**07.09.22 Update:**<br>Audit findings of recent work presented to Trust Group in September. | **In process** |

| | Issue | Action required | Timescale & Identified Lead | Progress Update | Evidence/RAG rating |
|---|---|---|---|---|---|
| | | | | **05.08.22 Update:**<br>See below<br>**08.07.22 Update:**<br>Joint work undertaken as planned. Audit findings to be presented at next Trust Group by RWT adult lead (who conducted the audit in June).<br>**05.06.2022 Update:**<br>Joint work in process with RWT re response to national report (due July). Audit to be undertaken in June across RWT to review all case records to establish that MCA and DoLS process is robust as part of the feedback required to establish workload generated from the ?LPS due to commence end of 2023/24.<br>**06.05.2022 Update:**<br>Work has commenced. National report/paper released in April. (paper presented at Trust Group in April 22).<br>NHSE National Group is meeting (WHT in attendance) and Black Country STP Group meeting to be attended in May.<br>RWT/WHT Safeguarding Adult Team LPS 'away day' organised.<br>Further updates will be prepared for TSG. | |
| **9** | **June 2022**<br>**Walsall Partnership Safeguarding Board & Groups**<br><br>Review of WHT attendance (at groups) to be undertaken in Q2. | Review Walsall Partnership (Safeguarding Adult/Children) Committees and Groups to ensure appropriate attendance. | **Oct 2022**<br><br>Head of Safeguarding | **09.12.22 COMPLETED**<br>**Walsall Partnership Groups/Internal group representation have been scoped by SG Team and information sent to partnership for their information and communication.**<br><br>08.11.22<br>Walsall Partnership have been advised of the recruitment to new leads within WHT Trust. Plan to review all groups and provide overview of | Green |

| | Issue | Action required | Timescale & Identified Lead | Progress Update | Evidence/RAG rating |
|---|---|---|---|---|---|
| | | | | attendance during November. Work commenced during October with new Deputy Head of Safeguarding and Team Leads.<br>**07.09.22 Update:**<br>05.06.2022 Update:<br>Liaison with Walsall Partnership re current groups/committees has commenced. | |
| **10** | **JANUARY 2023**<br>**Walsall Joint Area Inspection (JTAI)**<br><br>Inspection undertaken in November 2022.<br>Final feedback received January 2023 | Review the final report and ensure any actions for WHT are completed. | **April 23** | **05.01.23**<br>**Final report received. Actions to be reviewed with partnership and updated.** | **In process** |

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

Quality of Health Review- Acute care across the Black Country

Changing our lives February 2022

Position statement

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

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

| | | | | |
|---|---|---|---|---|
| autistic people are admitted to hospital. As far as possible, flagging systems should also be shared with other relevant partners such as GP surgeries, community health teams or community social care teams. | | | | |
| Walsall Manor operates differently to the other trusts as its ALNs are employed by Black Country Healthcare Foundation Trust. Information should be gathered about how this impacts on the delivery of care for people with learning disabilities and autistic people and any relevant learning should be used to improve practice and shared with the other three trusts. | The Trust provide a very limited services for people with LD. | A business case is being developed and will require funding. The Trust requires a team of staff who are able to support the additional needs of people of all ages with LD and or autism. | Aug 23 | |
| Hospitals should have clear policies in place to ensure that the quality of care people get outside of ALN teams' core hours is consistent with the care they get when ALNs are present. | Currently the Trust does not have policies for the care of people with LD and or autism | Clear policies for the additional support needs for people with LD and or autism are required<br><br>If the Trust is not able to achieve a 7 day a week service, an Intranet page needs to be established with information and guidance for staff outside of office hours. | Aug 23 | |
| All staff in all hospitals should have regular training that addresses health inequalities for people with learning disabilities, reasonable adjustments and people's rights including knowledge of the Mental Capacity Act. Evidence should be captured about whether this training has improved | The Trust currently deliver LD awareness during the safeguarding training package. There is no stand-alone package for LD and or autism. | The Oliver McGowan LD and autism training became a statutory requirement for all health and social care staff in Nov 2022. The ICB are currently reviewing how this can be delivered with BCHC. | Aug 23 | |

| | | | | |
|---|---|---|---|---|
| understanding and practice, and future training adjusted accordingly. | | | | |
| Trusts that have not undertaken an audit of their DNACPRs for autistic people and people with learning disabilities should do so and inappropriate DNACPRs should be removed or amended as necessary. | The Trust do not currently undertake an audit for DNACPR's for people with LD and or autism. | An audit programme needs to be established for the care of people with LD and or autism. | April 23 | |
| All trusts should demonstrate efforts to improve people and families' understanding of their rights. They should ensure that key pieces of work are coproduced with people and family carers and that recruitment processes for specialist learning disability roles and for all senior leadership roles include people with learning disabilities, autistic people and family carers. | | The Trust needs to identify people with LD and or autism who can support in the recruitment process. | Aug 23 | |
| All trusts should include people with learning disabilities, autistic people and family carers in learning from complaints, investigations and mortality reviews. | | The Trust needs to identify people with LD and or autism who can support in the complaints, investigations and mortality review process. | Aug 23 | |

| **Meeting of the Trust Board Committee Wednesday 8th February 2023** | | | |
|---|---|---|---|
| **Care at Home Report** | | | |
| **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:**<br>**Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☒ | | |
| **Assure** | • ***RSV hub:*** All partners experienced pressure in the provision of paediatric services linked to demand arising from respiratory illness. The RSV hub in Walsall town centre was extended to cover the winter and this capacity was increased in December in response to an additional surge in demand<br>• ***Avoiding Hospital Admissions:*** Community services for adults also increased their activity in December in response to acknowledged system pressures. Many of these services reported their highest ever recorded levels of activity [Care Navigation Centre; Rapid Response team; Integrated Front Door service]<br>• ***Virtual Wards:*** A range of community-based virtual wards covering paediatric, respiratory and heart failure pathways have been implemented as an alternative to hospital in-patient care. This has provided additional capacity to respond to surges in non-elective demand. Up to 26th January, the adult virtual wards had accepted 285 patients who had been stepped down from acute hospital beds. | | |
| **Advise** | • ***Discharge Funds:*** The national allocation to support discharge is being used to mitigate the financial pressures in care home and domiciliary care utilisation<br>• ***Health Visiting:*** The service continues with its programme of recruitment in both Health Visiting and other support roles. A recovery trajectory has been developed by the service and is being considered jointly with commissioners<br>• ***Walsall Together:*** The Walsall Together Partnership Board and Walsall Joint Commissioning Committee will operate the agreed model for place-based governance in shadow form from 1st April 23. | | |
| **Alert** | • ***Medically Stable for Discharge:*** Demand for complex discharges has increased. The Intermediate Care Service has both held the numbers stable and kept the length of stay low for those who are deemed No Criteria to Reside Categories 1-3 at Walsall Manor Hospital. This has resulted in greater pressure on funding within the out of hospital domiciliary and care home pathways<br>• ***Intermediate Care Service:*** The sustained growth in demand for complex discharges is projected to continue, which will exceed the long term operational and financial model commissioned. Discussions are taking place with commissioners regarding the resource required 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** | 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

# December 2022

## 1. PURPOSE OF REPORT

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

## 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'.

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 January.

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

**3.1 Demand:** Demand for Community Locality Services remained stable. There was an increase in demand for non-elective acute community care however, with the Care Navigation Centre, the Rapid Response Team and the Integrated Front Door team having their highest ever recorded levels of activity. Demand within paediatric services surged linked respiratory illness

**3.2 Capacity:**

***Locality Teams:*** The Locality Community Teams met 90% of the demand in month.

***RSV Hub:*** The Walsall Together Partnership agreed to extend the GP-led RSV hub in Walsall town centre over winter and commissioned a further increase in capacity in December in response to the levels of demand

***Virtual Wards:*** The following pathways have been implemented this year: Children, Acute Respiratory, Heart Failure, Hospital at Home, with the final ward (Frailty) commencing operational delivery on 26th January 2023. Since their inception the (adult) virtual wards have accepted 285 referrals for patients that have been stepped down from acute hospital beds.

***Discharge & Step-Up Pathways:*** The average number of patients who were Medically Stable for discharge at Walsall Manor Hospital was 50 during December (reaching 23 people on 27th December). The profile was volatile however, ranging from 23 – 81 patients during the month, an indication of the surges in demand during the month. Despite this, the average length of time that each person with complex needs was medically stable prior to discharge was 3.5 days (compared with 51 average and 4.6 days in September 2022).

There has been sustained pressure on the number of beds and packages of care being used to support hospital discharge and in equipment for patients with complex needs. These are leading to overspends in both the Walsall Intermediate Care Service and the Integrated Community Equipment Service, which will be mitigated by using the national discharge funds.

The sustained growth in demand for complex discharges is projected to continue, which will exceed the long term operational and financial model commissioned. Discussions are taking place with commissioners regarding the resource required for 2023/24, while the service is also developing a business case for WHT regarding investment to further reduce the length of stay for patients who are medically stable for discharge.

***Health Visiting:*** The service continues with its programme of recruitment in both Health Visiting and other support roles. A recovery trajectory has been developed by the service and is being considered jointly with commissioners.

## 4. RISK REGISTER

The overall risk score on the Care at Home Board Assurance Framework (BAF) has reduced to level 8 following approval of:

- Joint Health & Wellbeing Strategy for Walsall
- Walsall Together Population Health & Inequalities Strategy
- Review of Partnership strategic aims and objectives
- Place-based governance arrangements, to operate in shadow form from 1st April 2023

Additionally, the ICB have agreed for the partnership to jointly agree the outcomes and associated KPIs that will be included in the WHT community contract for 2023/24, marking a significant shift in the nature of collaborative working across commissioner and provider organisations.

The BAF remains under review by the partnership and in parallel to the review of the Trust Strategy.

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

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

## 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 as reported previously to the Trust Board.

A formal request for delegation of responsibilities from the Integrated Care Board (ICB) and the Council (Cabinet/HWB) to a newly established Place Integrated Commissioning Committee (PICC) has been made. Whilst informal responses have been positive, we are yet to receive formal confirmation of an operating model for the Black Country System. Health & Wellbeing Board members have reviewed the proposal as part of a development session and is expected to receive a formal report for approval at its March meeting. The ICB has indicated that place governance models will operate in shadow form from 1st April 2023.

From February, the existing Partnership Management Committee will transition to the Joint Planning Group in line with the place governance model. The Group will report jointly into the Walsall Together Partnership Board and the Place Integrated Commissioning Committee. Terms of Reference are in development, though key responsibilities will include collaboration on several processes traditionally associated with and undertaken solely by commissioning, to increase the level of collaboration across all partners including providers, as provided for by The Health & Care Act (2022). Statutory commissioning responsibilities will be retained by the PICC.

## 6. RECOMMENDATIONS

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

## APPENDICES

**Appendix 1:** Operational Performance Report for December 2022: Walsall Together

Walsall Together

# Walsall Together Partnership Operational Update: January 2023

Matthew Dodd
Director of Integration

Collaborating for happier communities

# [Emergent] Score Card for WT Tiers – Tiers 0

| Tier | Activity | Thresholds | | | Sep-22 | Oct-22 | Nov-22 |
|---|---|---|---|---|---|---|---|
| Tier 0: Resilient Communities | | | | | | | |
| Social Prescribing | whg - No. referrrals received | | | | 36 | 51 | Awaiting |
| | 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 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Workforce: Anchor institutions | No. staff employed by whg via scheme | | | | 75 | 79 | 86 | 96 | 96 | 100 | 108 | 98 | 95 | 120 | Awaiting | Awaiting |
| | % whg customer's | | | | 37% | 37% | 38% | 39% | 38% | 38% | 38% | 38% | 36% | 40% | Awaiting | Awaiting |

# [Emergent] Score Card for WT Tiers – Tiers 1

Walsall Together

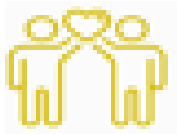
| Tier | Activity in-month | Thresholds | | | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community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

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

| Tier | Activity in-month | Thresholds | | | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tier 3 : Interimediate Care, Unplnanned Care & Crisis Services | | | | | | | | | | | | | | | | |
| Care Navigation Centre | Calls received | <435 | 435-512 | >512 | 1225 | 1170 | 1338 | 1278 | 1270 | 1307 | 1323 | 1207 | 1171 | 1142 | 1310 | 1475 |
| | | | | | | | | | | | | | | | | |
| Rapid Response Team | Referrals received | <160 | 160-247 | >247 | 260 | 254 | 294 | 281 | 294 | 242 | 277 | 245 | 250 | 285 | 307 | 339 |
| | % admission avoidance | <73% | 73%-87% | >87% | 90.4% | 91.3% | 85.7% | 91.9% | 89.2% | 98.0% | 90.0% | 90.2% | 90.1% | 90.2% | 93.8% | 90.3% |
| | | | | | | | | | | | | | | | | |
| Medically Stable For Discharge | Average number of MSFD in WMH | >57.5 | 50- 57.5 | <50 | 48.00 | 45.88 | 52.67 | 50.28 | 46.40 | 50.10 | 54.10 | 52.10 | 51.30 | 50.59 | 49.17 | 50.33 |
| | Average number of days MSFD | >5.75 | 5.0 - 5.75 | <5.0 | 3.4 | 3.5 | 3.8 | 4.3 | 4.0 | 4.0 | 4.0 | 4.6 | 4.6 | 4.0 | 3.4 | 3.5 |
| | | | | | | | | | | | | | | | | |
| Domiciliary & Bed Based Pathways | Domiciliary Pathways - Discharged ALOS | >25 | 21 - 25 | 21< | 32 | 26 | 28 | 28 | 27 | 25 | 27 | 26 | 27 | 25 | 34 | 27 |
| | Domiciliary Pathways - Average service users | | | | 200.2 | 181.5 | 180.25 | 198.25 | 213.6 | 222.2 | 203.5 | 204.4 | 177 | 223.8 | 244.25 | 275.5 |
| | Bed-based Pathways - Discharged ALOS | >36 | 24 - 36 | 24< | 43 | 38 | 37 | 54 | 48 | 48 | 47 | 48 | 36 | 52 | 39 | 46 |
| | Bed-based Pathways - Average beds in use | | | | 74 | 82.5 | 90 | 75 | 82 | 81 | 78 | 81 | 93.25 | 78 | 82 | 64 |
| | | | | | | | | | | | | | | | | |
| Integrated Assessment Hub | Hospital Avoidance | 20< | 20-28 | >28 | 158 | 168 | 162 | 210 | 193 | 224 | 219 | 157 | 165 | 210 | 174 | 230 |
| | Prevent Readmission | 35< | 35-50 | >50 | 41 | 37 | 27 | 20 | 19 | 10 | 5 | 9 | 23 | 11 | 7 | 21 |
| | Early Supported Discharge | 40< | 40-54 | >54 | 35 | 44 | 45 | 29 | 31 | 48 | 85 | 49 | 52 | 61 | 40 | 55 |
| | Assisted Discharge | 35< | 35-50 | >50 | 54 | 40 | 35 | 56 | 68 | 76 | 44 | 74 | 86 | 82 | 109 | 99 |
| | | | | | | | | | | | | | | | | |

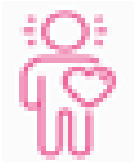
# Tier 0 Resilient whg The H Factor Social Prescribing Programme .

332 Clever Conversations



51 sign up to the Social Prescribing programme

17 improving Warwick & Edinburgh Score

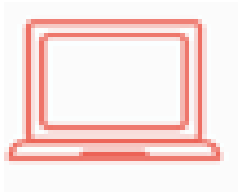


34 increased their confidence / self esteem

20 Referrals made to external support service Referrals

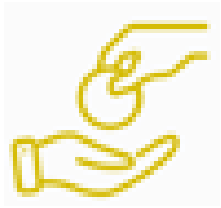
3 Completing training or education

24 Referral to whg Money Advice Service



7 Referrals to Clickstart Digital Support

15 Referrals for a fuel or Food voucher



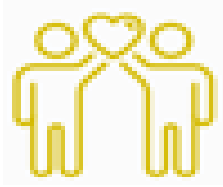
£377 requested from the Household Support Fund

9 Referral to whg Hardship Fund

November 2022

# Tier 0 Resilient Communities  Diabetes Matters

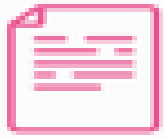
138 Clever Conversations



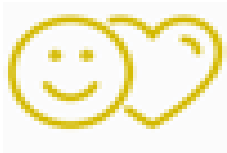
12 new customers were identified as needing support

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

2 Hospital/GP appointments attended by the team



1 Medication review has been arranged by the team

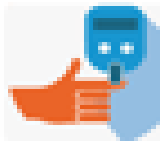


1 customer has reversed the blood sugar levels and is no longer considered diabetic

3 Referrals to whg Money Advice Service

3 Referrals to Aids and Adaptations

3 External Health Referrals made



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

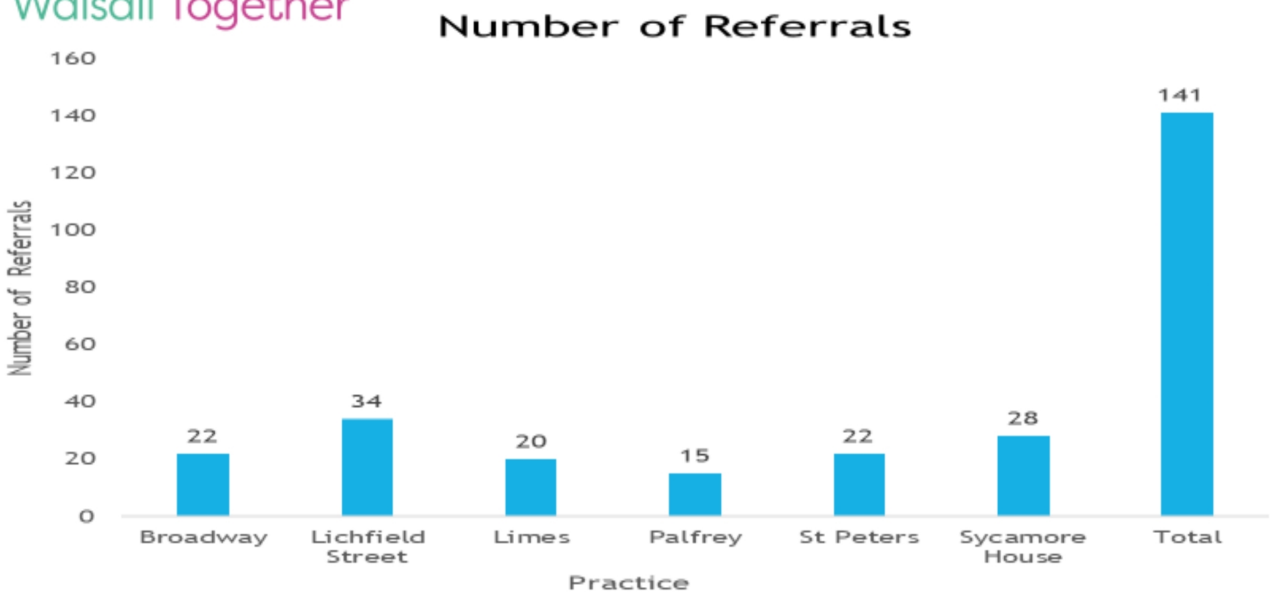
18 Community Events attended

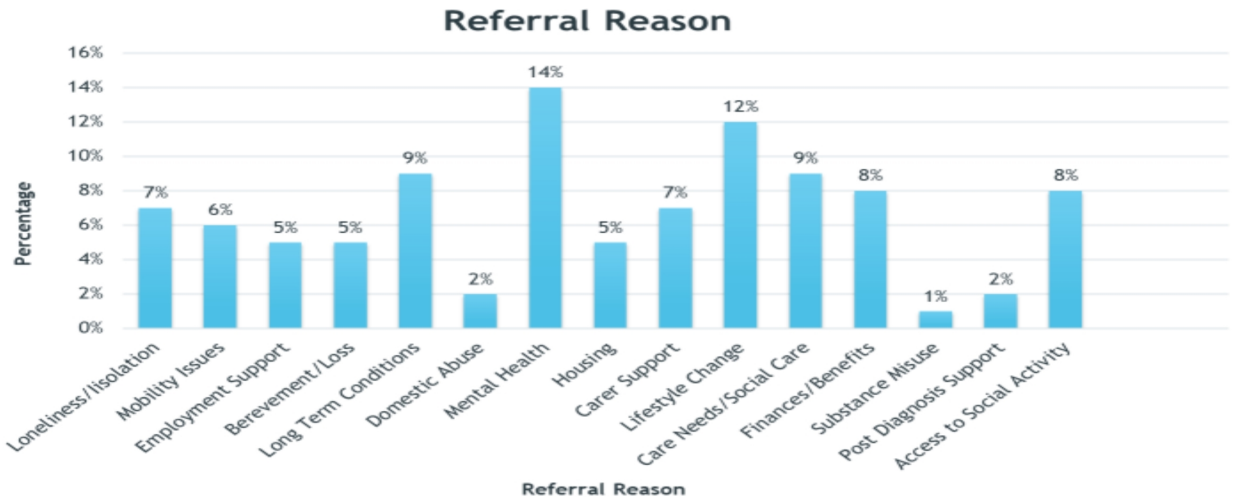
4 Community Organisations worked alongside

November 2022

# Social Prescribing – South 2

- 140-150 referrals per quarter on average - 1.5% over the full financial year
- Mental Health and Finance the majority of the issues
- SPs supporting wider PCN work in:
  - Increasing uptake in cervical screening
  - Weight management referrals
  - Cancer Care support Review

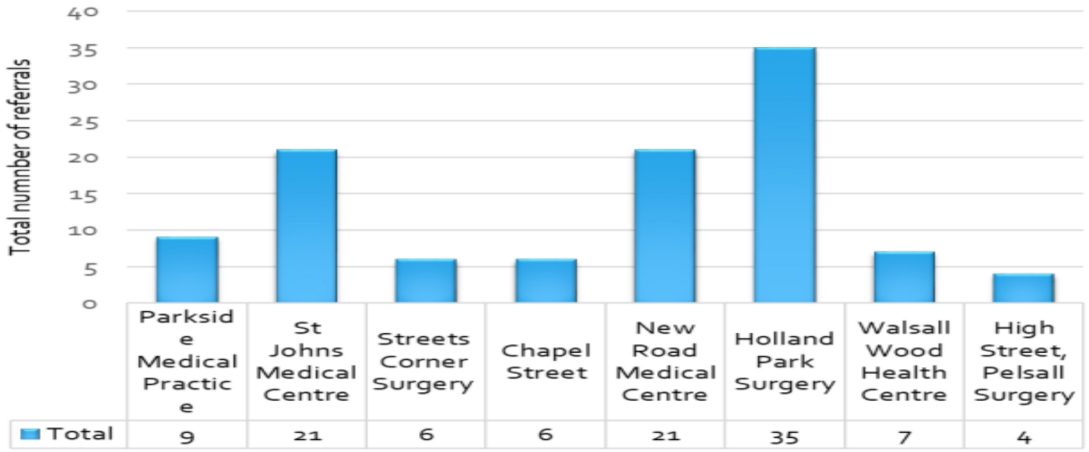


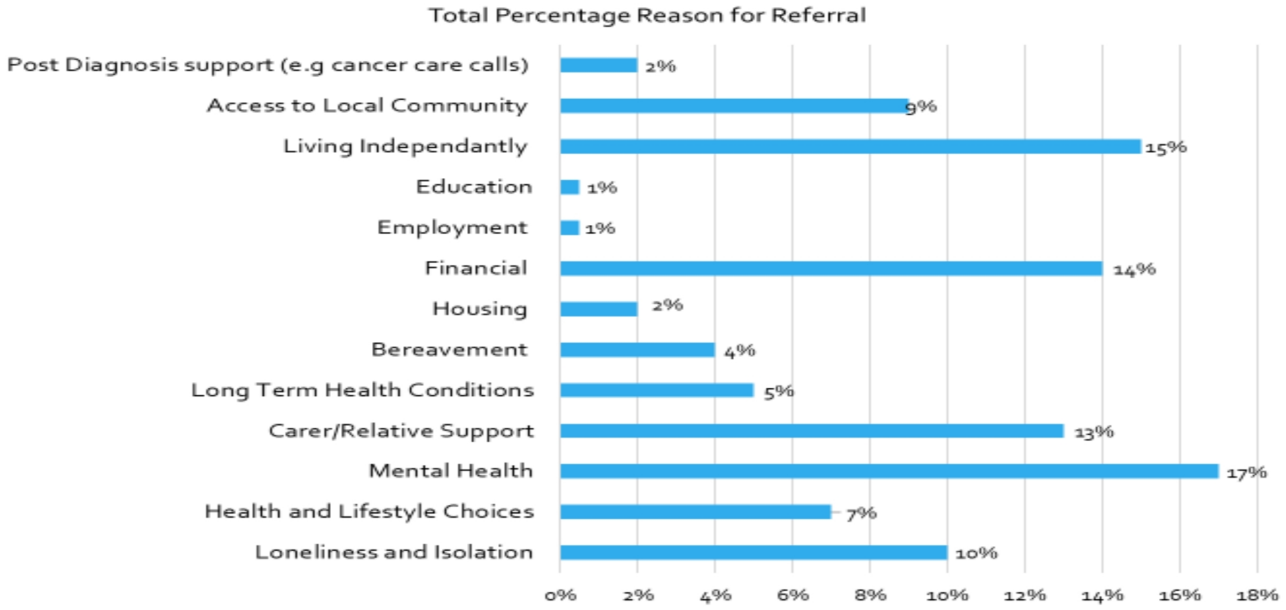




Last updated on July 2022

# 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



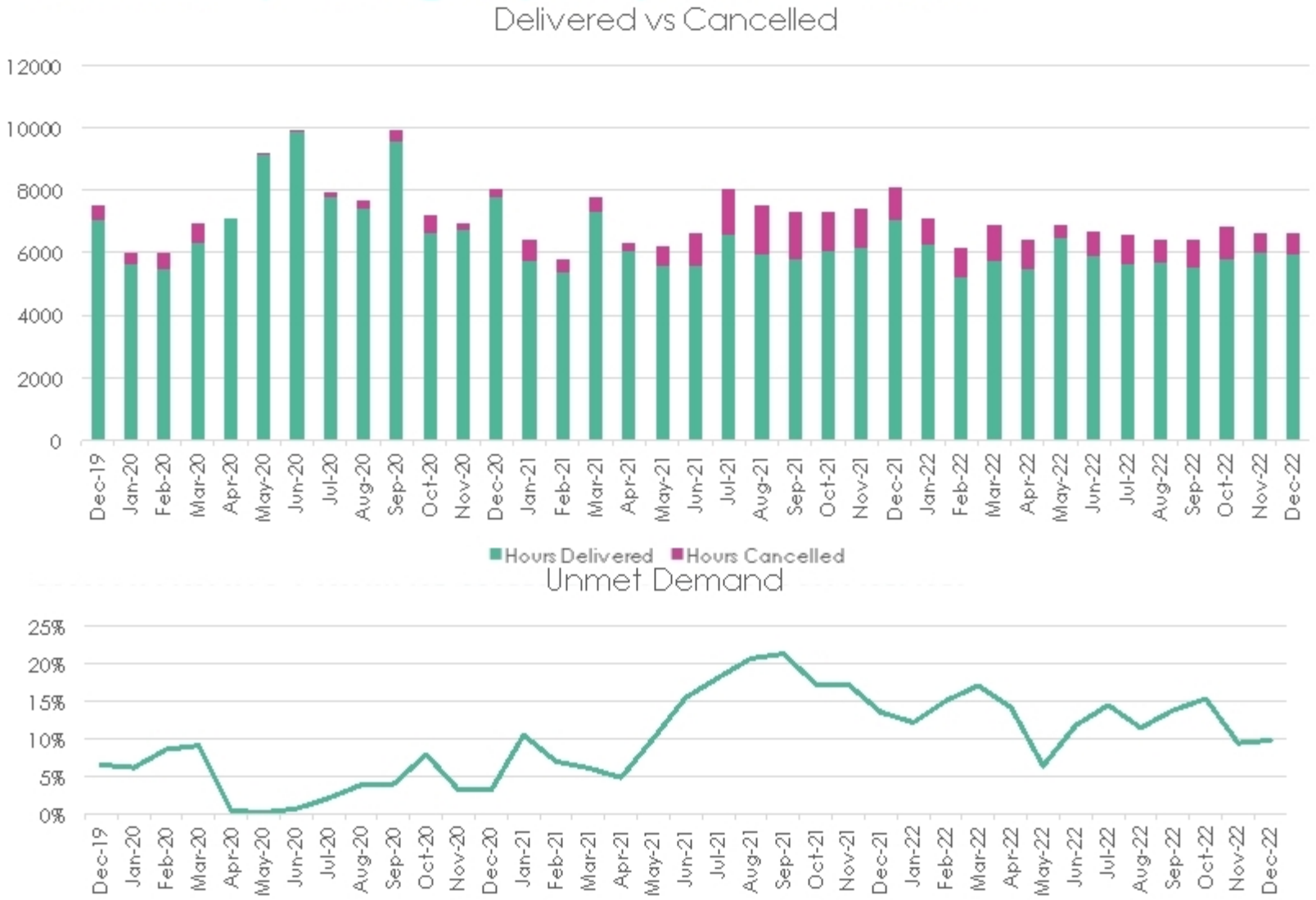






Last updated on July 2022

# 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 : January 2023

# **Tier 1:** Primary Care Standard Operating Procedure (SOP)

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

Current Pressures:

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

Last updated on May 20212

# Tier 1: Making Connections Walsall

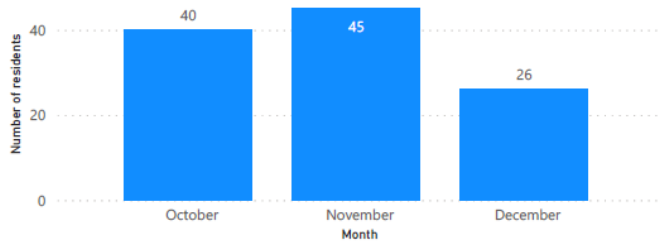
## Making Connections Walsall - Client summary

*Source: DCRS (Data Collection & Reporting Service)*

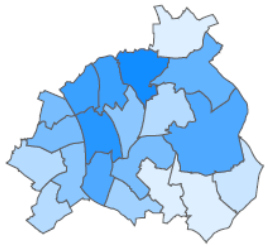
**Referral date**

01/10/2022 29/12/2022

### Total residents



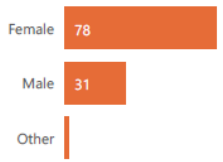

### Electoral ward



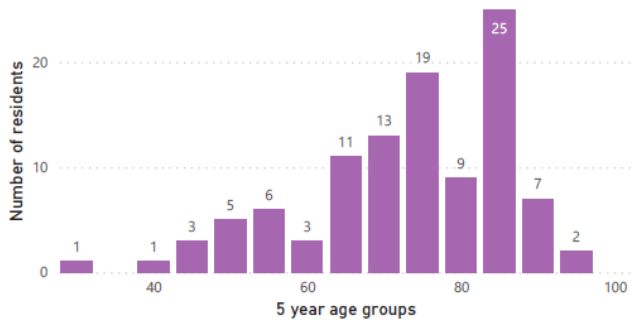
### LSOA (Lower Super Output Area)

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

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




### Residents age




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

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

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

**Total residents**

111

**Total contacts**

342

Last updated - January 2023

# Tier 1: Making Connections Walsall

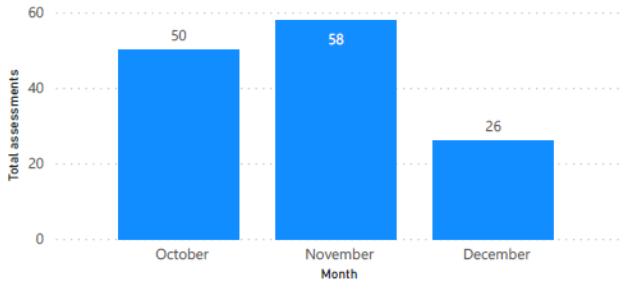
## Making Connections Walsall - Assessment & Goals Summary

*Source: DCRS (Data Collection & Reporting Service)*

01/10/2022 21/12/2022

client_type
- COVID_19
- Making Connections

### Assessments




### Assessments 134

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

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

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

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

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

### Goals 131

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

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

Last updated - January 2023

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

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

ARRS Workers in Post

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

ARRS workers due to start:

- South 2 -1 WTE

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

- Banding/NMP under review

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

Last updated : 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 308 concerns which is 10%l 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 82 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.

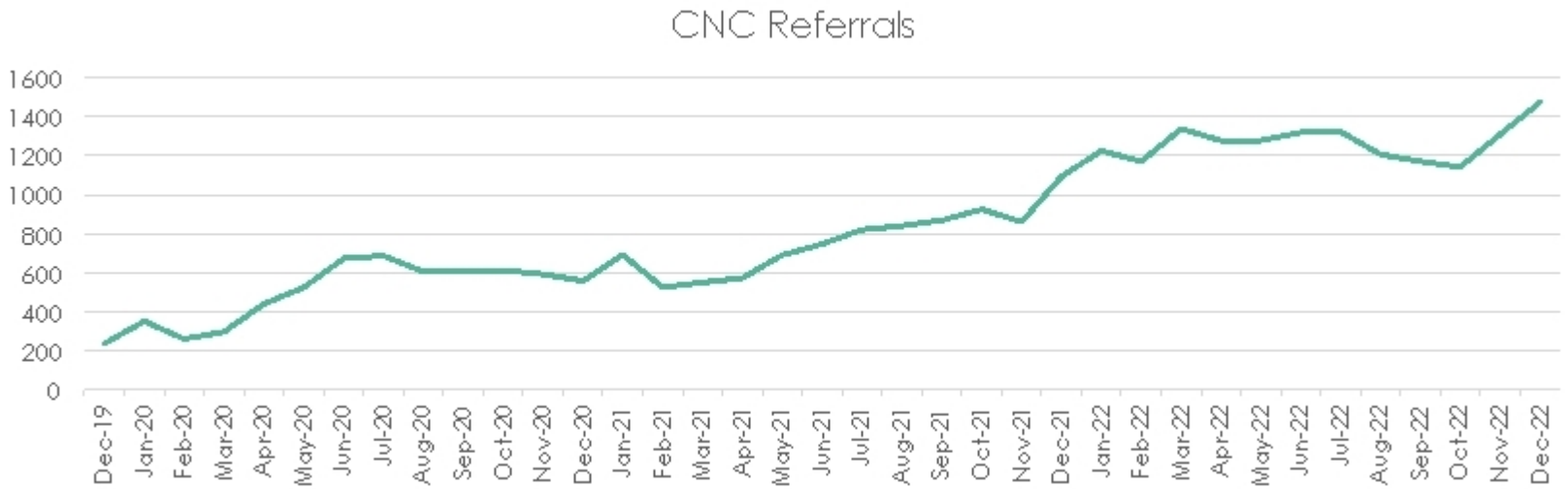

Last updated : January 2023

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

# Tier 3:
# Care Navigation Centre (CNC):





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

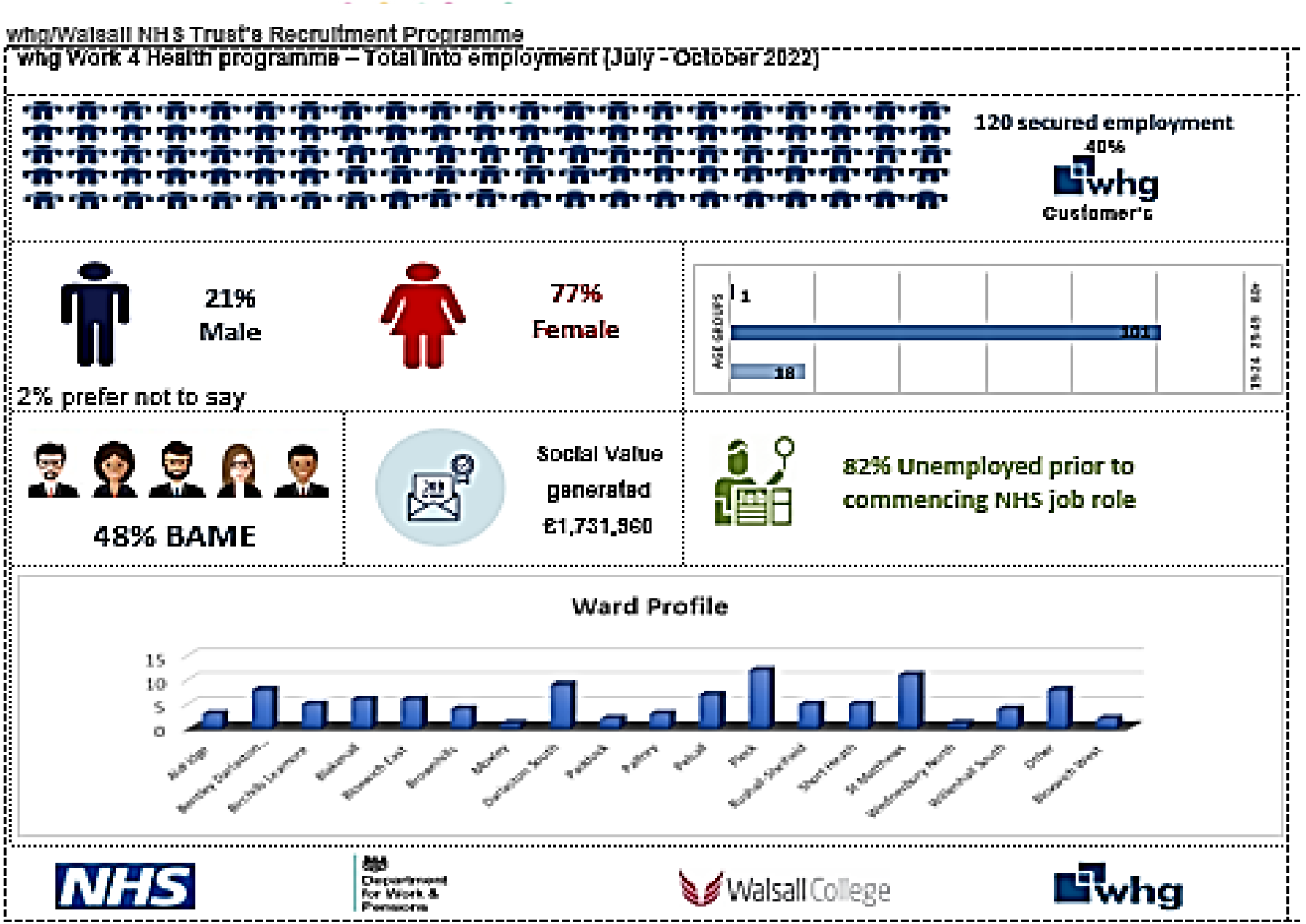
The expansion of capacity that has been embedded has enabled the CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

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.

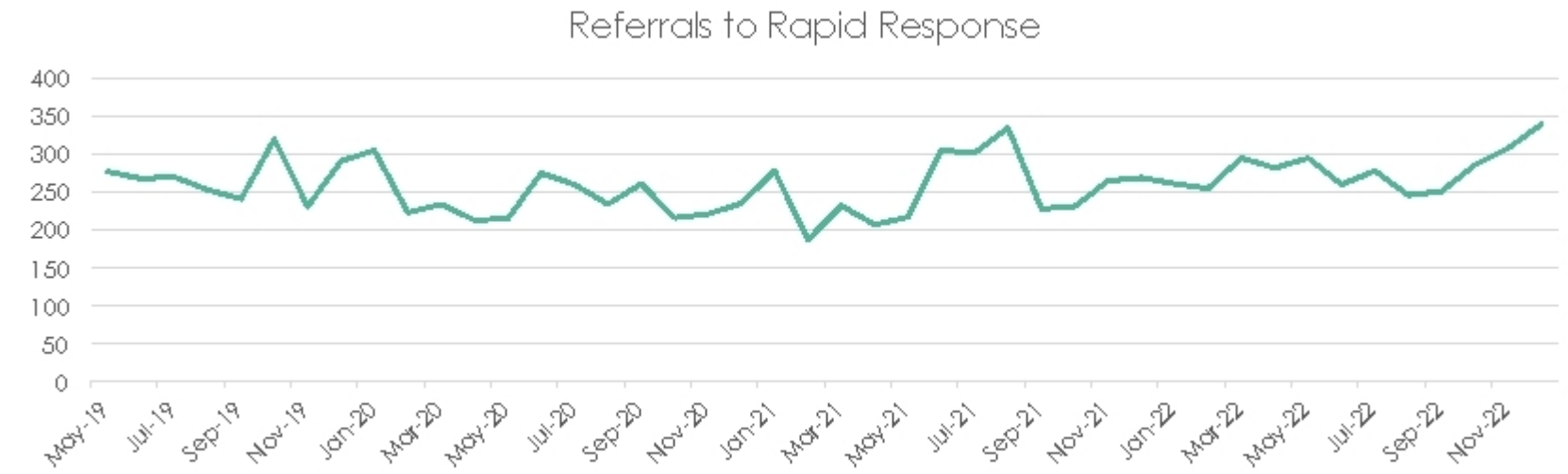
Additionally, a 999/111 SPA has been implemented through CNC for ED divert into FES, AEC, SACU and Gynae Early Pregnancy services. A direct push model from the WMAS CAD has been implemented so that more patients can be diverted into Community Services

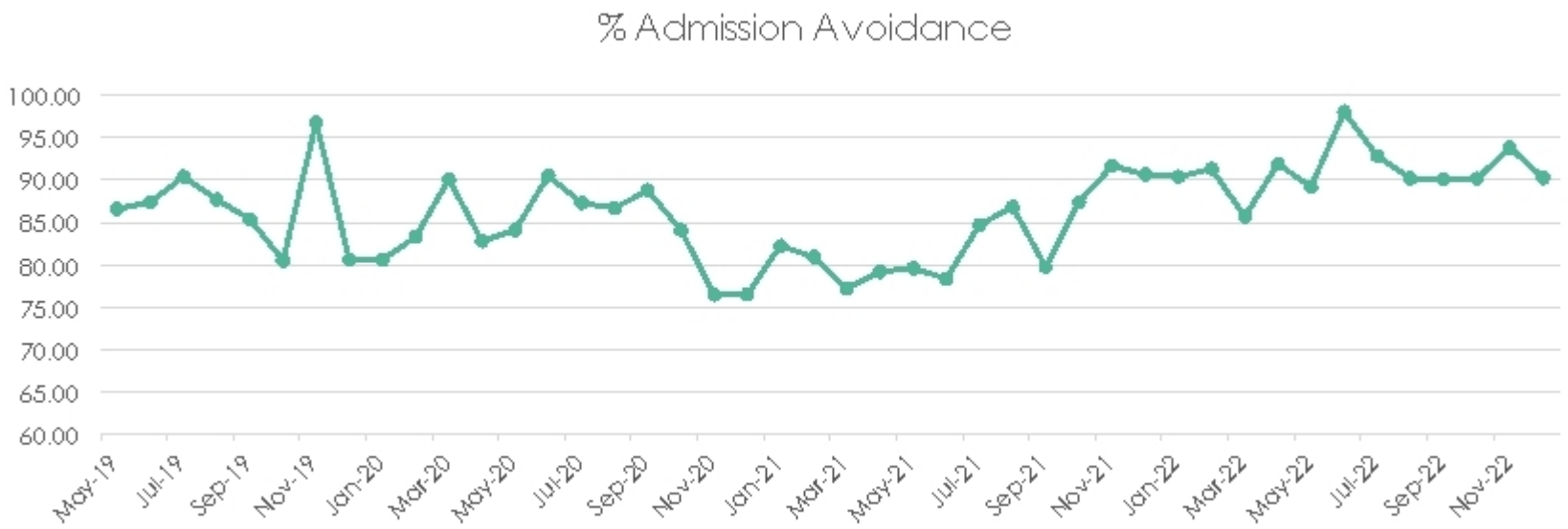
Last updated : January 2023

# TIER 2 Workforce Development Work 4 Health



# **Tier 3:** Rapid Response



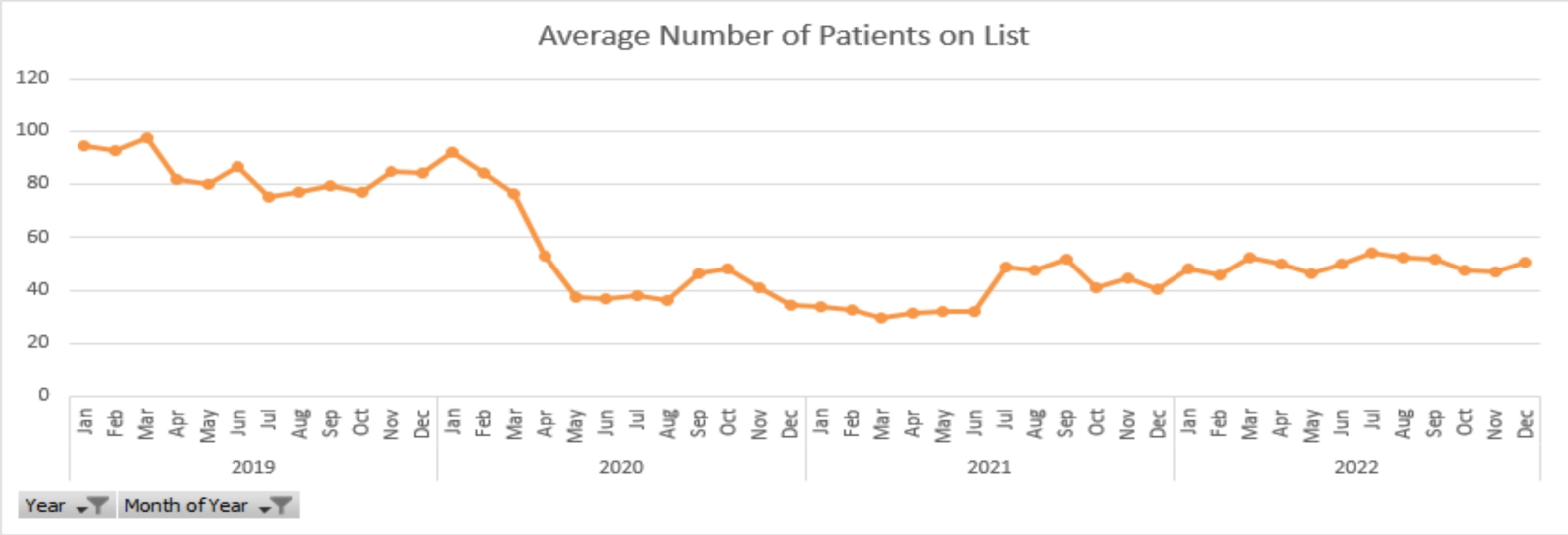



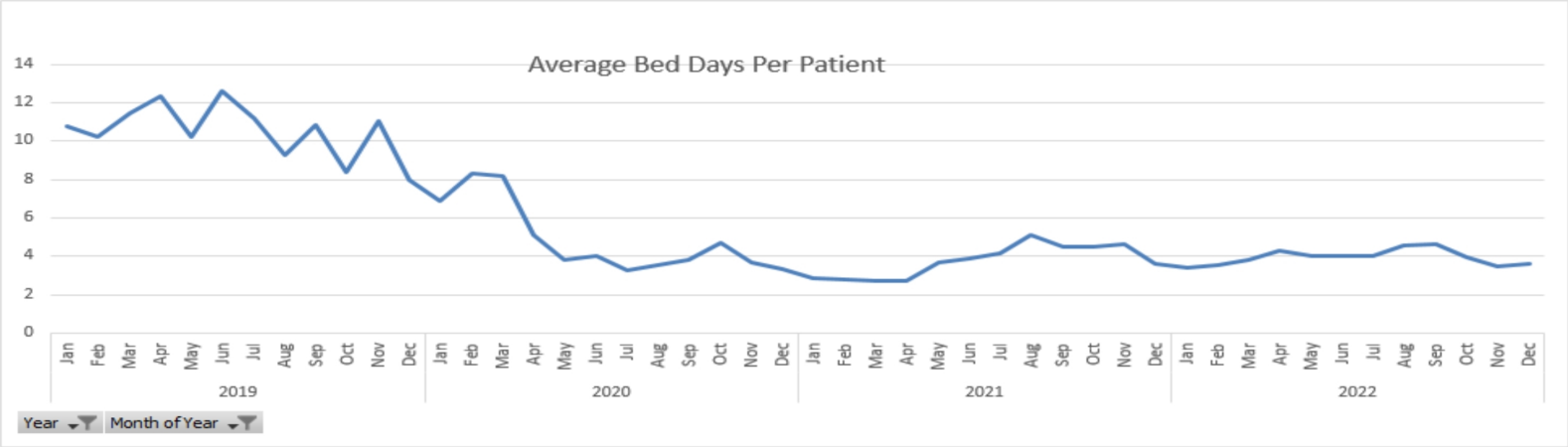

Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals( non –clinical calls as a 3 month pilot with 6 identified conditions). This has not led to a significant level of referrals to date and is being managed within the present 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 : January 2023

# Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 50 patients during December 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.

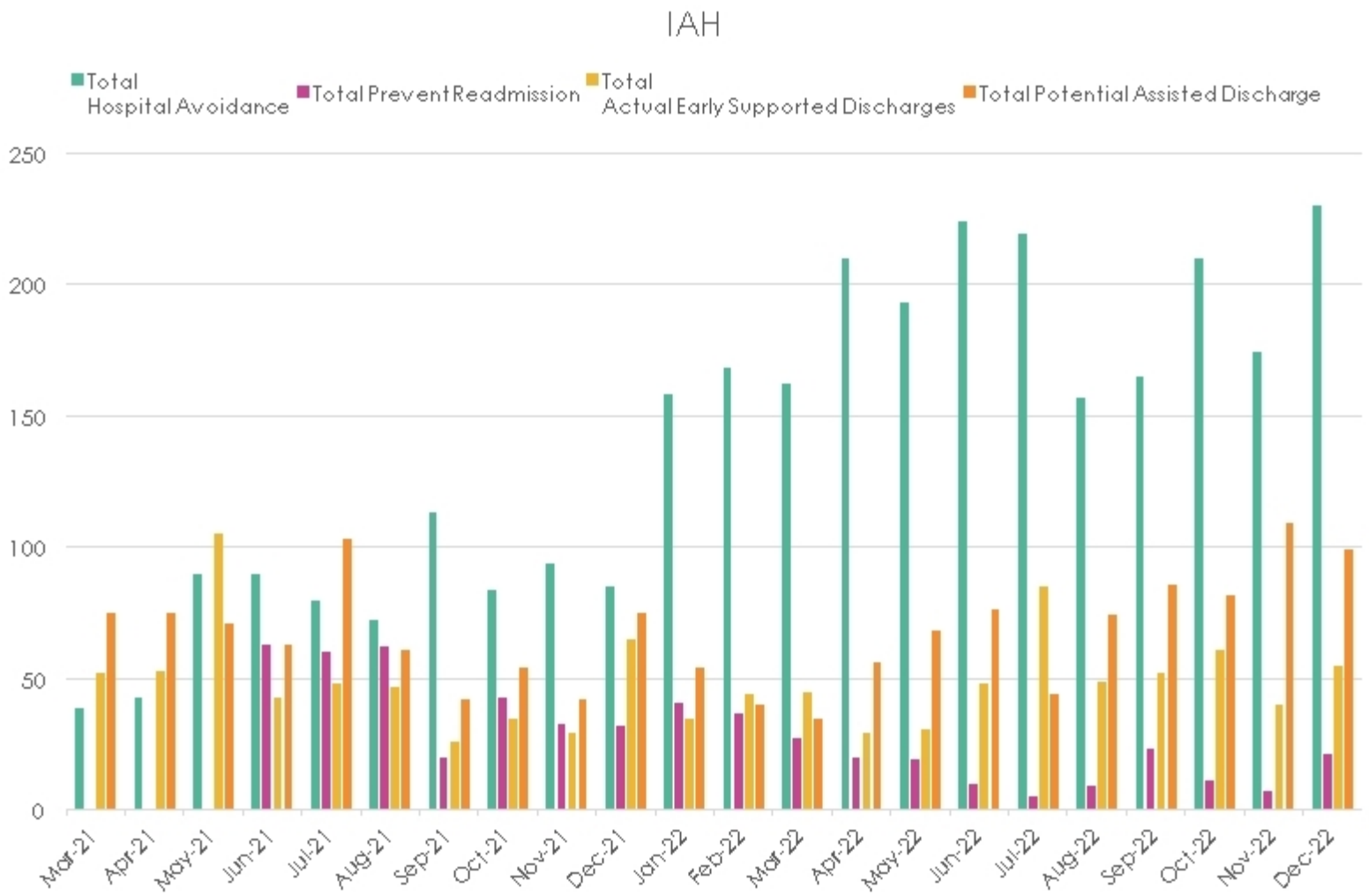
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients.

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 : January 2023

# Tier 3/4:
# Integrated Assessment Hub:

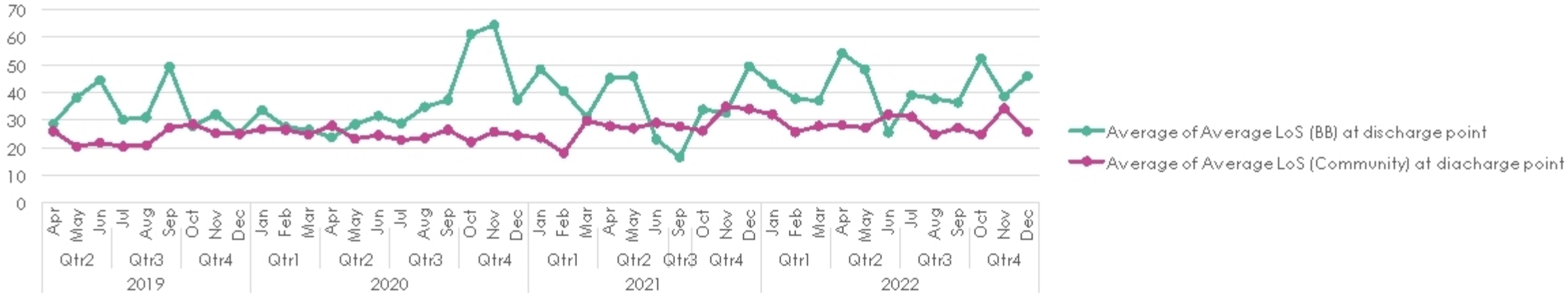



## Integrated Assessment Hub

- **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 : January 2023

# Tier 3: Domiciliary and Bed-Based Pathways




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

Last updated : January 2023

# Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

| | |
|---|---|
| **Name of Committee/Group:** | Charitable Funds Committee |
| **Date(s) of Committee/Group Meetings** | Friday 16th December 2022 |
| **Chair of Committee/Group:** | Paul Assinder |
| **Date of Report:** | Tuesday 1st February 2023 |

| | |
|---|---|
| **ALERT**<br>**Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee** | • The Charity is, in part, reliant upon its portfolio of investments to generate income. With the recent conflict in Ukraine and subsequent economic sanctions, coupled with more interventionist economic measures instituted by the UK Government, the international markets and thus our portfolio, will be subject to volatility in the coming months.<br>• The Charity employs professional Investment Managers to advise upon the ethical investment of surplus funds. The value of the investments held by Brewin Dolphin on our behalf as at 31st October 2022 was £681,000.<br>• The overall movement in the book value of investment during the quarter was a book loss of £13,000. |
| **ADVISE**<br>**Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought** | One of the principal roles of the Charitable Funds Committee is to scrutinise the spending bids against the Charitable fund to ensure these comply with the objects of the Charity.<br><br>• The Committee scutinised bids approved by Fund Managers (under £5,000) under delegated authority during Q1 (April to September) of £28,754.<br><br>• The Committee considered and approved three bids for expenditure above £5,000 but below £100,000:<br>  • Gold Standard Training in Palliative Care £27,860<br>  • Jubilee Celebration afternoon tea £8,400<br>  • Paediatric Play Area at the Manor £16,584<br><br>• There were no bids for expenditure over £100,000 – for referral to the Full Board. |

| | |
|---|---|
| **ASSURE**<br>**Positive assurances & highlights of note for the Board/Committee** | • The Charity's excellent fundraising activity programme continues to be successful and popular. For the Sept to Dec Quarter, of note are:<br>  • 8th October Football Match at Silverdale FC<br>  • 14th October Boxing Evening at Rushall Club<br>  • Make a Will Fortnight November Enoch Evans<br>  • Quiz November<br>• For the period 1st April to 31st October 2022, the Charity Fund increased by c£111,000 and stood at £1,150,000 at the period end.<br>• Current future spending commitments are £152,000, against this fund, leaving an uncommitted balance of c£998,000.<br>• The Finance Team should be commended that, for Financial Year 2022/23, the Accounts were prepared for Audit in record time and received a 'clean' Auditors Report from Mazars. |
| **Recommendation(s) to the Board/Committee** | The Board of Trustees is asked to note this report |
| **Changes to BAF Risk(s) & TRR Risk(s) agreed** | None |
| **ACTIONS**<br>**Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)** | None |
| **ACTIVITY SUMMARY**<br>**Presentations/Reports of note received including those Approved** | None |
| **ACTIVITY SUMMARY**<br>**Major agenda items discussed including those Approved** | Not Applicable |
| **Matters presented for information or noting** | None |
| **Self-evaluation/ Terms of Reference/ Future Work Plan** | |
| **Items for Reference Pack** | |

Walsall Healthcare NHS
NHS Trust

# Trust Board Report

| | |
|---|---|
| **Meeting Date:** | Wednesday 8th February 2023 |
| **Title:** | Update from the Black Country Provider Collaboration Programme |
| **Action Requested:** | Following discussions held at the Provider Collaboration Board over recent months, the Board is asked to:<br><br>• Approve the report including next steps regarding configuration |
| **For the attention of the Board** | |
| **Assure** | • The proposals contained within the reports have been considered by The Chief Executive and Chair via the Programme Board |
| **Advise** | • The governance work to develop the Joint Committee and Scheme of Delegation will be presented to the Trust Board for approval prior to agreement |
| **Alert** | • Work on the corporate improvement programme is still being scoped and is under development |
| **Author + Contact Details:** | Tel 01902 694290 Email simon.evans8@nhs.net<br>Group Chief Strategy Officer |
| **Links to Trust Strategic Objectives** | 1. Excel in the delivery of Care<br>2. Support our Colleagues<br>3. Effective Collaboration<br>4. Improve the health and wellbeing of our Communities |
| **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.<br>Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.<br>Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.<br>Responsive: services are organised so that they meet people's needs.<br>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:<br>• Equality of treatment and access to services<br>• High standards of excellence and professionalism<br>• Service user preferences<br>• Cross community working<br>• Best Value<br>• Accountability through local influence and scrutiny |

# Provider Collaboration Programme – December Update

## 1. Programme Update

### Clinical Improvement programme

The Clinical Improvement Programme is focused on delivering a range of Transformation Projects, Critical Milestones and Tasks which support delivery of key priorities for the system. The progress updates confirmed that 65-70% of priorities should be completed by March 2023.

It was agreed that the Collaborative Executive would do a 'deep dive' into each of the 13 projects over the next few meetings.

### Corporate Improvement Programme

This programme is being re-energised to explore options productivity and efficiency opportunities for functional corporate services across the ICS, Pan-ICS and regionally where appropriate.
It has been suggested that the SRO consider scale beyond the ICS boundaries where appropriate, and the ICB has also made a plea that its functions could / should also be included in this work as part of a review of the Systems Operating Model.

### Update on Governance

Issues of 'delegations' and optimal form (a move from a 'Committee in Common to a 'Joint Committee') are being explored with a view to limiting the bureaucracy and enhancing the speed of decision making alongside clearly defining the parameters of any such arrangements.
A paper / proposal will be presented to the Collaborative Board and Executive for consideration in the near future. This will cover a principles-based set of delegations from Sovereign Trust Boards which would support faster decision making to implement proposals from Clinical Networks centred around key clinical pathways, protocols, and standards.

There was general consensus from the Board that moving towards a '*Joint Committee'* arrangement may be the best and most logical option, which was largely in keeping with the general direction of a 'Single Chair and Group Model' in the near future and would provide a vehicle for any future ICB delegations.

There was general agreement that further information was required, and an options appraisal needed developing, focusing on the key implications of moving to a '*Joint Committee'* model, any risks that sovereign Boards needed to be sighted on. Trust Board Secretaries and Directors of Governance/Strategy from all partners would be involved in the development of this.

## 2. Strengthening Collaboration within the Black Country

An update on DIHC was received. The ICB is now exploring an options appraisal which will identify the most suitable solutions to deliver the agreed models of care, including primary care development and support.

## 3. Workforce Update

The key components of the workforce work programme cover:

- Aligning workforce processes & systems
- Reducing vacancies
- Supporting easier staff movement

An update was also presented on the work undertaken to align 'Waiting List Initiative' (WLI) rates which are now broadly consistent across the Black Country. Work is also underway to explore options around the nurse bank alignment.

There has been good success with International Recruitment efforts with large system targets for recruitment of Nurses, Midwives, Diagnostic Radiographers and Podiatrists & OTs yielding positive results.

It was also noted that there is a lot of good work going on across the system on 'alignment' of things like 'Hot meals' and 'Pop-up Shops'.

**4. Digital update**

It was acknowledged that Black Country providers have a varying level of Digital maturity, but there was good working between the CIO's to stock-take Digital, Data and Technology priorities with most solutions across the system converging over time.
Clinical viewpoints vary (depending upon specialty) on the need to converge to same systems, with some comfortable with read only access, whilst others requiring the ability to both read and edit functionality. There is further work required in this area as it will be important to have a more robust view as we develop system wide solutions.

It was noted that a divergence will occur with the necessary implementation of a PAS for RWT, which has been in the procurement process for some time and is urgently required to address a possible future clinical safety concern. However, it was acknowledged that there were no known contractual barriers preventing convergence if a preferred system solution was identified in the future.

Significant capacity and resource challenges remain as barriers to delivering at speed and it was recognised that there will need to be some form of prioritisation on areas of collaboration, a report due in the final quarter of 22/23.

**5. Communications Update**

It is hoped that the new Black Country Provider Collaborative website will be visible in a draft and iterative form from January, the public and staff will be able to learn more about the activities of the Provider Collaborative and its programmes of work.

Current sections such as 'About Us' and insights to the Clinical Networks and their work priorities are being developed, and it is intended that performance reports, newsletters, and ways in which staff and the public can get involved will be highlighted.

**6. Service Transformation – 'Development of Centres of Excellence' progress update**

A paper was presented focused on transformation through the creation / establishment of 'Centres of Excellence' across the Black Country, these include:

- Orthopaedics at Walsall and Dudley as a consequence of implementing the North Hub 'elective cold site' at Cannock Chase Hospital
- The implementation of Surgical Robotics at DGFT and SWBH (to complement those already at RWT & WHT) which would see the creation of 'centres of excellence' at SWBH (Gynae-oncology), RWT (Urological pelvic cancer work), and DGFT (Renal Cancer surgery) in the first instance
- MoHs Surgery for SKIN Cancer resection at RWT
- Networking of surgical services for ENT and Bariatric Surgery across the Black Country

The journey towards the development of these 'centres of excellence' will commence early in the New Year, the implications of the proposed service changes will be presented and discussed with

respective Sovereign NHS Trusts. The next phase of the work will be overseen by the Collaborative Executive.

## 7. Next Steps

**PC Innovators Scheme** – An application was submitted to NHSE in December we expect to hear the outcome of the application in Q2 2022/23. If successful, NHS England will provide hands-on support for between 7 and 9 selected provider collaboratives to accelerate the benefits in the quality and efficiency of patient care.

**'Away Afternoon'** – This is planned for 15th February. The intent is to reflect on the journey to date, priorities established and progressed, and next steps for the forthcoming year, aligning capacity and resources in the process.

**Clinical Summit** – A final 'Clinical Summit' for the 22/23 financial year is planned for March at the Grand Station in Wolverhampton. This will continue the good work underway with the clinical programme.

## 8. Recommendations

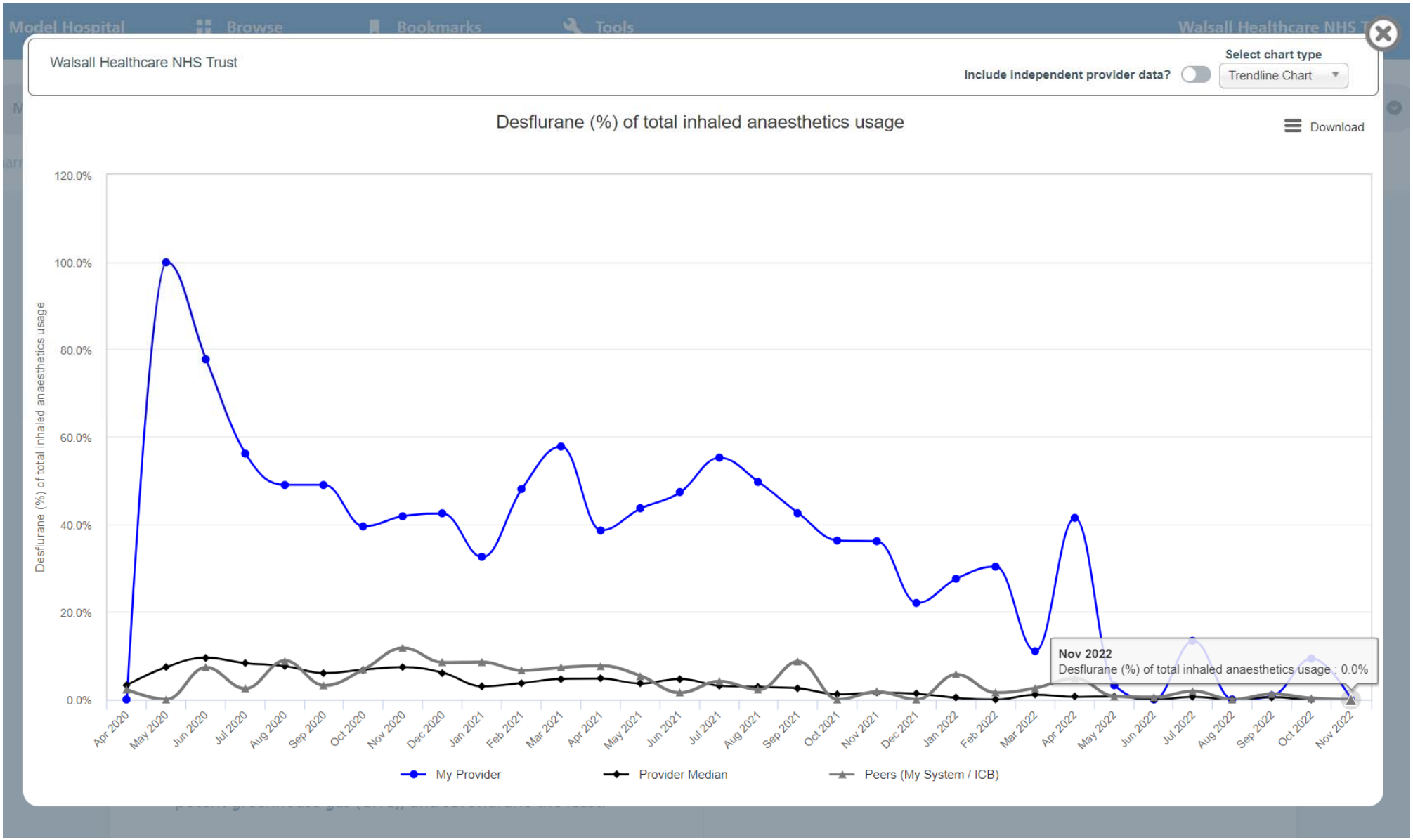
The Board are asked to:

- Note the progress of the Provider Collaboration
- Take assurance that all proposals regarding future governance will require approval of the board prior to agreement

| MEETING OF THE TRUST BOARD – 8th FEBRUARY 2023 | | | |
|---|---|---|---|
| SUSTAINABILITY REPORT | | | |
| **Report Author and Job Title:** | Janet Smith<br>Head of Sustainability | **Responsible Director:** | Simon Evans,<br>Group Chief Strategy Officer |
| **Recommendation & Action Required** | Members of the Trust Board are asked to:<br>Approve ☐ Discuss ☒ Inform ☐ Assure ☐<br><br>To discuss the Green Plan progress, the Net Zero Estates Delivery Plan deliverables for 2023-24, the priorities for the next 6 months, the funding opportunities, and the resource implication for planned initiatives. | | |
| **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.<br>• Advise on opportunities to promote the Trust Sustainability Agenda.<br>• 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 | | |
| **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** | N/A | | |
| **Legal and/or Equality and Diversity implications** | N/A | | |
| **Strategic Objectives** | Excel in the delivery of Care | a) Embed a culture of learning and continuous improvement<br>b) Prioritise the treatment of cancer patients<br>c) Safe and responsive urgent and emergency care<br>d) Deliver the priorities within the National Elective Care Strategy<br>We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations | |

| | | |
|---|---|---|
| | Support our Colleagues | a) Be in the top quartile for vacancy levels<br>b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing<br>c) Improve overall staff engagement<br>Deliver improvement against the Workforce Equality Standards |
| | Improve the Healthcare of our Communities | a) Develop a health inequalities strategy<br>b) Reduction in the carbon footprint of clinical services by 1 April 2025<br>Deliver improvements at PLACE in the health of our communities |
| | Effective Collaboration | a) Improve population health outcomes through provider collaborative<br>b) Improve clinical service sustainability<br>c) Implement technological solutions that improve patient experience<br>d) Progress joint working across Wolverhampton and Walsall<br>c) Facilitate research that improves the quality of care |

# DESFLURANE USE AS OF NOVEMBER 2022



*Attachment 2*

**Summary of actions, dates, and responsible groups (green) in the Estates Net Zero Delivery Plan Technical Annex**

| Action | Date | Responsible Groups | | | | WHT 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 | + | + | | | | Ongoing |
| 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 | + | + | | | | Status to be discussed with Estates & Facilities Management |
| 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 | + | | | | | Status to be discussed with Estates & Facilities Management |
| 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 | | | | | | Progress is reported on bi-monthly basis |
| 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 | | | | | | Status to be discussed with Estates & Facilities Management |
| NHS trusts, NHS foundation trusts and primary care to review options to install building-level water metering at all sites | By 2023/24 | + | | | + | | Status to be discussed with Estates & Facilities Management |
| NHS trusts and NHS foundation trusts to review options to install leak detection systems | By 2026 | + | | | | | Status to be discussed with Estates & Facilities Management |
| NHS trusts and NHS foundation trusts to carry out sustainable urban drainage system assessments | By 2028 | + | | | | | Status to be discussed with Estates & Facilities Management |
| 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 | + | | | | | Access to Energy Manager through partnership with RWT |
| Trusts and Foundation Trusts to incorporate energy use accountability into estates staff inductions | 2023/24 | + | | | | | Delivery still to be agreed with Estates & Facilities Management |
| ***Strategic Action 2: Run on 100% clean, renewable energy*** | | | | | | | |
| All NHS trusts and NHS foundation trusts to have a heat decarbonisation plan, identifying and prioritising the phasing out of existing systems | 2023/24 | + | | | | | Requires substantial amount of revenue funding to pull together |
| 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 | + | | | | | Dependend on the Heat Decarbonisation Plan being developed |
| Remove all coal and oil-led primary heating systems (Long Term Plan commitment) | By 2028 | | | | | | |
| 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 | | | | | | Trust energy supply is from 100% renewable source |
| ***Strategic Action 3: Increase resource productivity*** | | | | | | | |
| 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 | + | + | | | | Waste management policy and practices are under review |
| 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 | + | | | | | Through partnership working with RWT |
| ***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 | + | | | | | Ongoing schemes to reduce waste from source in partnership with RWT |
| ***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 | | | | | | Working in partnership with RWT |
| ***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 | + | + | | | | Ongoing review of options with RWT |
| 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 | + | | | | | Ongoing review of options with RWT |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***Strategic Action 7: Ensuring our suppliers meet the minimum standards expected on net zero and social value and capital spend is net zero carbon and all tenders included a minimum of 10% weighting for social value*** | | | | | | | ***Strategic Action 8: Ensure all our construction*** |
| 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 | | | | | | Working in partnership with RWT |
| 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 | | | | | | Working in partnership with RWT |
| ***Strategic Action 9: Increasing healthier, more sustainable menu choices*** | | | | | | | |
| NHS trusts and NHS foundation trusts to review and adapt menus to offer healthier, lower carbon options for patients, staff, and visitors | 2023/24 | + | | | | | Working in partnership with RWT |
| 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 | + | | | | | Working in partnership with RWT |
| 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 | | | | | | Working in partnership with RWT |
| ***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 | | | | | | |
| 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 | + | + | | | | |
| ***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*

# Audit Committee
# Chair Assurance Report

Walsall Healthcare NHS Trust

| | |
|---|---|
| **Name of Committee/Group:** | Audit Committee |
| **Date(s) of Committee/Group Meetings** | 5 December 2022 – Virtual meeting |
| **Chair of Committee/Group:** | Mary Martin |
| **Date of Report:** | 23 January 2023 |

| | |
|---|---|
| **ALERT**<br>**Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee** | • The security report highlighted that the Trust CCTV system needed an urgent upgrade.<br>• The Internal Audit report on payroll indicated reasonable assurance. It did highlight the significant value of overpayments made due to the late notification of leavers. As at 31 August 2022 £409k, of which £103k related to prior years, was shown as outstanding from previous employees. Concern was expressed over both leavers and joiners processes.<br>• The Internal Audit report on Temporary Workforce has been delayed due to staff shortages caused by sickness in this office. The committee were concerned no additional support had been provided given the key role in controlling costs. |
| **ADVISE**<br>**Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought** | • The Mandate Fraud suffered in June 2022 was now part of a much larger investigation nationally involving over 20 other affected organisations.<br>• The internal Audit report on Financial Sustainability covered the evidence for the Trust's self-assessment on the NHS questionnaire. The Trust scored itself 4 or 5 on 94% of the statements. Action plans are being drawn up for improvement. CIP and the underlying deficit were areas of concern. |
| **ASSURE**<br>**Positive assurances & highlights of note for the Board/Committee** | • The External Audit national reporting timetable is now published, and meetings are taking place to finalise the timing of the audit work and sign offs.<br>• The Internal Audit report on Creditors was noted as having Substantial Assurance<br>• An interim report on recommendation tracking will be circulated in January. |
| **Recommendation(s) to the Board/Committee** | |
| **Changes to BAF Risk(s) & TRR Risk(s) agreed** | • A new Board Assurance Framework template will be introduced in January in line with the revised Strategic Objectives. |

| | |
|---|---|
| **ACTIONS**<br>**Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)** | • A summary report to be prepared covering the processes around the payment of Losses and Special Payments.<br>• The 2022/23 External Annual Audit plan noted that there would be special emphasis on revenue recognition as so many parts of the NHS system were in deficit.<br>• The concerns over leavers and joiners processes to be drawn to the attention of TMC.<br>• Staff shortages in the Temporary staffing office to be followed up urgently with HR |
| **ACTIVITY SUMMARY**<br>**Presentations/Reports of note received including those Approved** | • The Cyber Security Report highlighted the significant amount of work being undertaken. The business case for additional cyber resources covering Walsall and Wolverhampton jointly had been approved. |
| **ACTIVITY SUMMARY**<br>**Major agenda items discussed including those Approved** | • Single Tender action report was discussed.<br>• The review of Losses and Payments was discussed.<br>• Counter Fraud progress report was discussed. |
| **Matters presented for information or noting** | |
| **Self-evaluation/ Terms of Reference/ Future Work Plan** | |
| **Issues identified potentially relating to Equality, Diversity, and Inclusion** | |

# Audit Committee
# Chair Assurance Report

Walsall Healthcare NHS Trust

| | |
|---|---|
| **Name of Committee/Group:** | Audit Committee |
| **Date(s) of Committee/Group Meetings** | 6 February 2023 – Virtual meeting |
| **Chair of Committee/Group:** | Mary Martin |
| **Date of Report:** | 6 February 2023 |

| | |
|---|---|
| **ALERT**<br>**Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee** | • The Head of Internal Audit shared a "draft" annual opinion which is the same as last year. "There are weaknesses in the framework of governance, risk management and controls such that it could become inadequate and ineffective." There are still three internal audits to be completed and one piece of advisory work on theater efficiency but the opinion is not expected to change. The committee has asked to work with Internal Audit to look at what remedial work is required and set sensible dates for implementation of recommendations.<br><br>The Trust had prioritised some areas where it was known improvements were required:<br><br>• The Internal Audit report on Covid Recovery was scored "Minimal assurance". It specifically focused on the management of harm occurring to patients where their treatment is delayed. Only ophthalmology has carried out a detailed review of patients exceeding their guaranteed access date. There are 2 high and 3 medium recommendations. The report is being circulated to QPES.<br><br>• The Internal Audit report on Rostering including bank and agency bookings was scored "Minimal assurance". There are 3 high, 13 medium and 2 low recommendations. The chief nurse is working with HR and Finance to implement these.<br><br>• The Internal Audit report on data quality Sepsis was scored "Partial |
| | • The Internal Auditors have set up the Recommendations Tracker and only 4 were showing as overdue. If they have not been closed be the next Audit Committee meeting the executive lead will be invited to attend and present progress on the implementation of the recommendation. |
| **ASSURE**<br>**Positive assurances & highlights of note for the Board/Committee** | • The work around ensuring all staff have access to an active nhs.net email account has made good progress. Further work with HR is underway.<br>• The External Audit timetable is being finalized. |

| | |
|---|---|
| **Recommendation(s) to the Board/Committee** | • The Revised Terms of Reference were agreed with one small addition and will be recommended for Board approval. |
| **Changes to BAF Risk(s) & TRR Risk(s) agreed** | • The new Board Assurance Framework will be live from 1st April 2023 and be in line with the revised Strategic Objectives. |
| **ACTIONS**<br>**Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)** | • A periodic review of overpayments to leavers to be set up and brought to the committee.<br>• The contract with AFJ Limited who provide patient transport services is to be regularized by procurement.<br>• The internal Audit work plan to be circulated to the committee after review/amendment at TMC to ensure it is approved by 1 April 2023. |
| **ACTIVITY SUMMARY**<br>**Presentations/Reports of note received including those Approved** | • The Cyber Security Report highlighted the joint IT cyber service with Wolverhampton was now up and running. It also outlined the timetable for the role out of Multifactor Authentication.<br>• The Internal Audit work plan longlist was presented and discussed. The need for more days to cover essential work will be referred to TMC.<br>• The draft 23/24 Local Counter Fraud work plan was presented and agreed. |
| **ACTIVITY SUMMARY**<br>**Major agenda items discussed including those Approved** | • Single Tender action report was discussed.<br>• The review of Losses and Payments was discussed.<br>• Counter Fraud progress report was discussed.<br>• External Reviews and Inspections report covered CQC visits From September to November 2022 and HSE visit 11&12/01/23 |
| **Matters presented for information or noting** | |
| **Self-evaluation/ Terms of Reference/ Future Work Plan** | • The annual self-evaluation questionnaire has been issued to all committee members for completion. |
| **Issues identified potentially relating to Equality, Diversity, and Inclusion** | |

Walsall Healthcare NHS
NHS Trust

# MEETING OF THE QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE HELD ON FRIDAY 25th NOVEMBER 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 |
| Mr N Hobbs | Chief Operating Officer |
| Mrs O Muflahi | Associate Non-Executive Director |
| Dr M Shehmar | Chief Medical Officer |
| Prof L Toner | Non-Executive Director |
| Mr R Virdee | Associate Non-Executive Director |

In attendance

| | |
|---|---|
| Mrs C Jones-Charles | Divisional Director of Midwifery |
| Mr G Perry | Associate Director of Patient Relations & Experience |
| Mrs J Toor | Senior Exec PA |
| Mrs A Hill | Executive Assistant (minutes) |

Apologies

| | |
|---|---|
| Prof A M Cannaby | Group Chief Nurse & Deputy Chief Executive |
| Mr K Wilshere | Company Secretary |

| | |
|---|---|
| **333/22** | **Welcome and Introductions** |
| | Dr Parkes welcomed everyone to the meeting and introductions were made. |
| **334/22** | **Apologies for Absence** |
| | Apologies for absence, as listed above, were noted. |
| **335/22** | **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. |
| **336/22** | **Minutes of Previous Meeting** |
| | The minutes from the October 2022 meeting were agreed as a true record. Mrs Muflahi advised that page 3 last sentence contained repetitive use of 'equality' and change was made to ensure clarity. |
| **337/22** | **Items for Redaction** |
| | There were no items for redaction and minutes were approved for publication. |
| **338/22** | **Matters Arising & Action Log** |
| | **188/22** – work is underway with all the relevant teams to understand the actions needed to improve audit data and regular reporting into Clinical Effectiveness Group is taking place. Agreed to close this action and review when next Clinical Effectiveness Group update is bought to Committee. |

| | |
|---|---|
| | **223/22** – Mrs Jones-Charles advised that she has spoken to the informatics team and the data in line with the census breakdown is digitally available and will be aligned in the next report in January 2023.<br>**285/22 -** Mrs Carrol confirmed that the thank you letter advising consequent actions taken has been sent to Michelle. |
| **339/22** | **Medicines Management Update** |
| | Dr Shehmar advised that the presented paper differs slightly from the usual update and includes feedback from the CQC visit to MLTC, where significant concerns were raised regarding medicines management. As a result, the Trust has been issued a Section 29a Notice which requires significant improvement by 31st December regarding patient safety issues with medicines management. A group has been set up to identify the actions required to address the safety issues and provide a more resilient plan on medicines management. A high-level executive plan has been sent to the CQC and this has been accepted and is currently underway. This plan not only addresses the different aspects of medicines management, but also the governance of the service, reporting and terms of reference of Medicines Management Group and alignment with RWT. It is also planned to introduce a three-level education plan regarding prescribing with an immediate eLearning platform for all medical and non-medical prescribers, with in-depth training for nursing and medical staff and a feedback and audit process will be put in place to ensure progress and compliance. Key items and themes have been built into Power Bi dashboards to provide accurate data. Improvement and progress will be monitored via the usual governance process through the Medicines Management Group and any safety issues will be taken through Patient Safety Group and these will feed back assurance to QPES Committee.<br><br>Mr Virdee asked if there would be a standardised template sent to wards for data collection and also would freedom to speak out be available to peer groups. Dr Shehmar advised that some of the actions will take 6-18 months, but safety actions have been identified that can be put into place immediately and freedom to speak up guardians are available for all staff.<br><br>Professor Toner advised that when participating in a recent walk round EPU, Ward 29 and Cath Lab they found very positive staff engagement, however there were several issues relating to medicines management noted and staff were not able to articulate the detail regarding the CQC visit and the issue of the Section 29a Notice regarding medicines management. Staff advised that once electronic prescribing came into use, this should help address many of the medication issues that currently arise. She confirmed that all the incidents that they noted had been included in the feedback report for walkabouts. Dr Shehmar advised that the feedback has been received and Mrs Carroll advised that some immediate actions had been put in place relating to this feedback. Mrs Carroll expressed some concern regarding the lack of detail that staff were aware of for the Section 29a notice as several communications have taken place and discussion is taking place in every safety huddle. Mr Bostock advised that it is important to take into account that these visits are snapshots and different shifts of staff will highlight different issues and it is important to put this into a whole picture. However, it is acknowledged that there is now more staff engagement and a willingness to communicate. Dr Shemar advised that it is important to note that this is not just a comms strategy but 1:1 education with staff and safe medicines management practice is in an individual's roles and responsibility. |

| | |
|---|---|
| **340/22** | **Constitutional Standards & Acute Service Restoration & Recovery Report** |
| | Mr Hobbs took the report as read and highlighted the main key points.<br><br>The Trust continues to deliver the best ambulance hand over times in the West Midlands and is in the upper third national performance for 4 hour emergency access standard. The consistency of the emergency care performance is attracting increasing external interest and the Trust featured in an NHS Provider's case study last month and as an Association of Ambulance Chief Executives case study this month and has been invited to speak at the Welsh Government Ambulance Handover Summit this month. However, it is important that Committee see the performance of the Trust in the context of a continual decline in National performance against urgent and emergency care measures.<br><br>There has been an improvement from September to October in diagnostic care, with a reduction in the proportion of patients waiting over 6 weeks from 22.7% to 17.7%, the majority of which is driven by improvements in cardiac physiology with the recovery plan in place. Endoscopy remains a concern and until the business case is endorsed at the December Investment Group meeting, assurance cannot be provided to Committee that there is a resilient ability to recover endoscopy waiting times.<br><br>Currently patients with cancer are being treated more quickly at WHT relative to other West Midlands and National providers with 67.6% of patients being treated within 62 days of GP referral. However, there is still some concern with the challenges within the Breast Cancer Service with patients referred by their GP on a two week wait with suspected breast cancer experiencing longer waiting times. The appointment of the Breast Surgery Practitioner and the additional clinical capacity that this will provide, is expected to see an impact from January 2023.<br><br>Mr Virdee enquired if the Trust has any evidence of how many patients are opting to acquire private healthcare rather than wait for NHS treatment. Mr Hobbs advised that for Cancer Care especially, there are very limited private providers that have the infrastructure to provide multi-disciplinary team cancer care, but for routine elective services some patients do choose to pay privately. In Walsall, the ICB have commissioned the private Spire Hospital to provide capacity for treating a number of NHS patients. The Trust is undertaking a patient contact exercise through text messaging and written correspondence to ask patients whether they have sought treatment elsewhere to ensure waiting lists are as accurate and up to date as possible. |
| **341/22** | **Performance Constitutional Standards Report Community** |
| | Mr Dodd took the report as read and highlighted key points.<br><br>The current out of area activity is causing pressure in the medically stable for discharge in terms of complex discharges and a set of rules has been produced and presented to the ICB who have agreed to manage this through the Winter period to ensure all local citizens are treated equally whichever hospital they are treated in. These principles are being applied to the services that are provided at the front door of the hospital.<br><br>The Trust has been asked to be a National Pilot Model Site following the discharge exemplar and this will focus on supporting therapists to make decisions regarding moving patients on the 'Home First Pathway' back to their homes and completing a full assessment of therapy needs at home. Being part of the National Site will |

| | |
|---|---|
| | ensure there is support in undertaking a joint approach risk assessment with the patient.<br><br>There are currently higher volumes of activity with more complex needs in discharge and this is causing pressure on Council funding and Joint Health and Social Care funding. Work is underway to identify further funding streams to subsidise the current discharge pressures, but this may detract from some planned future community development in order to maintain the current discharge flow.<br><br>A Health Inequalities Steering Group has been set up but does not currently report into any Committee of the Trust and a request is made for this to report into QPES on a quarterly basis for oversight.<br><br>**Committee agreed that the Health Inequalities Steering Group could report to QPES on a quarterly basis.**<br><br>Mr Virdee sought assurance that the out of area discharge can be managed and Mr Dodd advised that continuing updates will be given to Committee, and this is the reason for the ask that all councils treat their residents with equal access to discharge facilities regardless of which hospital they are receiving their care in.<br><br>Mr Hobbs advised that the increasing amount of out of area patients attending WHT, many of which are bought in by the ambulance service due to long waits to offload at other hospitals, is a pressure on quality of care and complex discharge pathways and a resource issue and the Trust continues to work with the ICB to encourage other providers to reduce their handover times to reduce the amount of out of area patients being admitted to WHT.<br><br>Mrs Muflahi advised that the figure for patients referred for Long Covid has increased in October and queried if there was sufficient resource to cover this. Mr Dodd advised that the service that was in place for this has been opened up to Primary Care and the vast majority of referrals are now made by GP's rather than from hospital admission. The current service provided is an MDT model for dealing with chronic illness and incorporates the long covid patients.<br><br>Professor Toner requested further information on the cancelled hours process and Mr Dodd advised that during Covid a rag scoring was developed and agreed through the Ethics Committee for current caseload and referrals from GPs on prioritisation. Cancellations are generally made for less complex green rag ratings; however, these patients do need to be seen and these patients are under constant review to ensure there is no deterioration in care. |
| **342/22** | **Safe High Quality Care Oversight Report** |
| | Mrs Carroll took the report as read and highlighted the main points.<br><br>Falls per 1000 bed days was 3.30 for October, with the National average performance being 6.63. The Trust has maintained lower than this average for 28 months consecutively. There have been 4 falls reported with moderate or severe harm which are under investigation and will be discussed at the Falls Accountability Group and reported through to QPES with results of findings. Each month these falls are correlated against the red flags for this period to ensure there is no connection to 1:1 care not being fulfilled and there has been no evidence of this correlation. Staff continue to encourage patients to mobilise and take the necessary actions regarding risk assessments. |

| | |
|---|---|
| | With regards to Sepsis; in the Emergency Department 77.81% of patients received antibiotics within the first hour in October and 80.17% in inpatient areas, with the National average being between 60-80%. The Trust continues to strive for improvement but benchmarks well against the National average. The RSM Risk Assurance Service has carried out an external audit on the sepsis work of the Trust and the results of this will be reported at the next QPES meeting.<br><br>There have been 7 cases of Clostridium Difficile toxin reported in October 2022 which has taken the Trust over trajectory for performance. Each case is reviewed and there were 2 cases deemed avoidable last month and the October cases are under review. There have been no key themes identified and evidence shows that there is an increasing national trend in C.Diff cases. Investigative work continues to try and improve performance in this area to reduce cases.<br><br>MCA compliance for October was 30.95% which is a decrease from September. After investigation of the lowering figures, it has been discovered that the data being reported is being obtained from the Respect audits taking place to advise if the box has been ticked and not whether this evidence has been documented elsewhere in the patient notes. From the data that Mrs Carroll shared with QPES, it was evidenced that in 88.24% of cases, mental capacity was discussed with relatives or attorney and the completion of Deprivation of Liberty Safeguarding (DOLS) paperwork was completed in 100% of cases. Mrs Carroll has asked the team to review the audit form to ensure the correct information is being recorded and the report that she shared with Committee will be included in the report to QPES each month for better clarity of information and evidence obtained.<br><br>Professor Toner enquired about the issue of missing notes appearing to be a continual theme in tissue viability and therefore lack of assurance of care for some incidents. Mrs Carroll advised that in some cases the team are not being able to obtain the patient notes in a timely manner and she has asked for more accurate figures and information on this matter.<br><br>Mr Hobbs asked if there was any evidence to show that the Trust low falls rate is not related to staff mobilising patients less than at other Trusts. Mrs Carroll advised that the Eat Drink Move to Improve initiative is about to commence within the Trust and this will be monitored to see if it increases the number of patient falls. Currently the evidence at the Trust rehabilitation centre at Hollybank House shows that there are not large numbers of falls for rehab patients, and they are correctly risk assessed.<br><br>Mrs Muflahi stated that she had noted that the theme of lack of documentation arose in several sections of the report and acknowledged that there are a number of initiatives in place to try and improve this, but all staff have a professional duty of care and accountability to improve documentation. Mrs Carroll agreed that this is discussed in staff roles and responsibilities and new documentation has been rolled out across the Trust to improve documentation and care plans. Dr Shehmar advised that assurance cannot be given on documentation, and this is currently on the Risk Register and relates to the lack of electronic patient records. Missing notes is also on the Corporate Risk Register and the Trust has a document management scheme in place to prospectively scan in paper records, whilst waiting for the electronic patient record.<br><br>Mr Virdee enquired about the assistance the Trust is obtaining with regards to Clinical Guidelines and Dr Shehmar confirmed that the Trust is seeking external web-based companies that supply these guidelines. Mr Virdee also observed that |

| | |
|---|---|
| | it is pleasing to see the Friday 'back to the floor' initiative which should encourage more open culture within the organisation. He asked if the issue of 1:1 red flags not being met was a capacity issue. Mrs Carroll advised that the Trust has seen an increase in the number of patients needing 1:1 care particularly from a mental health perspective and the Trust is building a bank of mental health support workers which, along with other initiatives in place such as cohorting patients when necessary, should help to manage the increase in patients needing 1:1 care. |
| **343/22** | **Maternity Services Update** |
| | Mrs Jones-Charles took the report as read and highlighted the main points.<br><br>Staffing remains a challenge despite a good recruitment drive and attendance at recruitment events. There are several students who will be qualifying in September so there is still some time to wait for those to be in post. There is a current rise in maternity leave which is impacting in the overall absence across maternity services.<br><br>Birth-rate Plus acuity tool continues to be used to monitor the unit's acuity 6 times a day on the delivery suite and the average acuity of October was 63% against the national recommendation of 85%. Shortfalls are currently managed mainly by delaying induction of labour.<br><br>Perinatal mortality rates continue to be monitored monthly with all losses subject to a review and reporting at the Trust's Mortality Group meeting.<br><br>In October a new telephone system was introduced in triage to monitor calls and ensure they are answered in a timely fashion and call response time. Reporting so far shows that 87.9% of calls were answered and the average wait time was 2 minutes. A business case has been developed for a support worker to help with this system.<br><br>The service has submitted evidence to demonstrate compliance with CNST (Clinical Negligence Scheme for Trusts) for year 4, which has been reviewed by the Director of Nursing and is due to go to Trust Board for approval in December. The declaration form is due for submission on 3rd February 2023. Assurance was given that the Trust is compliant for year 4.<br><br>Mrs Muflahi advised that there has been significant positive change happening in the service despite the challenges in the workforce and she has received positive feedback regarding leadership of the service from staff and also positive comments from patients and offered her congratulations to the service for the progress made and good to see that the Maternity Support Worker role is now being included in the workforce.<br><br>Professor Toner enquired about the expected duties of the Maternity Support Worker in the triage environment and Mrs Jones-Charles advised that this would be basic practical support in taking observations, urine samples, answering phone, starting the documentation to assist the maternity staff. Professor Toner also enquired about the incident reviewed under perinatal mortality when there was reduced fetal movement and patient was not offered induction in line with current guidelines and what actions are taken in the event of this. Mrs Jones-Charles advised that the junior doctor took the decision to refer back to the clinical consultant rather than the labour ward and has now been fully advised of the correct procedures and guidelines. Dr Shehmar has asked the division to look at their SI's over the past year and identify the doctors involved and provide |

| | |
|---|---|
| | assurance that the actions have been completed on feedback and reflection and was pleased with the response and quality of the data that was recorded on appraisals.<br><br>Mr Virdee asked if the Cultural Review that was carried out could be shared with the rest of the organisation for learning. Mrs Jones-Charles advised that this was still in progress and what has been received to date is a preliminary report, but happy to provide progress. |
| **344/22** | **Serious Incident Update** |
| | Mr Bostock took the paper as read and highlighted the main points.<br><br>During October there were 3 serious incidents declared and these are reducing over time as shown in the 12-month rolling table. There are some areas in double digits, but these are mainly when historic cases came together as clusters. It also indicates that there are fewer serious incidents, and they are occurring less frequently, which are both indicators of an improving safety picture within the Trust.<br><br>There is an improvement in the closure of serious incidents with the Commissioners and the area of most concern is the Surgery Division. A new divisional governance team is starting work with the division this month to assist in this process.<br><br>The narrative in learning and development section has been reduced and is now identifying what the item was, what the improvement is and how it is being achieved to make this clearer and this will continue to improve and over time reports will become less narrative.<br><br>Duty of candour is improving in compliance due to focus in this area. There are a number of overdue serious incidents and assurance work continues to be undertaken to review these and an improvement is beginning to be seen.<br><br>Committee is advised that the level of assurance is limited due to the capability of the current systems being used but this will greatly improve with the new electronic systems when they are launched in January 2023.<br><br>Mrs Muflahi advised that the report is now much easier to read and understand the learning identified. She asked for further information on the never event which stated that confrontational behaviour was a root cause and human factors training has been provided to staff. Mr Bostock advised that currently the team investigating may not always use the appropriate root cause and in this event, it was a contributory factor rather than a root cause. However, the Patient Safety Incident Response Framework (PSIRF) is being launched nationally in April and this will look at more themed analysis and pathways/wider system learning so this should give more clarity in future. However, as a Trust there is an issue with high levels of violence and aggression and this is attributed partly to the local population and partly to staff approaches and where human behaviour is identified as a contributory factor to an incident, human factor training is put in place. Dr Shehmar added that this incident shows the change in culture within the Trust and is grateful that the incident was highlighted. The individual concerned has been given the report and individual feedback and has reflected upon their behaviour in order to make changes. |

| | |
|---|---|
| | Mr Bostock advised that there has been another never event this week that is not yet noted in the report but was important to highlight. This was an unintentional aspiration pneumonia from a misplaced nasogastric tube and has been reported to the CQC and Commissioners and the usual investigation process has commenced. Further information will be given at the next QPES meeting. |
| **345/22** | **Mortality Update** |
| | Dr Shehmar took the report as read and highlighted the main points.<br><br>The SHMI for the acute site is 99.5%, which is within expected range.<br><br>The Medical Examiner Service has reviewed 100% of all eligible deaths and the Trust is part of a pilot for ME roll out to the community programme. This pilot has now ended and currently awaiting a date for roll out to all GP practices in the Walsall area. There are some Structured Judgement Reviews outstanding for the learning from death process, mainly due to missing notes.<br><br>The top causes of deaths remain respiratory and long-term conditions such as heart failure and acute renal injury and an ethnic breakdown is included in the Covid deaths section of the report.<br><br>Alerts to the Trust come from the HED database which includes the acute trust, Goscote and Hollybank rehabilitation, which is relevant as it includes deaths across 30 days of discharge. These patient notes are reviewed and any learning on the pathways are identified. And there are a number of alerts relating to cancer and improvement actions are included in the 104-day harms report.<br><br>Specialities report on a six-monthly basis to the Mortality Surveillance Group and advise on what lessons have been learned and changes made to practice and procedures. One of the current areas of focus is acute renal injury and the Renal Team have reviewed their team structure with an AKI nurse 7-day service commencing in November supported by consultants. This will be an outreach team and also work in other areas. Work is taking place with the coding team on agreed documentation for better identification of data for AKI mortality to improve coding of patients and also on ITU admission criteria for supporting patients with renal requirements which include a timely review by specialists, particularly the Nephrostomy service, with a new pathway, escalation and referral process in place with RWT.<br><br>A quarterly update on perinatal mortality and child death report and the learning from these reviews is also included in the report.<br><br>Mr Virdee enquired if postcode information could be extrapolated for Covid data to highlight if there are any areas of deprivation identified and also if there were any patterns or themes with the renal cause of death in terms of ethnicity. Dr Shehmar advised she will look into whether this data can be obtained.<br><br>Professor Toner enquired about the funding for EMIS licences for the roll out of community ME services. Dr Shehmar advised that the ME has to examine the community deaths and currently there is an agreement with GP practices to view the last 3 month episode of care but the Trust do not have licences to access EMIS which is the GP electronic record. This is an issue for many Trusts and the Regional ME is reviewing whether full access is necessary and the cost implications. |

| | |
|---|---|
| **346/22** | **Patient Experience Enabling Strategy & Q2 Report** |
| | Mr Perry took the report as read and highlighted the key points.<br><br>The Enabling Strategy is the forward plan of activity for the next three years and regular updates will be given on progress made against priorities and this is a joint strategy plan with RWT. There is evidence of good engagement and cross collaboration, particularly in the area of faith matters.<br><br>The Quarter 2 report advises that there is continuing good engagement and FFT (Friends and Family Test) is stable and the response rate is good and work is ongoing to translate this information into the recommendations the team is undertaking.<br><br>Professor Toner advised that the strategy document went to the equivalent QPES group at RWT and was well received. The only suggestion made was looking at milestones to be added in to see progress being made. She also asked about the 29 baby funerals included in the report which seemed a high figure. Mr Perry advised that the figure was across both WHT and RWT and Mrs Jones-Charles advised that this also included miscarriage figures.<br><br>Mrs Muflahi thanked Mr Perry for the positive report and advised as the service grows the Trust need to think about wider protected characteristics and equity, for instance with the LGBTQ community and Mr Perry advised that the team is actively engaging with all section of the community, carers and participating in inclusive events. |
| **347/22** | **Safeguarding Q2 Update** |
| | Mrs Carroll took the report as read and highlighted key points.<br><br>The Safeguarding Team is now fully recruited. During Q2 there was some sickness absence, particularly in the Children's Team which caused considerable pressure on the team, and necessitated remote attendance at MASH, this is now rectified and the delay in some of the health assessments is now up to date.<br><br>Positive feedback has been received on the Development Plan and most of the actions are now complete and feedback from the ICB and Local Authority is that they are now are assured with the processes in place.<br><br>The Safeguarding Team participated in the Joint Targeted Area Inspection which looks at Safeguarding systems across Health, Education and the Police service and no immediate actions for Health were identified. A copy of the final letter and findings is expected in the new few weeks. |
| **348/22** | **Infection Control Quarterly Update** |
| | Mrs Carroll presented the highlights from the report.<br><br>Concerns relating to the C.Diff rate have been covered earlier in the Safe High Quality Care report above.<br><br>An increasing number of patients presenting with diarrhoea symptoms is putting pressure on the isolation facilities. The Bioquell isolation pods are helping with this, but it is still a challenge and the Infection Control Team are working with the Ops Team and wards to ensure patients for isolation are prioritised. |

| | |
|---|---|
| | There has been one case of MSSA bacteraemia which has been upgraded to a serious incident, after investigation the cause of the infection has been identified as pneumonia, so it is like that this will be stood down as an SI once the investigation has been finalised and an update will be bought to QPES.<br><br>On a positive note, the Head of Infection Control presented at the National Infection Prevention Society Conference regarding compassionate visiting and infection control during Covid and also made two poster presentations on improving indoor air quality and respiratory pathway which has been implemented across the organisation which have both been shared regionally and nationally as an example of good practice. |
| **349/22** | **104 Day Harm Update** |
| | Report taken as read and no questions were raised. |
| **350/22** | **Research Governance Framework** |
| | Report was taken as read.<br><br>Mr Virdee advised he had met with the R & D Manager and it is positive to see that there is space for Research and Development across the two Trusts and an excellent initiative.<br><br>Professor Toner advised that Committee in Common activities has established a group called Improvement, Research and Innovation which has been set up to look at what is happening in those three areas across the two Trusts.<br><br>Dr Shemar advised that there is work on further innovative studies and Walsall is currently a pilot site for a study to look at how the Trust is supporting and mentoring doctors in a national study. She is also working with counterparts at RWT to look at other academic links and studies. |
| **351/22** | **Exception Reports from Sub Groups** |
| | No exception reports were received for discussion. |
| **352/22** | **Any Other Business** |
| | There was no other business to discuss. |
| **353/22** | **Matters for Escalation to the Trust Board** |
| | There were no items for escalation. |
| **354/22** | **Reflections on the Meeting** |
| | Chair asked if Committee thought the changes made to the running of this meeting provided a smoother meeting and Committee agreed the changes made were positive. The meeting finished at 1.20 pm. |
| **355/22** | **Date of Next Meeting** |
| | Friday 20th January 2023, 11.30 – 1.30 |

Minutes approved as a true and accurate record

Signed ..... Date .....20th January 2023.....

Dr J Parkes - Chair

Walsall Healthcare NHS
NHS Trust

# MEETING OF THE PERFORMANCE AND FINANCE COMMITTEE HELD ON WEDNESDAY 30th NOVEMBER 2022 AT 15:00 HELD VIRTUALLY VIA MICROSOFT TEAMS

## PRESENT

| | |
|---|---|
| Members | |
| Mr P Assinder | Non-Executive Director **(Chair)** |
| Mrs M Martin | Non-Executive Director |
| Ms D Brathwaite | Non-Executive Director **(Left during Item 123/22)** |
| Mr M Dodd | Interim Director of Transformation |
| Mr N Hobbs | Chief Operating Officer |
| | |
| In Attendance | |
| Mr D Mortiboys | Interim Director of Finance |
| Miss B Edwards | Executive Assistant **(Minutes)** |
| Mr K Wilshere | Group Company Secretary **(Joined during Item 123/22)** |
| Mrs J Toor | Senior Executive Assistant **(Joined during Item 123/22)** |
| Mr S Watson | Director of Estates Development |
| Mr R Pearson | Chief Information Officer |
| | |
| Apologies | |
| Mr R Caldicott | Chief Financial Officer |
| Mrs L Carroll | Director of Nursing |
| Dr M Shehmar | Chief Medical Officer |

| | |
|---|---|
| **120/22** | **Chair's welcome; apologies and confirmation of quorum** |
| | Mr Assinder welcomed everyone to the meeting. The meeting was declared quorate and apologies are noted above. |
| **121/22** | **Declarations of interest** |
| | There were no declarations of interest. |
| **122/22** | **Minutes of last meeting: Wednesday 26th October 2022** |
| | The minutes of the previous meeting were approved. |
| **123/22** | **Matters arising and action log** |
| | EPRR Self-Assessment<br>Mr Hobbs advised members following the self-assessment being presented at the Committee as substantially compliant, it had been moderated by the ICB with initial moderation with NHSE and concluded the Trust's rating to be partially compliant. Members were informed the evidence required for the core standards to be achieved this year was high and had resulted in other organisations within the Black Country compliance level decreasing.<br><br>Mr Assinder requested a report was brought to the next meeting to highlight the concerns, the plan to address the concerns, the financial consequence and the different between the self-assessment and the assessment done by NHSE. Mr Hobbs advised the Trusts work |

| | |
|---|---|
| | programme would remain unchanged and expressed that he expected the Trust to be substantially compliant in the 2023/24 assessment. It was confirmed this rating did not impact the CNST premium.<br><br>Mr Evans provided members with an update on the ICS.<br><br>**Mrs Braithwaite left the meeting at 15:06.**<br>**Mr Wilshere and Mrs Toor joined the meeting at 15:23.**<br><br>**Action**<br>- **Mr Hobbs to bring a report to the next meeting to highlight the concerns, the plan to address the concerns, the financial consequence and the different between the self-assessment and the assessment done by NHSE.** |
| **124/22** | **Financial Report** |
| | **Month 7**<br>Mr Mortiboys presented to members. It was noted the Trust reported a £3.6m deficit at Month 7, £6.5m away from the financial plan. It was highlighted to members the drivers for being off plan were the shortage of additional ERF income, use of temporary workforce and additional beds for COVID-19 and emergency pressures.<br><br>Mr Mortiboys highlighted there were 2 keys risks within the Capital programme that were MAKO robot and theatres. No communication had been received on the bids put forward to fund these 2 areas. It was added the delay in the opening of the new Emergency Department build had resulted in other programmes being delayed. Members were informed it was likely that funding for the ED shell space would be released and the MAKO robot would be the first project to be funded.<br><br>Mrs Martin requested the front sheet was reviewed for future meetings, in particular the assurance section. Mrs Martin noted funds were being engineered into the system but expressed concern that she was not sure if the funds would cover what was required and the approach taken was a less cautious position on the balance sheet. Mrs Martin questioned if the profile would be revised. Mr Mortiboys agreed to refresh the capital programme schedule as soon as possible. This could be two schedules, one assuming bids are approved and one assuming they are not.<br><br>Mrs Martin questioned if the delays to the new ED build were resulting in additional revenue costing. Mr Mortiboys confirmed the Trust was 1% down on the level of emergency department demand expected through the business case and therefore recruited staff were mainly being deployed to deal with this demand.<br><br>**Mr Watson joined the meeting at 15:34.**<br><br>In relation to the delays in the ED scheme Mr Watson expressed the delays and their financial implication, would be reviewed but stated that there were mitigations within the contract in relation to industry delays and this area would be reviewed after the project had been completed. |

Mrs Martin requested assurance on the actions taken on outstanding debt and questioned if the cash balance was monitored on a monthly basis. Mr Assinder agreed and requested Mr Mortiboys to review working capital generally outside of the Committee discussions and to escalate any issues to Professor Loughton. Mr Mortiboys agreed to include a cash flow forecast at the next meeting and review the outstanding debt. Mr Mortiboys confirmed that the Trust was in dispute with the ICB for £5m and there were ongoing conversations but confirmed he would continue to pursue this matter.

Mrs Martin stated the funding for the increase in pay had not been resolved. Mr Mortiboys expressed this was not only a Walsall issue but funding would continue to be chased.

**Forecast Outturn 2022/23**

Mr Mortiboys presented to members. Members noted the position had changed since the report had been distributed to Committee. The change was caused by a meeting of the Provider Collaborative some 24 hours before. The Provider Collaborative in the BC ICB had met to put together a package that would allow the Trust and the ICB a route to breakeven and prevent the activation of the NHSE deficit protocol. It was highlighted that the organisation would start at an unmitigated £8.8m deficit position; the ICB would then contribute £4.8m to WHT (the funds coming from the ICB and a surplus from the Ambulance and Mental Health Services). Thus leaving a residual £4m to be managed locally.

Mr Mortiboys advised that the Black Country had supported the concept of removing the annual leave accrual within the balance sheet of trusts (£2.4m in WHT), therefore leaving a net £1.6m gap to break even.

Members noted the mitigations outlined within the report that amount to £3.2m with a number already in progress. Mr Mortiboys expressed the plan would need to satisfy external audit and stated there was risk in intermediate care and would look to use social care discharge funds to mitigate this risk. It was noted, the approach was not risk free and there was a meeting between the Chief Financial Officers and Chief Executive Officers currently and if the overall approach was agreed further detail would need to be developed.

Mrs Martin expressed that she was unhappy in relation to the level prudence left in the accounts and added she was unsure if External Audit would be supportive of the approach. Mrs Martin further added she would not want to propose that the Trust Board accept this approach. Members discussed the protocol and the limiting factors it would have on the operational profile of services and Mrs Martin suggested that Professor Loughton's view was required.

Mr Assinder proposed that the Committee endorse the approach suggested to manage the Trust's deficit, subject to clarity being received in relation to the £4.7m, money owed to the Trust by the ICB. He added

| | |
|---|---|
| | that the annual leave accrual could cause the Auditors to disagree with the accounting treatment, resulting in a prior year adjustment or a bigger in year provision being created. He suggested potentially referring the issue it to Audit Committee. His final condition for supporting the approach was the residual £1.6m and confirmation from the Executives that this wasn't being removed from operational teams budgets. Mr Assinder added a further conversation was required with Professor Loughton and Mr Kevin Stringer.<br><br>Mr Evans questioned if there was a timeframe for this to be endorsed and stated there was a Private Trust Board session that could be used to discuss. Mr Mortiboys agreed and added he would pull together a report in advance of the next Private Trust Board.<br><br>Mr Hobbs questioned to what extent the ICB is pursuing money from neighbouring systems for work that the Black Country is doing for neighbouring systems patients. Mr Hobbs added he did not think the Committee was in a position to take a definitive decision without further information and assurance.<br><br>**Actions**<br>- **Monthly Finance report front sheet to be revised.**<br>- **Mr Mortiboys to pull together 2 spend profiles and share with members.**<br>- **Mr Mortiboys to include a cash flow forecast within the Month 8 report.**<br>- **Mr Mortiboys to review the outstanding debt and escalate as appropriate.** |
| **125/22** | **Estates Backlog Maintenance and Strategy Update** |
| | Mr Watson presented to the Committee. Members noted the report had been aligned for joint working across both Walsall and Wolverhampton.<br><br>Mr Watson highlighted the focus was on condition status B, affecting operationally safe and minor deterioration across the structure of the buildings with the expectation the refresh would be completed within the next 5 years. It was added condition C was the worst part of the estate and the capital investment would be prioritised. Mr Watson advised the reporting was done through returns but noted there was a delay and work was on going to look at realigning the Trust reporting.<br><br>Members noted the total backlog cost across Walsall was around £474 per meter squared and was confirmed to be a lot higher in cost but a smaller site compared to the Royal Wolverhampton NHS Trust. Mr Watson highlighted PFI parties are obligated within contract to provide a backlog forecast and it came back with a £36m forecast across 5 years. Mr Watson confirmed a measured assessment had been performed and the figure had been reduced to roughly £2m per year. It was added there were no more significant risks across the backlog that warranted Board member's concern. |

| | |
|---|---|
| | Mr Watson added that more capital investment was being performed and further capital funds was brought into the organisation. It was highlighted the Capital Review Group was working with the Space Utilisation Group to prioritise the investments. It was added the Trust had entered a bid to recently try to secure an additional £17m for decarbonisation works as a joint bid on the system from the ICS.<br><br>Mr Watson informed members the Trust Estates Strategy had expired but the ICS were looking at putting a system strategy in place and confirmed he was the Chair for the ICS Estates Strategy Group. It was added the joint working and sharing of resources was paying dividends and was now focused on bringing the external capital in from outside the NHS to mitigate some of the pressures with one being the public sector decarbonisation funding.<br><br>Mr Hobbs passed on his thanks to Mr Watson for the hard work over the past 12-18 months and the benefit of the collaboration and expertise received from Mr Watson and the capital development team.<br><br>Mrs Martin questioned what grip the Trust had if the work was under control of the PFI partner. Mr Watson expressed there was challenge back to the PFI partner if more evidence was required to provide certainty around the figures but stated this would cause delays to the work to ensure value for money. Mr Watson highlighted he would be working with Mr Mortiboys to ensure the right level of value is received but to ensure the risk is mitigated. Mrs Martin expressed there would be a knock-on effect on to the projects planned to be done next year. Mr Watson agreed and added there was a constant reprioritisation with the backlog to ensure everything was reviewed on an ongoing basis.<br><br>It was agreed Mr Watson would come back once agreement had been reached in relation to the broader Estates Strategy, it would be brought back to the Committee for members views on shaping the position.<br><br>**Action**<br>- **Mr Watson to bring back the Estates Strategy to the Committee.** |
| **126/22** | **Performance Constitutional Standards Report** |
| | **Community**<br>Mr Dodd presented to members. It was noted out of area patients were leading to additional pressures both within the medically fit for discharge cohort and those people who could be turned around at the front door. Mr Dodd added the Trust would be a pilot site for the National Intermediate Care Services Recovery programme and provided an opportunity to pilot the concept of therapy assessment & review at home on the day of discharge. Mr Dodd added this was a big step forward and would lead to a new approach to management of risk on discharge. Mr Dodd stated that the sustained demand for complex support on discharge was leading to pressures within the intermediate care community budgets. This was being reviewed by the Trust in conjunction with the Council and ICB commissioners. |

| | |
|---|---|
| | **Acute**<br>Mr Hobbs presented to members. It was highlighted the Emergency Care performance remained strong with performance being in the upper third nationally. It was added ambulance handover times remained positive and was attracting external interest resulting in the Trust featuring as the NHS Providers case study in October as well as being invited to speak at the Welsh Government summit. Cardiac Physiology was seeing benefits from the recovery plan in the overall waiting times for the Trust. Mr Hobbs confirmed he had not received assurance there was a sustainable endoscopy recovery plan to date but advised a business case would be presented to Investment Group in December that could provide a sustainable route for endoscopy to manage the level of demand. Mr Hobbs added Breast care remains challenged but confirmed the Trust continued to be on track for the practitioner to be running clinics from January 23.<br><br>Mrs Martin raised there was a slip for 18 week RTT for Surgery each month and questioned if the cause was known with extra sessions being ran at Cannock Chase Hospital. Mr Hobbs advised the patients were not on a waiting list for surgery but for assessments, diagnostic or a definitive treatment plan but expressed there were factors affecting the surgical division. Mr Hobbs informed members consultant expansion had been approved as it was recognised there wasn't sufficient clinical capacity. Mrs Martin further questioned what the Cancer Alliance was doing across the Black Country to get resources and lessons shared. Mr Hobbs expressed cancer was a common challenge in capacity to diagnose. There were strengths and weaknesses across the Black Country with Walsall playing a key role on skin cancer as it is not performed as well in other organisations with the weaknesses being around the breast pathway as there was a long standing issue that needed to be addressed.<br><br>Mr Assinder stated 50% of the 4 hour breaches were minors and questioned if enough attention was being given to these patients. Mr Hobbs expressed this was a consequence of insufficient medical and ACP capacity within the ED department. Members were assured the expansion of the ED workforce had been approved at Trust Board and would be a sustainable solution. Mr Hobbs expressed concern the biggest risk was the increasing volume of emergency care demand at Walsall at a rate not seen everywhere and the organisations ability to manage in future years. |
| **127/22** | **Digital Strategy** |
| | Mr Pearson joined the meeting and presented an overview to members. Members noted the strategy had been developed to achieve a level of digital maturity set nationally by the end of 2024/25 and targeted projects that were already live or in progress. The Trust had been working with NHS digital all year around frontline digitisation but work progress had been delayed due to political changes. Members were advised the Trust had secured an allocation of £7.8m to support in the delivery over a 5 year period with there being no additional funding commitment required. Mr Pearson showed members a chart that displayed what was in progress, |

| | |
|---|---|
| | what had not been started and what was required to be purchased. Members were informed a partner business case had been submitted to the Investment Group to secure digital clinical resource to provide additional clinical capacity to work on the developments. Mr Pearson advised the prioritisation of models was driven by the Design Authority Group and work was ongoing with Dr Shehmar in relation to the medicines management module and how the development could be expedited to reprioritise the delivery. It was highlighted to members the project was to digitise the health records library with children 0 to 19 years olds completed.<br><br>Mrs Martin questioned the percentage of patient records that are digital. Mr Pearson advised the only records that were fully digitalised were children aged 0 to 19 years old but confirmed he was not aware of the overall percentage. Mrs Martin expressed she did not feel the digitalisation of medical records did not appear to be the priority. Mr Pearson confirmed it was a high priority but the ask was to focus on the age 0 to 19 year olds due to the level of risk and expressed there was a report with Mr Stringer to expedite the acute EDM roll out but raised this would result in an increase in resources. Mrs Martin expressed further concern that she was worried the Trust needed to get the funds and the staff to achieve the deadline set out. Mr Pearson agreed and added it was a concern raised in relation to the delivery of the clinical capability and the team were optimistic to receive additional funding for dedicated clinical resource through the business case.<br><br>Mr Assinder questioned if it would be achievable in the timescale required and Mrs Martin further questioned what the risks would be. Mr Pearson advised there wasn't any additional revenue impact and the strategy had been discussed with clinical and divisional colleagues that have confirmed the strategy's alignment to the operational and clinical prioritise.<br><br>Mr Evans informed members the strategy should be presented at the Joint Digital Committee and confirmed its purpose was to review the strategic delivery.<br><br>Mr Hobbs advised the strategy had the clinical operational support for development and recognised a risk to the capacity of the organisation to implement digital developments but expressed the importance of getting the strategy implemented soon.<br><br>Mrs Martin expressed she could approve the strategy with the agreement when it is presented to Trust Board it highlights what the Trusts needs and the potential risks.<br><br>Mr Wilshere advised a cyber attack BAF risk had been produced and would be brought back to the next Committee.<br><br>**The Committee approved the Digital Strategy.** |
| **128/22** | **Efficiency Programme Update** |

| | |
|---|---|
| | Committee members noted the report. |
| **129/22** | **PFI Update** |
| | Mr Mortiboys advised he and Mr Stringer had met with Bevan Brittan and was looking to arrange a meeting with P2G. It was confirmed an update would be provided at the next meeting. |
| **130/22** | **Appointment Scheduling Assurance and the Management of the Follow Up Backlog Business Case** |
| | Mr Hobbs presented to members. It was noted an external review into the outpatient booking process and had resulted in a few recommendations that have been included within the constitutional standards report as one element pertained to the number of follow-up pathways. Members noted due to the clinical risk amongst the cohort it was agreed to undertake a full validation exercise to close the pathway legitimately or assist with the prioritisation of the patients being reviewed.<br><br>Mrs Martin requested assurance all patients were on the new PAS system. Mr Hobbs advised the transition from Lorenzo to Medway data quality assurance was successfully completed with the migration but advised the main concern was the change from one pathway per patient to multiple pathways and as a consequence all the open pathways required validation but assurance had been received all active pathways were successfully migrated over.<br><br>**Mr Evans left the meeting at 16:59.**<br><br>It was confirmed the Group Director of Assurance was aware and the clinical risk aspect was being monitored.<br><br>**The Committee approved the Appointment Scheduling Assurance and the Management of the Follow Up Backlog Business Case.** |
| **131/22** | **Emergency Department Build Update** |
| | Committee members noted the report. |
| **132/22** | **Board Assurance Framework and Corporate Risk Register** |
| | Committee members noted the report. Mr Wilshere advised a meeting had been arranged to review the new BAF risks and stated the new format should be ready for the next meeting. |
| **133/22** | **Any other Business** |
| | **Self-Assessment**<br>Mr Wilshere advised the equivalent meeting at the Royal Wolverhampton had commenced their self-evaluation through an online survey. Mr Assinder requested a similar approach for Walsall. |
| **134/22** | **Date and Time of Next Meeting: Wednesday 25th January 2023** |

Walsall Healthcare NHS
NHS Trust

# MEETING OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

## HELD ON MONDAY 19TH DAY OF DECEMBER 2022 AT 13:30
## HELD VIRTUALLY VIA MICROSOFT TEAMS

**Members Present**

| | |
|---|---|
| Mr Junior Hemans (Chair) | Non- Executive Director |
| Mr Paul Assinder | Non-Executive Director |
| Mr Alan Duffell | Group Chief People Officer |
| Mrs Lisa Carroll | Director of Nursing |
| Ms Catherine Griffiths | Chief People Officer |
| Ms Clair Bond | Deputy Director of People and Culture |
| Mrs Sabrina Richards | Equality, Diversity and Inclusion Lead |

**In Attendance**

| | |
|---|---|
| Mrs Patricia Usher | Joint Staff Side Lead |
| Mrs Jane Wilson | Joint Staff Side Lead |
| Mrs Catherine Wilson | Deputy Director of Nursing |
| Mrs Jaswinder Toor (Part) | Senior Operational Co-Ordinator |
| Mr Keith Wilshere | Group Company Secretary |
| Mr Brad Allen (Minutes) | Executive Personal Assistant |

**Apologies**

| | |
|---|---|
| Mrs Dawn Brathwaite | Non-Executive Director |

| | |
|---|---|
| **134/22** | **Chair's welcome, apologies, and confirmation of quorum** |
| | Mr Hemans welcomed all members to the meeting and passed on his thanks for their attendance and declared the meeting to be inquorate due to the lack of attendance of Non-Executive Directors. Mr Hemans advised committee that Mr Assinder would join the meeting shortly to ratify this.<br><br>Formal apologies were received and noted as above. |
| **135/22** | **Declarations of Interest** |
| | Declarations were noted from the following attendees:<br><br>Mr Alan Duffell declared an interest as interim Director of People and Culture for The Dudley Group NHS Foundation Trust.<br><br>Mr Wilshere declared an interest as interim Company Secretary for the Dudley Group NHS Foundation Trust. |
| **136/22** | **Minutes of Previous Meeting – November 2022** |
| | |

| | |
|---|---|
| | Mr Assinder Joined the meeting at 14:10. There were no comments or amendments from members therefore committee **resolved** to **approve** the minutes of the meeting that took place on Monday 28th November 2022 as a true and accurate record of decisions and discussions that took place. |
| **137/22** | **Matters arising and Action Log** |
| | The Action Log was reviewed and updated by action owners as necessary by using the iBabs service. |
| **138/22** | **Integrated Care Board Update** |
| | Ms Griffiths advised committee that further updates would be provided at the next meeting in January 2023 following a review of priorities.<br><br>There were no further comments or questions from members. |
| **139/22** | **Staff Story – BAME Council Success Stories and Achievements** |
| | Mrs Richards introduced the item and referred members to the attached Power Point Presentation detailing success stories, achievements, challenges and recognition elements in which the Council had been Featured. Mrs Richards then updated committee on a newly developed survey due to be distributed to all areas to allow staff to provide feedback on their own experiences in the workplace.<br><br>Mr Duffell queried whether any learning points had been identified that could be shared with colleagues based at Wolverhampton. Mrs Richards responded to Mr Duffell to advise that several events were due to take place, all of which have been shared with Wolverhampton colleagues for reference.<br><br>Ms Griffiths advised that a shared governance approach was in place and that the Council had been encouraged by the Board with their terms of direction in encouraging them to become a voice of power and influence. Ms Griffiths concluded by expressing the need to continue the development of the Council's model to further decrease levels of discrimination in the workplace.<br><br>Mr Hemans suggested discussing achievements with the communications team to share success stories and expertise for wider learning.<br><br>There were no comments or questions from members. |
| **140/22** | **Corporate Risk Register** |
| | Ms Bond introduced the report and summarised the committee's ownership of five corporate risks, of which three were workforce related. Ms Bond then went on to report the following updates: |

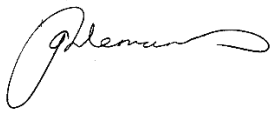
| | |
|---|---|
| | • A total of two risks have been reduced in rating, a further two have remained at moderate and one risk had been increased relating to Industrial Action.<br><br>• All three Board Assurance Frameworks were stood at a score of twelve with relevant actions in place to ensure they are monitored.<br><br>Mr Duffell referred members to the corporate risk of the Trusts inability to recruit and retain staff and suggested this be split into two separate risks due to their nature.<br><br>Mr Wilshere advised that there would be two sessions at the next joint Board Development Session to discuss this.<br><br>There were no further comments from members therefore committee **resolved** to **note** the contents of the report. |
| **141/22** | **Safe Staffing Report** |
| | Mrs Carroll introduced the report as read and highlighted the below points to committee:<br><br>• A further 32 Clinical Fellow Nurses have commenced employment at the Trust bringing the total to 262.<br>• A further 22 Student Nurses are due to qualify during Spring 2023 and have been offered substantive posts within the Trust.<br>• A total of nineteen areas were reported to not be utilising agency staffing, however, off-framework figures had increased during November 2022 and will be sustained during December due to capacity issues.<br>• Overall vacancy rates were reported to be decreasing.<br><br>Mr Hemans queried whether qualified Clinical Fellowship Nurses would be recruited into new posts within the accident and emergency department. Mrs Carroll responded to Mr Hemans to advise that posts had already been offered and that additional competency checks were underway to ensure staff are sufficiently trained.<br><br>There were no further comments or questions from members. Committee resolved to **note** the report. |
| **142/22** | **Trust Workforce Metrics** |
| | Ms Griffiths introduced the report and advised members that data relating to Bank and Agency usage would be presented to the committee at the meeting scheduled for January 2023. Ms Griffiths Informed members that stress and anxiety figures had reduced but still remains the main reason for long term sickness absence and that annual appraisal figures were beginning to stabilise around the Trust's set target. |

| | |
|---|---|
| | Mr Duffell referred members to the retention paragraph within the report and queried whether a separate retention graph could be put together for committee reference. Ms Griffiths advised this data could be obtained and would be shared with colleagues and that necessary action plans are being collated to support staff retention figures with a target to retain staff for a minimum of 24 months. Ms Griffiths concluded to advise that ~~a~~ quarterly assurance reports would be presented to committee for information.<br><br>Mr Duffell queried whether a deadline had been set to support staff retention figures and targets, as well as give teams more oversight as to when the trust expects to see significant improvements to staffing numbers. Ms Griffiths advised that a deadline had not yet been set, but continual monitoring of progress would be reported to committee.<br><br>Mr Hemans referred committee to Nursing appraisal figures and queried whether figures were low due to vacancies within the new Urgent and Emergency Care Centre project. Mrs Carroll responded to Mr Hemans and confirmed that this was the case and it had been picked up with Divisional colleagues as necessary<br><br>There were no further comments from members, therefore committee **resolved** to **note** the contents of the report. |
| **143/22** | **Staff Survey Report** |
| | Ms Bond introduced the report and began by advising members that the total response rate for the Staff Survey had achieved 49.6% and that overall, improvements had been reported in each of the seven areas presented from the survey produced in 2022, including engagement and overall morale.<br><br>Mr Duffell referred members to the overall reduced response rate and advised that other Trusts from across the country had equally seen a reduction in engagement.<br><br>*Mr Assinder joined the meeting at this point at 14:03.*<br><br>Mr Hemans expressed his support for the survey results, emphasising it was positive that so many people had come forward to voice their opinions. He then queried if the Grant Thornton report had been resolved. Ms Bond responded to Mr Hemans to advise the report had been resolved and would require formal approval from the committee.<br><br>Mr Duffell urged members to proceed with caution until National Staff Survey figures had been produced. |

| | |
|---|---|
| | Mr Assinder expressed his support for the outlined improvements but queried whether any learning points had been identified.<br><br>Ms Griffiths suggested an investigation take place to determine what factors had caused the increase to each identified improvement and escalate this to the Oversight Group.<br><br>Mrs Richards concurred with points raised by Ms Griffiths and highlighted an improvement made to response rates from BAME (Black and Minority Ethnic) colleagues.<br><br>Mr Hemans queried the format in which the surveys had been undertaken. Ms Bond responded to advise that all colleagues had received email communication, with paper copies being available in ward areas to improve response rates. Ms Bond then advised a pilot had been undertaken to identify areas of poor response to allow colleagues to dedicate additional resources for improvements.<br><br>There were no further comments from members therefore committee **resolved** to **note** the contents of the report. |
| **144/22** | **LGBTQ & Inclusion Report** |
| | Mrs Richards introduced the report and began by advising committee of the recently-launched Rainbow Badge scheme to raise awareness of LGBTQ+ inclusivity in the workplace. Ms Richards then summarised the improvements made within the Trust to inclusivity and gave examples including the development, introduction and recognition of the Trans Inclusion policy for both patients and staff.<br><br>Mrs Richards concluded by advising members that a new Chair had been recruited from within the Trust to lead on LGBTQ+ inclusivity, and that a recently developed survey for LGBTQ+ staff would be circulated for completion to evidence where the Trust is and is not performing well in areas. Mrs Richards assured that all developments and events would be communicated with the committee and Wolverhampton colleagues for their information.<br><br>Mr Hemans referred committee to data collated from the survey and queried what mitigatory measures had been implemented to address concerns raised. Mrs Richards advised that conversations were taking place with the LGBTQ+ Inclusion Centre to engage with members, of which further information would be presented to committee in February 2023.<br><br>Mr Hemans queried whether concerns raised would be followed up, even in a generic form should the concern raised come from an anonymous source. Mr Hemans then suggested generic communications be sent to colleagues to assure them themes had been identified and highlight what methods had been implemented to reduce stigma. Mr Assinder and Duffell concurred with points and suggestions made my Mr Hemans. |

| | |
|---|---|
| | .<br><br>There were no further comments from members, therefore committee **resolved** to **note** the contents report. |
| **145/22** | **Integrated Care Board Priorities** |
| | Committee **noted** that further discussions would be held on this item when updates had been received from the Care Board. |
| **146/22** | **Colleague in Difficulty Report** |
| | Committee **resolved** to **approve** the report as set out. |
| **147/22** | **Items for Information** |
| | There were no comments or queries from members relating to the reports as set out below, therefore **resolved** to **note** the contents of the reports as set out. They were as follows:<br><br>• Minutes of the Local Negotiating Committee (LNC)<br>• Minutes of the Joint Negotiating and Consultative Committee (JNCC)<br>• Minutes and Action Log of the Health and Wellbeing Strategy Group.<br>• Minutes and Action Log of the Equality, Diversity and Inclusion Group. |
| **148/22** | **Escalations to Trust Board** |
| | Committee **resolved** that the following items be referred to the Trust Board for further discussion and information:<br><br>• BAME Council Successes.<br>• Retention and Recruitment Challenges and Monitoring.<br>• On-going efforts to ensure Divisional colleagues continue to monitor appraisal rates.<br>• Staff dispute and tribunal outcomes.<br>• LGBTQ+ Inclusion Report improvements. |
| **149/22** | **Any other Business** |
| | There were no additional items of business raised by members for discussion. |
| **150/22** | **Date and Time of the Next Meeting** |
| | |

| | |
|---|---|
| | Committee **noted** that the next committee meeting is due to take place on Monday 30th January 2023 at 13:30 via Microsoft Teams. |

Signed: 

Committee Chair - Mr Junior Hemans

Date: