Bundle Trust Board Meeting to be held in Public 14 February 2024

1 10:00 - A Pack: Chair's Welcome, Apologies and Confirmation of Quorum
Lead: Sir David Nicholson, Group Chair
Apologies Received:
Paul Assinder, Deputy Chair/Non-Executive Director
Simon Evans, Chief Strategy Officer
Keith Wilshere, Group Company Secretary
Meeting is confirmed as quorate
In Attendance:
For the Patient Story (Agenda Item No 2):
Sindy Dhallu, Professional Lead, Palliative and End of Life Care & Lead Manager, Goscote Hospice
Rachel Tomkins, Interim Divisional Director of Nursing, Division of Medicine and Long Term Conditions
Melissa Perry, Ward Manager for AMU
Fiona Micheli, Clinical Lead, Urgent Community Response
Mr Suleman Jeewa, Freedom to Speak Up Guardian (for Agenda Item No: 7.1)

2 10:01 - A Pack: Patient Voice - Verbal Report
Please copy and paste the link below into your chrome browser to view the video on Youtube:
https://www.youtube.com/watch?v=3iakZ9rVOvE
Lead: Lisa Carroll, Chief Nurse Officer
Action: To Inform
In Attendance:
Sindy Dhallu, Professional Lead, Palliative and End of Life Care & Lead Manager, Goscote Hospice
Rachel Tomkins, Interim Divisional Director of Nursing, Division of Medicine and Long Term Conditions
Melissa Perry, Ward Manager for AMU
Fiona Micheli, Clinical Lead, Urgent Community Response

3 10:21 - A Pack: Register of Declarations of Interest
Lead: Sir David Nicholson, 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.
ENC 3 Declarations of Interest - January 24 - v1

4 10:23 - A Pack: Draft Minutes of the Previous Meeting held 13 December 2023
Lead: Sir David Nicholson, Group Chair
Action: To Receive and Approve
ENC 4 Draft Minutes of the December Public Board 2023

5 10:25 - A Pack: Action Log and Matters Arising
Lead: Sir David Nicholson, Group Chair
Action: To Receive Updates on Actions and any Matters Arising
ENC 5 - Action items

6 10:27 - A Pack: Chair's Report - Verbal
Lead: Sir David Nicholson, Group Chair
Action: To Inform and Assure

7 10:29 - A Pack: Group Chief Executive's Report
Lead: Prof. David Loughton, Group Chief Executive
Action: To Inform and Assure
ENC 7 WHT. Chief Executive Trust Board report 14.02.24

7.1 10:31 - A Pack: Freedom to Speak Up
Presenter: Sol Jeewa, Freedom to Speak up Guardian
Lead: Prof David Loughton, Group Chief Executive
Action: To Approve
ENC 7.1 F2SU Board Report February 2024

7.2 10:36 - A Pack: Trust Management Committee - Chair's Report
Lead: Ned Hobbs, Chair, Trust Management Committee/Chief Operating Officer/Deputy Chief Executive
Action: To Inform and Assure
Comprises:
Research and Development (B Pack - Item 7.2.1)
Schwartz Round (B Pack - Item 7.2.2)
ENC 7.2 WHT. Trust Board report of TMC 25.01.24 v2

7.2.1 10:41 - B Pack: Research and Education
Enc 7.2.1 RD Bi-Annual Report - Feb 24 - READING ROOM

7.2.2 10:41 - B Pack: Schwartz Round
Enc 7.2.2 Schwartz Round Annual Report - October 2023

8 10:41 - A Pack: EXCEL IN THE DELIVERY OF CARE (Section Heading)

8.1 10:41 - A Pack: Board Level Metrics - CARE
Leads: Ned Hobbs, Chief Operating Officer & Dan Mortiboys, Interim Director of Finance
Action: To Inform and Assure
ENC 8.1 Board Level Metrics - CARE

8.2 10:46 - A Pack: Finance & Productivity Committee - Chair's Report
Lead: Mary Martin, Non-Executive Director on behalf of Paul Assinder (Chair, Finance and Productivity Committee)
Action: To Inform and Assure
ENC 8.2 Chairs Report Performance Finance Committee 24 January 2024
Enc 8.2 Chairs Report Performance Finance Committee December 2023

8.3 10:51 - A Pack: Quality Committee - Chair's Report
Lead: Dr Julian Parkes, Chair, Quality Committee/Non-Executive Director
Action: To Inform and Assure
ENC 8.3 - Quality Committee - Chair's Report

8.4 10:56 - A Pack: Audit Committee - Chair's Report - To Follow
Lead: Mary Martin, Chair, Audit Committee/Non-Executive Director
Action: To Inform and Assure

8.5 11:01 - A Pack: Group Chief Financial Officer Report
Lead: Kevin Stringer, Group Chief Financial Officer & Dan Mortiboys, Interim Director of Finance
Action: To Inform & Assure & Approve Standing Orders/Standing Financial Instructions enclosed as B Pack: 8.5.2
Comprises:
Month 10 Finance Report (B Pack: 8.5.1)
Standing Orders/Standing Financial Instructions (B Pack: 8.5.2)
ENC 8.5 Group CFO Report Feb 24

8.5.1 11:06 - B Pack: Month 10 Finance Report
ENC 8.5.1 CFO Month Position Report Feb 24 Pack B

8.5.2 11:06 - B Pack: Review of Standing Financial Instructions/Standing Orders
ENC 8.5.2 SFI Covering Report Feb 2024
ENC 8.5.2 WHT-GI02 V5 Draft KW Standing Orders
ENC 8.5.2 WHT-GI02 V5.3 SFI REVIEW 301123

8.6 11:06 - A Pack: Financial Recovery Plan - Verbal Update
Lead: Kevin Stringer, Chief Financial Officer/ Deputy Chief Executive
Action: To Inform and Assure

8.6.1 11:11 - A Pack: COMFORT BREAK

8.7 11:21 - A Pack: Chief Nursing Officer Report by Exception
Lead: Lisa Carroll, Chief Nursing Officer
Action: To Inform and Assure
Comprises:
NatPSA/2023/010/MHRA - National Patient Safety Alert Paper (B Pack: 8.7.1)
Patient Experience and Complaints Report (B Pack: 8.7.2)
Workforce Safeguards (B Pack: 8.7.3)
ENC 8.7 CNO report to Trust Board February 2024

8.7.1 11:26 - B Pack: NatPSA/2023/010/MHRA - National Patient Safety Alert update paper
ENC 8.7.1 NatPSA MHRA bed rails alert paper for Public Trust Board February 2024

8.7.2 11:26 - B Pack: Patient Experience & Complaints Report
ENC 8.7.2 Patient Voice Quality Report SEPT-DEC 23
ENC 8.7.2 Patient-voice-sept-dec-23

8.7.3 11:26 - B Pack: Nursing and Midwifery Workforce Safeguards
ENC 8.7.3 Workforce Safeguards Paper Public Trust Board Febraury 2024
ENC 8.7.3 - Copy of Workforce Safeguards assurance framework action plan January 2024

8.8 11:26 - A Pack: Director of Midwifery Report
Lead: Joselle Wright, Director of Midwifery
Action: To Inform and Assure
ENC 8.8 Maternity Report for Public Trust Board February 2024

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To Inform and Assure
Comprises:
Medicines Safety Officer (MSO) Report (B Pack: 8.9.1)
Chief Pharmacist Report (B Pack: 8.9.2)
Controlled Drugs Accountable Officer (CDAO) Report (B Pack: 8.9.3)
Safe High Quality Care Report (B Pack: 8.9.4)
Reduction in Temporary Medical Staffing Spend Report (B Pack: 8.9.5)
Mental Health Report (B Pack: 8.9.6)

ENC 8.9 CMO Report to Public Trust Board Feb 24

8.9.1 11:36 - B Pack: Medicines Safety Officer (MSO Report)

ENC 8.9.1 MSO Report - Feb 24 - READING ROOM

8.9.2 11:36 - B Pack: Chief Pharmacist Report

ENC 8.9.2 Chief Pharmacist Quarterly Report - Feb 24 - READING ROOM

8.9.3 11:36 - B Pack: Controlled Drugs Accountable Officer (CDAO) Report

ENC 8.9.3 CDAO Annual report - Feb 2024 - READING ROOM

8.9.4 11:36 - B Pack: Safe High Quality Care Report

ENC 8.9.4 Safe High Quality Care Report - Feb 2024 - READING ROOM

ENC 8.9.4 - Safe High Quality Care Report - Feb 2024 - Appendix 1 Dashboard - READING ROOM

ENC 8.9.4 - Safe High Quality Care Report - Feb 2024 - Appendix 2 Dashboard Data - READING ROOM

ENC 8.9.4 Safe High Quality Care Report - Feb 2024 - Appendix 3 NatPSA MHRA bed rails alert paper - READING ROOM

8.9.5 11:36 - B Pack: Reduction in Temporary Medical Staffing Spend Report

ENC 8.9.5 Temporary Medical Spend Paper - Feb 24 - READING ROOM

8.9.6 11:36 - B Pack: Mental Health Report

ENC 8.9.6 Mental Health 6 monthly report - Feb 2024 - READING ROOM

8.10 11:36 - A Pack: Learning from Deaths Report
Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To Inform and Assure

ENC 8.10 Learning from Deaths report - Feb 2024

8.11 11:41 - A Pack: Group Director of Assurance Report by Exception - Verbal Report
Lead: Kevin Bostock, Group Director of Assurance
Action: To Inform and Assure
Comprises:
Board Assurance Framework Summary Report (B Pack: 8.11.1)

8.11.1 11:43 - B Pack: Board Assurance Framework Summary

ENC 8.11.1 - 1_TB Summary BAF February Public Board 24 v1.2 KW KB MM

8.12 11:43 - A Pack: Chief Operating Officer Report by Exception
Lead: Ned Hobbs, Deputy Chief Executive/Chief Operating Officer
Action: To Inform and Assure

ENC 8.12 Chief Operating Officer Report

9 11:48 - A Pack: SUPPORT OUR COLLEAGUES (SECTION HEADING)

9.1 11:48 - A Pack: Board Level Metrics - COLLEAGUES
Lead: Alan Duffell, Group Chief People Officer & Clair Bond, Interim Director of Operational HR
Action: To Inform and Assure

ENC 9.1 Board Level Metrics - Colleagues

9.2 11:53 - A Pack: People Committee - Chair's Report
Lead: Junior Hemans, Chair, People Committee/Non-Executive Director
Action: To Inform and Assure
& APPROVE
Joint Behavioural Framework (B Pack: 9.2.1)
Joint People Enabling Strategy (B Pack: 9.2.2)

ENC 9.2 People Committee jan 24 - Chair's Highlight Report

9.2.1 11:58 - B Pack: Joint Behavioural Framework

ENC 9.2.1 Joint Behavioural Framework -TB Feb 2024

ENC 9.2.1 App 2 RWT and WHT Joint Behavioural Framework plan on a page

9.2.2 11:58 - B Pack: Joint People Enabling Strategy

ENC 9.3.2 Joint People Enabling Strategy

Lead: Alan Duffell, Group Chief People Officer
Action: To Inform and Assure
Comprises
- Executive Workforce Metrics report (B Pack: 9.3.1)

ENC 9.3 Group CPO Board Update - Feb 24

9.3.1 12:03 - B Pack: Workforce Metrics

ENC 9.3.1 Group CPO Board Update - Feb 24

10 12:03 - A Pack: EFFECTIVE COLLABORATION (SECTION HEADING)

10.1 12:03 - A Pack: Board Level Metrics - COLLABORATION
Leads:
Ned Hobbs, Chief Operating Officer/Deputy Chief Executive
Dr Jonathan Odum, Group Chief Medical Officer
Dr Manjeet Shehmar, Chief Medical Officer
Action: To Inform and Assure

ENC 10.1 Board Level Metrics - Collaboration

10.2 12:08 - A Pack: Charitable Funds Committee held December 23 - Chair's Report
Lead: Paul Assinder, Deputy Chair/Chair, Charitable Funds Committee
Action: To Inform & Assure

ENC 10.2 Chairs Report Charity Committee 18 December 2023

10.3 12:13 - B Pack: Group Chief Strategy Officers Report

ENC 10.3 WHT Group CSO Report Feb 2024

10.3.1 12:13 - B Pack: Continuous Improvement Team Update

ENC 10.3.1 Appendix 1 - WHT QI TMC 25-01-24

10.3.2 12:13 - B Pack: Sustainability Report

ENC 10.3.2 WHT Sustainability TB report V0.1 26.01.24

11 12:13 - A Pack: IMPROVE THE HEALTH OF OUR COMMUNITIES (Section Heading)

11.1 12:13 - A Pack: Board Level Metrics - COMMUNITIES
Lead: Stephanie Cartwright, Group Director of Place
Action: To Inform and Assure

ENC 11.1 Board Level Metrics - Communities

11.2 12:18 - A Pack: Walsall Together - Chair's Report
Lead: Prof. Patrick Vernon, Chair, Walsall Together
Action: To Inform and Assure

ENC 11.2 WTPB Highlight report January 24

11.3 12:23 - A Pack: Group Director of Place Report
Lead: Stephanie Cartwright, Group Director of Place
Action: To Inform and Assure
Comprises:
Partnership Operational Performance Pack (B Pack: 11.3.1)

ENC 11.3 Group Dir Place Feb 2024

11.3.1 12:28 - B Pack: Partnership Operational Performance Pack

ENC 11.3.1 Appendix 1 Partnership Operational Performance Pack January 2024

12 12:28 - A Pack: 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.

13 12:30 - A Pack: Any Other Business

13.1 12:32 - A Pack: Date and Time of Next Meeting: Wednesday 17 April 2024 @ 10am

14 12:33 - B Pack: Minutes of Committee Meetings of the Board (SECTION HEADING)

14.1 12:33 - B Pack: Minutes from the Finance and Productivity Committee Meetings

ENC 14.1 Finance and Productivity Committee Meeting Minutes December 2023 (Jan) Approved at Committee
ENC 14.1 MINUTES Finance and Productivity Committee November (Extraordinary) KG PA
ENC 14.1 MINUTES Finance and Productivity Committee November KG PA

14.2 12:33 - B Pack: Minutes from the Quality Committee Meetings

ENC 14.2 Approved QC Minutes - November 2023 JP - Committee Approved

14.3 12:33 - B Pack: Minutes from the People Committee Meeting

Enc 14.3 Minutes - People Committee - Nov 2023 APPROVED

14.4 12:33 - B Pack: Minutes from the Trust Management Committee Meeting
ENC 14.4 Final November 2023 TMC Minutes

14.5 12:33 - B Pack: Minutes from Charitable Funds Committee Meeting
ENC 14.5 MINUTES Charitable Funds Committeee Sept 2023

14.6 12:33 - B Pack: Minutes from the Audit Committee Meeting
ENC 14.6 Approved September Audit Committee Minutes

ENC 3

Employee	Current Role	Interest Type	Interest Description (Abbreviated)	Provider
Sir David Nicholson	Chair	Outside Employment	Chairman	Sandwell & West Birmingham Hospitals NHS Trust
Sir David Nicholson	Chair	Outside Employment	Non-Executive Director	Lifecycle
Sir David Nicholson	Chair	Outside Employment	Visiting Professor	Global Health Innovation, Imperial College
Sir David Nicholson	Chair	Shareholdings and other ownership	Sole Director	David Nichoslon Healthcare Solutions
Sir David Nicholson	Chair	Outside Employment	Member	IPPR Health Advisory Committee
Sir David Nicholson	Chair	Outside Employment	Advisor	KMPG Global
Sir David Nicholson	Chair	Outside Employment	Senior Operating Partner	Healfund (Investor in healthcare Africa)
Sir David Nicholson	Chair	Loyalty Interests	Spouse	National Director of Urgent and Emergency Care and Deputy Chief
Sir David Nicholson	Chair	Outside Employment	Chairman	The Royal Wolverhampton NHS Trust
Sir David Nicholson	Chair	Outside Employment	Chairman	The Dudley Group NHS Foundation Trust
Ms Catherine Griffiths	Director of People and Culture	Shareholdings and other ownership	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
Professor David Loughton	Chief Executive	Loyalty Interests	Member	Companion of Institute of Health and Social Care Management (CIHSCM)
Ms Dawn Brathwaite	Non-Executive Director	Outside Employment	Consultant/Former Partner	Mills & Reeve LLP
Mr Edward Hobbs	Deputy Chief Executive/Chief Operating Officer	Loyalty Interests	Father – Governor Oxford Health FT	Governor Oxford Health FT
Mr Edward Hobbs	Deputy Chief Executive/Chief Operating Officer	Loyalty Interests	Sister in Law – Head of Specialist Services St Giles Hospice (Ended 31/12/23)	St Giles Hospice
Mr Edward Hobbs	Deputy Chief Executive/Chief Operating Officer	Outside Employment	Director of Operational Improvement for Urgent & Emergency Care	NHS England
Mr Edward Hobbs	Deputy Chief Executive/Chief Operating Officer	Loyality Interests	Sister in Law – Deputy Group Director of Nursing	Sandwell & West Birmingham Hospitals NHS Trust
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 (Ended)	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	The Royal Wolverhampton NHS Trust
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Second Cousin works as a Pharmacist at The Royal Wolverhampton	The Royal Wolverhampton NHS Trust
Mr Junior Hemans	Non-Executive Director	Outside Employment	Director	Grizhem Holdings Ltd
Mr Keith Wilshere	Group Company Secretary	Shareholdings and other ownership	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	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	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)
Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Interim Company Secretary	Dudley Integrated Healthcare NHS Trust
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
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 **(Ended 31 December 2023)**	Interim Director of Finance	The Dudley Group NHS Foundation Trust
Ms Lisa Carroll	Chief Nursing Officer	Loyalty Interests	Spouse - Royal College of Paediatrics and Child Health (RCPCH) Officer for Research	RCPCH
Ms Lisa Carroll	Chief Nursing Officer	Loyalty Interests	Spouse - RCPCH Assistant Officer for exams	RCPCH
Ms Lisa Carroll	Chief Nursing Officer	Loyalty Interests	Spouse - Chair of NHS England/Improvement Children and Young	NHSE/I
Ms Lisa Carroll	Chief Nursing Officer	Loyalty Interests	Spouse - Consultant Paediatrician and Clinical Lead for Respiratory Paediatrics at University Hospitals of North Midlands NHS Trust	University Hospitals of North Midlands NHS Trust
Ms Lisa Carroll	Chief Nursing Officer	Loyalty Interests	Spouse - Guardian of Safe Working and Deputy Clinical Tutor UHNM	University Hospitals of North Midlands NHS Trust
Ms Lisa Carroll	Chief Nursing Officer	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	Chief Nursing Officer	Loyalty Interests	Spouse - Director of Medical Education at UHNM (commenced 1st	University Hospitals of North Midlands NHS Trust
Ms Lisa Carroll	Chief Nursing Officer	Loyalty Interests	Spouse - Professor of Child Health	Keele University
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	Member of the Education Focus Group (stood down as Chair)	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 (Ended Nov 23)	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	(Ended December 22) - Company Director Association of Early Pregnancy Units UK Non paying, no profit UK speciality Society for Early Pregnancy. Executive Board Member Secretary Board	Association of Early Pregnancy Units UK
Dr Manjeet Shehmar	Chief Medical Officer	Loyalty Interests	(Ended December 22) - Executive Member Association	Early Pregnancy Units UK
Dr Manjeet Shehmar	Chief Medical Officer	Loyalty Interests	(Ended December 22) - Company Director	Company Director Association of Early Pregnancies Units UK
Dr Manjeet Shehmar	Chief Medical Officer	Outside Employment	Private Practice	Little Aston Hospital Spire
Dr Manjeet Shehmar	Chief Medical Officer	Loyalty Interests (non-remunerated)	First Aid Provision	RSSB Spiritual Organisation
Ms Mary Martin	Non-Executive Director	Outside Employment	Trustee/Director, Non Executive Member of the Board for the	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
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 (Ended)	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
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Founder/Director (Unpaid Association)	BANMA - British Arab Nursing & Midwifery Association
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
Ms Sally Evans	Group Director of Communications	Outside Employment	Group Director of Communications and Stakeholder Engagement	Royal Wolverhampton NHS Trust
Ms Sally Rowe	Associate Non-Executive Director	Outside Employment	Independent chair, Birmingham Council Children's Services Improvement Board	Birmingham City Council
Ms Sally Rowe	Associate Non-Executive Director	Outside Employment	Improvement Advisor, Swindon Council Childrens Services	Department of Education, Swindon council
Ms Sally Rowe	Associate Non-Executive Director	Outside Employment	Independent Chair, Peterborough Council Childrens Services Improvement Board	Peterborough City Council
Ms Sally Rowe	Associate Non-Executive Director	Outside Employment	Keeping Bristol Safe Partnership Independent Chair and	Peterborough City Council
Ms Sally Rowe	Associate Non-Executive Director	Loyalty Interests (Ended 1 September 2023	Executive Director Children’s Services (Ended)	Walsall MBC
Ms Sally Rowe	Associate Non-Executive Director	Loyalty Interests (Ended 1 September 2023	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 Simon Evans	Group Chief Strategy Officer	Outside Employment	Governor (unpaid)	City of Wolverhampton College
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	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
Mr Alan Duffell	Group Chief People Officer	Outside Employment	Provider Collaborative HR & OD Lead	Black Country Provider Collaborative
Mr Alan Duffell	Group Chief People Officer	Outside Employment	Member	NHS Employers Policy Board
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	External private employment	Private out-patient consulting for general medical/hypertension and	Wolverhampton Nuffield Hospital
Dr Jonathan Odum	Group Chief Medical Officer	External Role	Chair	Black Country and West Birmingham ICS Clinical Leaders Group
Dr Jonathan Odum	Group Chief Medical Officer	External Association Fellowship	Fellow of the Royal College of Physicians	Royal College of Physicians of London
Mr Daniel Mortiboys	Interim Director of Finance	No interests to declare		
Ms Claire Bond	Interim Director of Operational HR &	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 Fiona Allinson	Associate Non-Executive Director	Loyalty Interests	Son works for Provider	Care Quality Commission
Ms Fiona Allinson	Associate Non-Executive Director	Outside Employment	Trustee	The Shakespeare Hospice
Ms Fiona Allinson	Associate Non-Executive Director	Outside Employment	Inspector	Locala
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 (Ended 7/11/23)	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
Ms Stephanie Cartwright	Group Director of Place	Nil Declaration		
Dr Salman Mirza	Deputy Chief Medical Officer	Loyalty Interests	Sister - Consultant Surgeon - Colorectal	The Royal Wolverhampton NHS Trust
Dr Salman Mirza	Deputy Chief Medical Officer	Loyalty Interests	Sister - Chiropodist	Solihull Hospital
Dr Salman Mirza	Deputy Chief Medical Officer	Loyalty Interests	Member	The Royal College of Surgeons
Dr Salman Mirza	Deputy Chief Medical Officer	Loyalty Interests	Sister-in-Law - GP	GP at Practice in Manchester
Dr Salman Mirza	Deputy Chief Medical Officer	Loyalty Interests	Member	Medical Protection Society
Mr William Roberts	Deputy Chief Operating Officer	Loyalty Interests	Wife is a Vascular Surgery Training Registrar	West Midlands Deanery
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Outside Employment	Professor of Nursing Sciences	Birmingham City University
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Loyalty Interests	Visiting Professor (Unpaid assignment)	Staffordshire University
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Loyalty Interests	Teaching (Fellow)	Higher Education Academy
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Loyalty Interests	Member	Royal College of Nursing
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Shareholdings and other ownership interests	Director	Ann-Marie Cannaby Ltd
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Outside Employment	Principal Clinical Advisor	British Telecom
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Outside Employment (ended)	Honorary Fellow (unpaid assignment)	La Trobe University, Victoria, Australia
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Outside Employment	Member of the Advisory Panel - Volunteer role	Cavell (Charity) Advisory Panel
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Loyalty Interests	Group Chief Nurse Officer	The Royal Wolverhampton NHS Trust

Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Outside Employment	Advisory Board Member	Charkos Global Ltd
Professor Ann-Marie Cannaby (left August 2023)	Deputy Chief Executive/Group Chief	Outside Employment (Unpaid)	Professor of Vice-Chancellor's Health Advisory Board	Coventry University

ENC 4

Walsall Healthcare NHS Trust

MEETING OF THE PUBLIC TRUST BOARD
HELD ON WEDNESDAY 13TH DECEMBER 2023 AT 10.00AM
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Mr P Assinder	Deputy Chair/Non-Executive Director
Prof D Loughton	Group Chief Executive
Mr N Hobbs	Deputy Chief Executive/Chief Operating Officer
Ms S Cartwright	Group Director of Place
Mr K Stringer	Group Chief Financial Officer/ Group Deputy Chief Executive
Mr A Duffell	Group Chief People Officer
Dr J Odum	Group Chief Medical Officer
Mr K Bostock	Group Director of Assurance
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Ms L Carroll	Chief Nursing Officer
Dr M Shehmar	Chief Medical Officer
Ms J Wright	Director of Midwifery, Gynaecology and Sexual Health WCCSS
Prof L Toner	Non-Executive Director
Dr J Parkes	Non-Executive Director
Ms S Rowe	Associate Non-Executive Director
Ms R Barber	Associate Non-Executive Director
Ms O Muflahi	Associate Non-Executive Director
Ms C Bond	Interim Director of Operational HR & OD
Mr M Dodd	Interim Director of Integration
Mr J Hemans	Non-Executive Director
Ms M Martin	Non-Executive Director
Ms D Brathwaite	Non-Executive Director
Ms F Allinson	Associate Non-Executive Director

In Attendance

Mr K Wilshere	Group Company Secretary
Ms J Toor	Senior Operational Coordinator
Ms G Nightingale	Directorate Manager to Group Chief Executive
Dr S Chand	Chief Pharmacist (**In Attendance for Agenda Item 618/23**)
Ms B Oakley	Pharmacy Assistant (**In Attendance for Agenda Item 618/23**)
Ms S Coward	Pharmacy Technician (**In Attendance for Agenda Item 618/23**)
Ms H Teladia	Student Pre-Registration Pharmacy Technician (**In Attendance for Agenda Item 618/23**)
Mr Q Enver	Rotational Pharmacist (**In Attendance for Agenda Item 618/23**)
Mr L Ferris	Head of EPRR
Ms P Boyle	Managing Director of Research and Development RWT & WHT
Ms C Flatt	Matron for Post Registration Education
Mr S Jeewa	Freedom to Speak Up Guardian **(In attendance for Agenda Item 624/23)**

Apologies

Sir D Nicholson	Group Chair
Prof P Vernon	Chair, Walsall Together
Mr S Evans	Group Chief Strategy Officer

617/23	**Chair's Welcome, Apologies and Confirmation of Quorum**
	Mr Assinder welcomed all to the meeting and apologies were received and noted. Mr Assinder confirmed the meeting as quorate.
618/23	**Staff Story – Pharmacy**
	Mr Duffell introduced Dr Chand, Director of Pharmacy and the members of the Pharmacy team at Walsall Healthcare NHS Trust (WHT) who provided a brief description of their roles at the Trust. Mr Enver said that he enjoyed working within the Trust's Pharmacy team and morale within the team was high. He said staffing levels remained a key challenge within the Pharmacy department. Ms Teladia advised that the atmosphere within the Pharmacy team was friendly and encouraging. She said that student pharmacists were

	often exposed to the same pressures as qualified technicians and this could impact learning. Dr Chand reported that the Trust continued to face problems with recruitment and staffing within the Pharmacy team, however, the Trust had reduced the pharmacist vacancy rate by 50% in 6 months and work would continue to expand all speciality roles within Pharmacy in 2024. She advised that the Trust's Aseptic suite had not met the required standards to produce chemotherapy which had resulted in the Trust using external services and were liaising and building relationships with services with neighbouring Trusts within the Integrated Care Board. Ms Wright thanked the Pharmacy team for their continued hard work across the Trust. She asked if the Pharmacy team felt they received the support they required and what additional support could be offered. Dr Chand reported that Pharmacy now sat firmly within the divisions and staff felt that they had a divisional voice. Ms Rowe asked how the Trust could support the growth of the staff within the Pharmacy team. Dr Chand advised that the Trust had put significant amounts of resource into education and training within the Department and work with the developmental team to ensure that apprentices continued to join the Trust who would receive the relevant training and experience for them to progress within their roles. Ms Rowe asked what had kept the longer serving members of the team working for the Trust. Ms Coward advised that she had worked within the Trust for 15 years and had covered numerous areas and aspects of pharmacy and thoroughly enjoyed her role. She said as the Education and Training Lead technician she continued to share her knowledge and experiences with newer staff members to help development. Ms Brathwaite asked what opportunities were available for the team to make significant changes in the short to medium term. Dr Chand said that she did not see pharmacy services as traditional dispensary and advised that the Trust would continue to move towards patient ward-based dispensing. Ms Muflahi asked what the future looked like for the Trust regarding specialist services in Pharmacy. Dr Chand advised that the Trust did not have a significant number of specialist pharmacists and the Trust continued to allow for pharmacists to develop into specialities. She said that every pharmacist that qualified from 2026 would be a prescriber. Prof Loughton congratulated Dr Chand on her successes within the Pharmacy Team since taking on the role of Chief Pharmacist. Dr Shehmar reported that the Trust had previously been issued with a Section 29 Warning Notice surrounding medicines management. She said the Pharmacy team had been vital in helping the Trust address the concerns that had been raised and the Trust was in a much better position. Mr Duffell thanked all the Pharmacy members of staff for taking the time to present their views and stories with Trust Board members. **Resolved: that the Staff Story – Pharmacy be received for information and assurance.**
619/23	**Register of Declarations of Interest**
	Mr Assinder advised that no further declarations of interest had been received which were not already included within the register provided. **Resolved: that the Register of Declarations of Interest be received and noted.**
620/23	**Minutes of the Previous Meeting held 11 October 2023**
	Mr Assinder confirmed the minutes of the meeting held on 11 October 2023 were approved as an accurate record. Ms Cartwright advised that following the Trust Board Meeting 11 October 23 the patient story of Taylor Griffiths was shared with the Walsall Together partnership to ensure it reached a wider connection of partners. **Resolved: that the minutes of the Previous Meeting held 11 October 2023 be received and APPROVED.**
621/23	**Action Log and Matters Arising**
	Mr Assinder confirmed that there were no matters arising. Mr Assinder noted the action log and updates were received as follows: **Action 966 – Mr Duffell to provide an update report at the December 23 Board Meeting detailing the results of**

	the deep dive into mandatory training and appraisal rate compliance. Mr Duffell advised that a summary of the deep dive would be presented within his Chief People Officer report. It was agreed that this action be closed. **Action 965 – As discussed at the community midwives staff story, it was agreed that Mr Stringer would liaise with payroll to review whether the fuel tracker needed to be out back in place for staff.** Mr Stringer advised that the Trust had converted to agenda for change rate on 1 April 23 and the Trust tracked the movements in fuel by month cumulatively to the end of November 23 and staff were better on the national pay rate than a local fuel tracker. It was agreed that this action be closed. **Action 839 – Dr Shehmar and Mr Stringer to provide an update to the Trust Board on the implementation timeline of Electronic Patient Records.** Mr Stringer advised there had been delays due to national money which for computer development in the NHS being used for other projects. He said the Trust was awaiting confirmation as to whether the money would be reconstituted from the 1 April 24. It was agreed that this action be extended until the Trust Board Meeting 14 February 24. **Resolved: that the updates to the Action Log and Matters Arising be received and noted.**
622/23	**Chair's Report – Verbal**
	Mr Assinder congratulated the Walsall Together Place Based Partnership and Integrated Care team for taking first prize in the Annual Health Service Journal (HSJ) awards. Mr Assinder advised that the Trust had received an accreditation visit on 19 October 23 from Professor Tim Briggs and had since been accredited as an elective hub. He thanked all staff who had been involved with the process and said there had been only 24 accreditations to date across the Country which was a great achievement for Walsall Healthcare NHS Trust. Mr Assinder reported that Prof Loughton had announced his retirement as Group Chief Executive at the end of April 2024. He said work was progressing to recruit a successor with shortlisting scheduled to take place in February 2024. **Resolved: that the Chair's Report – Verbal be received for information and assurance.**
623/23	**Group Chief Executive's Report**
	Prof Loughton reported on the away day which he had attended for speech and language therapy services at Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT). He said the event had demonstrated the strong working relationship between both Trusts and the work that was completed by the team. Prof Loughton reported that he would ensure that medical students continued to receive the best experience possible and would ensure the importance of this was communicated to his successor. He said the changes WHT had made to medical education had been phenomenal and jobs within medicine at WHT were highly recommended. He reported that consultant recruitment within WHT had improved and thanked Ms Carroll for helping to achieve a stable workforce within Nursing. Prof Loughton advised that the Trust mortality rate had continued to decrease and was ranked as 2nd within the Black Country. Prof Loughton reported that he continued to meet with the trade unions twice monthly and Ms Usher and Ms Wilson Joint Staffside Leads at WHT. He said the Trust continued to have a good relationship with trade unions. Prof Loughton advised that he had met with Sir David, Mr Marsha and Mr Cummings to discuss the opportunities of developing hospital at home and embedding it into ambulance control at Dudley Group NHS Foundation Trust to stop patients from being transported. Prof Loughton reported that he met with Ms Bennett the newly appointed chief executive at Walsall Council and had highlighted the benefits of the Walsall Together partnership. Prof Loughton advised that he continued to meet with Members of Parliament regarding the difficult position of NHS funding. He reported on the continued discussions with PA Consulting in relation to financial recovery and

	75% of schemes had been validated. Prof Loughton reported that WHT had an average ambulance offload time of 27 minutes and the Trust continued to be impacted by intelligence conveyancing and concerns continued to grow as other Trusts continued to perform poorly which resulted in divergences to WHT and RWT. Ms Martin asked for assurance ahead of the impending junior doctor strikes in January 2024. Prof Loughton advised that Dr Shehmar and Mr Hobbs would work to ensure adequate cover was provided during this period. Dr Shehmar advised that the Trust would prioritise all emergency urgent care areas to ensure they were covered safely. **Resolved: that the Chief Executive's Report be received for information and assurance.**
624/23	**Freedom to Speak Up (FTSU)**
	Mr Jeewa reported that in 2021/22 there had been a total of 110 concerns raised compared to the 144 concerns raised in 2022/23 and year to date for 2023/24 84 cases. He said up until the end of November 23 there had been 160 cases reported. Mr Jeewa advised that the increase in the number of cases reported related to inappropriate behaviour in civility, bullying and harassment. He said the Freedom to Speak up Team (F2SU) were reviewing data triangulation from numerous sources which included Safeguarding, Patient Advice and Liaison Service (PALS) and Governance and a report would be presented to the People Committee in January 2024. Mr Jeewa advised that the F2SU team had introduced weekly drop-in sessions for staff who were less likely to report cases and these sessions had proved successful. He said these drop-in sessions would continue from January 2024. Mr Jeewa reported that a monthly freedom to speak up stand would cover community. Ms Allinson asked if the Trust was aware of which staff groups were harder to reach. Mr Jeewa reported that the harder to reach areas of staff were senior staff members and Black, Asian and Minority Ethnic (BAME) groups. Mr Duffell reported that Mr Jeewa and F2SU team had begun to raise the profile of FTSU to ensure that staff had access to the services available. He said the F2SU would analyse the number of concerns raised to identify if there were any reoccurring concerns. Mr Hemans reported that ongoing work surrounding the civility programme included the F2SU guardians to ensure concerns were captured and highlighted to the People Committee. Ms Rowe asked that Non-Executive Directors be cited on the outcomes of concerns that had been raised and what actions had been taken to address the concerns and how the outcomes had been communicated back to staff. **ACTION: Future Freedom to Speak Up Reports to include the outcomes of raised concerns and how these are communicated back to wider staff groups.** Dr Shehmar advised that she had met with Mr Jeewa to discuss the Royal College of Surgeons report surrounding the treatment of surgical doctors and trainees in the past. She said the F2SU team were also working through the Women's Alliance Group to ensure the voices of women across the Trust were represented. Ms Muflahi asked if there had been particular challenges for BAME nursing and midwifery staff. Mr Jeewa reported that the nursing and midwifery staff group was the largest staff group who had raised concerns to F2SU related to incivility and inappropriate behaviours. Ms Barber asked how the Trust could be assured that F2SU reached across the whole of the Trust and all staff were aware of the services available. She asked how long it took the Trust to investigate and respond to concerns raised. Mr Jeewa advised that the role of the F2SU team was not to investigate concerns but to support, reassure and listen to staff and gain reassurance from departments regarding the concerns raised, whilst keeping individual cases confidential, and ensure that outcomes would be relayed back to the staff members. Ms Evans advised that the communications team worked closely with the F2SU team to ensure regular communications and promotion of the F2SU services. She said outcomes of cases were shared with staff but details of individual cases remained confidential. Ms Evans reported that she did not believe that all staff within

	the Trust were aware of available F2SU services due to the different channels of communication and how staff received those messages. Ms Brathwaite asked if future reports would identify any substantiated issues regarding bullying and harassment and if the Trust would consider an independent review. Mr Jeewa advised that the F2SU would continue to carry out data triangulation and present findings to the People Committee. Ms Wright thanked Mr Jeewa for the support the F2SU team were offering within Maternity Services. She said a group had been established which consisted of union reps, F2SU and professional midwifery advocates to review the themes that had been reported in Maternity Services. Mr Assinder thanked Mr Jeewa and the F2SU team for all their continuous hard work. **Resolved: that the Freedom to Speak Up report be received for information and assurance**
625/23	**Trust Management Committee – Chair's Report**
	Resolved: that the Trust Management Committee – Chair's Report be received for information and assurance.
626/23	**Improvement and Research Group**
	Prof Toner advised that the Improvement and Research Group would be renamed as the Improvement in Research Group and that the Digital Innovation Group would report through the Technology Digital Infrastructure Group. Prof Toner reported that the Trust had completed the NHS Impact Maturity Matrix and the results had been submitted to NHS England. She said the results had highlighted that the Trust was at a developing stage with the ambition to move the trajectory up. Prof Toner advised that a meeting would be scheduled with Executives and Non-Executives prior to the Trust Board Meeting 14 February 24 to agree the actions and the matrix moving forward. **Resolved that the Improvement and Research Group Report be received for Information and Assurance.**
	EFFECTIVE COLLABORTATION (SECTION HEADING)
627/23	**Board Level Metrics**
	Mr Assinder noted the use of the new performance metrics report and the Statistical Process Control (SPC) charts and advised colleagues of the guides that were available to help interpret the charts. Mr Assinder reported on the ongoing issues surrounding the recruitment of active researchers within the Trust. He highlighted the number of patients utilising the virtual wards across the Trust and said that Ms Cartwright would provide an update on this matter within the Walsall Together Report. **Resolved: that the People and Organisational Development Chair's Report be received for Information and Assurance**
628/23	**Group Chief Strategy Officer Report – Black Country Provider Collaborative Update**
	Resolved: that the Group Chief Strategy Officer Report – Black Country Provider Collaborative Update be received for information and assurance.
	IMPROVE THE HEALTH OF OUR COMMUNITIES (SECTION HEADING)
629/23	**Board Level Metrics**
	Mr Assinder advised that the Board Level Metrics highlighted issues surrounding carbon reduction and the number of medically fit patients who remained within the Trust and were supported by Walsall Together. **Resolved: that the Board Level Metrics be received for information and assurance.**
630/23	**Walsall Together – Chair's Report**
	Ms Cartwright reported that Walsall Together continued to support conversations surrounding the investment and sustainability of Walsall's social prescribing services. Ms Cartwright advised that Walsall Together members would continue to review the patient story that was presented at the October 23 Public Trust Board meeting to investigate the discharge system. Ms Cartwright reported that an event had been held 7 December 23 which brought together all primary care services across Walsall regarding the development of local primary care collaborative and strengthening of engagement within Walsall Together. Ms Cartwright advised that Walsall Together had been crowned winners of the Health Service Journal (HSJ) Place-

	Based Partnership and Integrated Care Award. She said this had been a fantastic win for Walsall Together. Ms Cartwright reported that progress continued to be made with the transformation programme but a number of projects had faced obstacles due to reductions in funding. Ms Cartwright advised that Walsall Together continued to work to increase mental health representation at partnership meetings. Ms Cartwright reported that the delegation of any health inequalities funding decisions would be assigned to the Population Health and Inequalities Steering Group. Mr Assinder noted that Walsall Together continued to be recognised as a National exemplar. Mr Odum asked if the Primary Care Collaborative and the Vehicle Delivery Model that were in development within Walsall Together worked in parallel of each other. Ms Cartwright advised that discussions had taken place for Walsall Together and how primary care was involved in the wider partnership. She said Mr Hobson, Chair of the Black Country Primary Care Collaborative had delivered a specific session on the development of the Black Country Primary Care Collaborative which had continued to strengthen. **Resolved: that the Walsall Together – Chair's Report be received for information and assurance.**
631/23	**Group Director of Place Report**
	Ms Cartwright reported that the Trust continued to maintain the level of medically stable patients for discharge at an average of 38 patients and that the average length of stay for medically stable patients was 3 days. Ms Cartwright advised that community services had maintained services to support the Trust regarding care navigation and rapid response and integrated front door to avoid hospital admissions and conveyances. She reported that the Healthy Child Program had been extended by Public Health England for 5 years from 1 April 24. Ms Rowe asked if the challenges surrounding the recruitment of health visiting staff had been resolved following the extension of the Healthy Child Program. Ms Cartwright advised that she and Ms Carroll had worked closely with ICB and Walsall Council and that the cabinet recognised the challenges the service was under and the significant improvements that had been made over the last 18 months. She advised that it was a difficult service to recruit to nationally and locally and the Trust would continue to support the team with the risks being managed at a partnership level. **ACTION: Ms Cartwright to include within future Director of Place Reports an update surrounding the ongoing challenges of recruitment of health visiting staff.** Ms Cartwright reported on the virtual ward summit held on 24 November 23 to encourage wider usage of the service. Ms Barber reported that it would be useful for Board Members to be aware of patient and family feedback of the Virtual Wards. Ms Cartwright advised that patient feedback was presented at the virtual ward summit and many patient quotes had detailed their appreciation of being able to be cared for at home. She said the Trust would continue to increase the use of the virtual wards and share the good outcomes across the Trust. **ACTION: Ms Cartwright to include within future Director of Place Reports the actions underway to ensure fuller utilisation of Virtual Wards.** Ms Allinson asked how the Trust targeted areas that were not utilising virtual wards and asked if the Trust was developing plans to reduce capacity to align closely with demand. Ms Cartwright reported that the Trust had adjusted staffing in relation to capacity levels to ensure a flexible model that was able to spread teams across other services within the community. She said the intention remained to increase the usage of the virtual wards. Ms Cartwright reported that the Trust continued to work closely with Integrated Care Board (ICB) colleagues on the development of the System Operating Model Ms Cartwright advised that work surrounding intermediate care services had highlighted a predicted overspend and work was continuing with ICB colleagues to maintain and manage the system. Ms Brathwaite asked if a timescale had been set for the ongoing conversations with the ICB regarding funding for

	intermediate care services and if this would increase the funding deficit for the remainder of 2023/24. Ms Cartwright reported that the ICB had recognised that to pull the service back into financial balance would require a significant reduction in services which would impact the quality of care and said that this was something they had not been prepared to agree on. She said she would provide an update to the Board once the issue had been resolved as conversations were ongoing weekly. Prof Toner highlighted the concerns surrounding the roles of social prescribers, health and well-being practitioners and care coordinators as these roles were featured within the NHS long term workforce plan with no national agreement to the salary scales. She said there needed to be a degree of consistency to help retain staff. **Resolved: that the Group Director of Place report be received for information and assurance.**
	The Board Convened for a 10-minute break at 11:17AM.
	EXCEL IN THE DELIVERY OF CARE (SECTION HEADING)
632/23	**Board Level Metrics (including Chair's Reports from Finance and Productivity Committee, Quality Committee and Audit Committee)**
	Resolved: that the Board Metrics report be received and noted.
633/23	**Finance and Productivity Committee, Chair's Report**
	Mr Assinder reported on the Finance and Productivity Committee's principal concerns which related to the long-term financial sustainability of the Trust, cash and working capital and capital spending programmes. Mr Assinder advised that due to the pressure on finances across the NHS there were concerns surrounding the Trust's long-term financial sustainability, in year position and the underlying position of the Trust. He said negotiations for 2024/25 contract were underway. Mr Assinder reported that the Trust had begun to receive external cash support in the final quarter of 2023/24 to aid concerns surrounding cash and working capital. He said the sustainability of the Trust's cash flow needed to be modelled carefully as plans progressed for 2024/25. Mr Assinder advised that the Trust had made great inroads into the capital development of old ward areas and theatre stock. He said this could come to a potential halt if the Trust was to run out of capital. **Resolved: that the Finance and Productivity Committee, Chair's Report be received for information and assurance.**
634/23	**Quality Committee, Chair's Report**
	Dr Parkes reported that the Equality Diversity and Inclusivity (EDI) post had been unfunded in Maternity Services for 4 months and work was ongoing to identify possible funding. Ms Carroll advised that the EDI midwife post had been discussed at the Black Country Chief Nursing Officers (CNO) meeting where Ms Roberts, Chair of the Local Maternity and Neonatal System Operational Board had raised concerns about the unfunded post. She said the Trust was awaiting confirmation that the posts could be funded moving forward. Dr Parkes advised that a Respiratory Support Unit (RSU) business case had been submitted to the Integrated Care Board (ICB). He said the Trust was the only Trust in the area without an RSU. Dr Parkes reported that venous thromboembolism (VTE) compliance remained below target at 90.31%. Dr Parkes advised that Level 3 children's and adult's safeguarding training could now be completed online alongside a joint training package with The Royal Wolverhampton NHS Trust (RWT) but compliance remained below target. Dr Parkes reported that there had been an increase in *C-Difficile* cases of which some had been deemed unavoidable. He said some cases had been deemed avoidable from an antibiotic point of view. **Resolved: that the Quality Committee, Chair's Report be received for information and assurance.**
635/23	**Audit Committee, Chair's Report**
	Ms Martin advised that the internal audit programme continued to make good progress. She said that a review on how to resolve suggestions on management actions had taken place and noted that the Trust's use of paper

	records was of concern as it was time and people intensive. Ms Martin reported that the Trust had a fantastic digital programme ready for implementation, however the Trust needed to find the resources to fund it. **Resolved: that the Audit Committee, Chair's Report be received for information and assurance.**
636/23	**Group Chief Financial Officer Report**
	Mr Stringer reported that additional National funding had been made available to Trusts on 8 November to deal with industrial action. He advised that this had followed a letter from NHSE that £800M would be released into services with £200-300M being identified as new money from the Treasury and £500M from National or top sliced budgets. Mr Stringer advised the letter had also provided an update on the elective recovery fund and the national targets. Mr Stringer advised that Systems and Trusts had been asked to complete a revised forecast year end by 22 November 23 and a meeting had been held with the National team, regional team and Integrated Care Board (ICB) on 6 December 23. He said the NHS was challenged nationally and that all ICBs were not achieving their original plan. Mr Stringer reported that the Black Country's ICB deficit plan was £69M in April 2023 and from 4 December 23 the ICB was short of that by £20M following a discussion on the capital to revenue issue which had been refused. Mr Stringer reported on discussions between the Trust and National and regional teams about their forecast year end and said that they Trust were being challenged on a number of issues. Mr Stringer advised that the work around the financial plan for 2024/25 continued with PA Consultancy. He said the cash issue would be critical for Trusts as they were trading on a deficit and Walsall Healthcare NHS Trust (WHT) had applied for a quarter 4 cash report. Mr Mortiboys advised that at the end of month 7, the Trust was £9.9M off the revised plan. He said the key drivers of this were rising inflation, industrial action, shortfall in cost improvement programme (CIP) and the demand pressures increasing the need for staff and non-pay. Mr Mortiboys reported that the Trust had submitted an application for cash support in quarter 4 by the deadline of 1 December 23. He said this had been received and the Trust was yet to receive confirmation of a potential date for cash support as several Trusts and ICBs had requested this. Mr Mortiboys advised that the Trust continued to work with NHS England in relation to the theatre scheme which was a top priority within the Trust. Mr Mortiboys reported that the bottom line had improved in month 8 as expected. He said the deficit of £750K compared to a run rate of £3M was supported by the backdated income that the Trust had received following the settlement. Mr Mortiboys advised that month 8 had seen the lowest spend on temporary medical staffing within the Trust for 2023. He said that due to the increased capacity, nursing temporary costs had increased in November 2023. Ms Muflahi asked if the Trust was confident that vacancies within nursing would improve. Ms Carroll reported that nursing vacancies was under 4% which had increased due to Ward 9 and Ward 14 being substantively funded and recruitment was underway. She said the Trust was still using agency to maintain safety in paediatrics but there were controls in place to monitor bank usage. Ms Martin queried the capital spend due to the various capital projects in progress. She asked for assurance that the Trust was accruing what was required to cover the work that had been done to date and the Trust was on course to spend up to the Trust's approved limits in 2023/24. Mr Mortiboys advised that the Trust had become more robust on the accrual process and the Trust was accruing in line with the development of projects. He said the Trust had a £1.8M spend in month 8 against the £9M ICB funded programme. He said the Trust would aim to deploy all money from the ICB to ensure there was no loss of capital. Mr Mortiboys reported that the Trust was working with the Public Sector Decarbonisation Scheme (PSDS) funder who required grant conditions to be met and procurement were heavily involved with the scheme to ensure as much spend was used by the end of 2023/24. He said that the Trust was unsure what capital it would receive for

	the frontline digitisation in year and once this had been confirmed it would be deployed. Mr Assinder queried the regulatory implications for a £30M deficit and what the Trust could expect to hear from PA Consulting's consultation. Mr Stringer advised that regulatory implications in a normal year would mean a response from NHS England (NHSE) who would take a view of performance of the Trust's financial delivery and the soft rating would be reviewed. He said there was potential for the Trust being added to a risk category, with NHSE overseeing regulatory intervention which could result in a number of requirements being imposed on the Trust Board. Mr Stringer advised that PA Consulting had completed their work on the drivers of the cost issues and these would be shared with subject leads for validation. Ms Barber asked if any of the information surrounding the Trust's current financial performance would be accessible within the public domain and queried the Trust's readiness to respond to queries. Mr Stringer advised that the Trust had shared the financial position and the understanding of key drivers in the public forum and the Trust's communication department would ensure that any articles were appropriately responded to. **Resolved: that the Group Chief Financial Officer Report be received for information and assurance.**
637/23	**Chief Nursing Officer Report**
	Ms Carroll reported that the timeliness of observations for October 2023 was 89% and the Acute Medical Unit (AMU), Emergency Department (ED) and Intensive Care Unit (ICU) remained areas of required focus. She said the Quality team had been working closely with the teams in those areas to improve compliance. Ms Carroll advised that a total of 7 *C-Difficile* cases had been reported in October 2023 of which 2 had been deemed avoidable with antibiotic usage. She said following an external review the Trust had been assured that improvements would be noted by the end of October 2023 following the measures the Trust had in place. Ms Carroll reported benchmarks across the Black County were improving dramatically and the actions the Trust were taking were having the desired impact. Ms Carroll reported that the Trust had received an Integrated Care Board (ICB) review on its' management of patients and *C-Difficile*. She said it had been a positive review and the only areas that had been identified were environmental issues surrounding seals around the toilet and a drain. She said the ICB were assured with the actions the Trust was taking to improve in these areas. Ms Carroll advised that as the Special Education Needs and Disability Team (SEND) Lead for the Trust, she would provide the Board with a SEND update every quarter. Ms Carroll reported that the Trust had received an advanced notification regarding an anticipated request for evidence to assist the Thirlwall Public Inquiry into Neonatal Services. She said the Trust had received 44 different questions that were required to be responded to by the end of December 2023 and that Dr Shehmar and Mr Hobbs were leading on this response. Prof Toner advised that one of the changes that had arisen from the Thirlwall Public Inquiry, would now allow policemen to be in attendance at Trusts to observe the taking of samples by the Coroner and said that this could be traumatic for staff. Ms Carroll reported that Neonatal services would be under scrutiny and the Trust was ensuring that staff and families were supported. Ms Muflahi reported that she had conducted a recent walkabout of Neonatal Services alongside Ms Carroll and Ms Wright and had been impressed by staff and medics who were leading on clinical initiatives. **Resolved: that the Chief Nursing Officer Report be received for information and assurance.**
638/23	**Director of Midwifery Report**
	Ms Wright reported that the Trust had one of the best recruited midwifery services in the West Midlands. She said the Trust had a midwifery vacancy of 6.8wte and these posts would be recruited to easily as the Trust's Maternity Services was a desirable place to work. Ms Wright advised that the Maternity Support Worker (MSW) vacancy rate remained at 18.75wte and following a recent recruitment event the Trust had successfully recruited 7 individuals. Ms Wright advised that the Trust had seen a decrease in perinatal mortality rates with a total of 3 cases reported throughout September, October and November 2023. She said the Trust remained at 3.85:1000 which showed

	the Trust as red in the still birth rate chart as it was recorded accumulative and not monthly. Ms Wright reported that the Trust was focused on maternal medicine pathways to ensure that women on complex pathways were receiving the right care and support. Ms Wright reported that the Trust's Equality, Diversity and Inclusion (EDI) midwife had secured transport to enable women to get to appointments who were otherwise unable to due to a lack of finances. She said the Trust had worked with National Express to secure 200 free bus passes. Ms Cartwright applauded the work Ms Wright and the team had completed to secure the 200 free bus passes. Ms Wright advised that the Trust continued to work alongside Warmer Homes West Midlands who offered a range of different initiatives to support individuals. She reported that the Trust had received a visit from Ms Brinkworth Chief Midwifery Officer (CMO) for England to review their work around inequalities and which would now be included within the next CMO bulletin. Mr Assinder congratulated Maternity Services on this achievement. Ms Wright reported that the Saving Babies Lives Care Bundle had been released in June 2023 and had met National compliance. She said the Trust had been rated as the best performing Trust in the Black Country for this initiative. Ms Wright advised that the Trust was supporting The Royal Wolverhampton NHS Trust (RWT) Maternity Services to repatriate the births that RWT had supported Walsall Healthcare NHS Trust (WHT) with in 2017. Mr Hemans asked if the Trust would enquire with patients if they had gas boilers present in their homes and if these were serviced regularly as part of the Carbon Monoxide (CO) monitoring of pregnant ladies. He asked if the Trust could engage in publicity with Walsall Together and Walsall Council to raise awareness of carbon monoxide testing. Ms Wright advised that patients who had large CO monitoring readings at appointments were informed on the importance of checking gas appliances. Prof Toner asked if discussions had taken place regarding the proposed changes in neonatal leadership across the Black Country. Ms Wright advised that the Trust worked closely with the NHS Divisional Director of Nursing. She said the Trust had started the Quadrant Front National Perinatal Training which would bring services closer together. Prof Toner reported that Ms H Hurst, Chief Midwifery Officer for the Black Country had organised a meeting with key people across the Black Country to discuss workforce requirements. Ms Wright advised that the Black Country Midwife group had been formed to review the services system-wide across the 4 providers to see what support could be offered to further strengthen the services. Ms Carroll reported that Ms Hurst was reviewing the possibility of setting up a neonatal network to ensure an aligned approach across the Black Country. Ms Muflahi noted the several great initiatives happening within the Trust's Maternity and Neonatal services and said this was indicative of the leadership by Ms Wright. She asked if the international midwifes could provide a staff story to future Board meetings as they provided a plethora of skills to the Trust. Mr Assinder thanked Ms Muflahi for all the support she provided to the Trust as the lead Associate Non-executive Director for Maternity Services. **ACTION: Ms Wright to arrange for the internationally educated midwives to attend a future Trust Board Meeting to discuss their roles and journey with Trust Board Members.** **Resolved: that the Director of Midwifery Report be received for information and assurance.**
639/23	**Chief Medical Officer Report by Exception**
	Dr Shehmar advised that the medical agency spend had reduced significantly and the Trust now had a better understanding of its' locum spend. She said the areas that still required locum spend were areas with associated clinical risk, reducing the locums in paediatrics, acute medical wards and acute surgery on call services which required substantive staff. She reported that she chaired a group who met monthly to ensure oversight of all temporary spend and the recruitment strategy. Dr Shehmar reported that there were 3 Medical Training Initiative (MTI) doctors who had joined the Trust through the fellowship surgery post. She said the doctors were recruited in line with the Academy of Royal

	Colleges processes paralleled with their terms and conditions. Dr Shehmar advised that the pharmacy establishment business case had been approved in principle subject to funding and that in the meantime the pharmacy team were depended on temporary pharmacists to keep the service functioning. She said there was high temporary spend within pharmacy and the Trust would continue to support the workforce. Mr Assinder thanked Dr Shehmar for her leadership within pharmacy and the support she provided to colleagues. **Resolved: that the Chief Medical Officer Report by Exception be received for information and assurance.**
640/23	**Learning From Deaths Report**
	Dr Shehmar reported that the Trust's Summary Hospital-level Mortality Indicator (SHMI) value for the 12-month rolling period was 0.9906 which was within the expected range. Dr Shehmar advised that Quarter 2 was reviewing 1.3% of all cases which would progress to a secondary review in line with the Trust's governance process to identify if any concerns or lessons were learned. Dr Shehmar advised that the Trust reviewed all deaths of patients with learning difficulties through the National Learning Disability Mortality Review (LeDer) process. She said the learning from these deaths took longer to be received and the Trust was still awaiting learning from the 5 deaths that had been reported. Dr Shehmar reported that all deaths had been reviewed by the Medical Examiner and immediate lessons had been shared. Dr Shehmar reported that from April 2024 it would be mandatory to expand the Medical Examiner service across the community. She said the Trust was working with General Practice (GP) colleagues and 62% of GPs were signed up to the process. Dr Shehmar advised that within the Walsall Region there had been a higher than expected number of deaths from respiratory causes such as chronic obstructive pulmonary disease and bronchiectasis. She said the Trust had reviewed the pathways to address any actions and lessons learnt. Dr Shehmar reported that the Trust had focused on a prevention team to ensure that patients who were not able to self-care received the right support to reduce their risk of hospital acquired pneumonia and aspiration. Dr Shehmar reported that the Trust was the only acute trust within the Black Country that did not have a respiratory support unit. She said this was a service that required commissioning and had been approved and endorsed in principle by the Trust's endorsement group and the Integrated Care System (ICS) Strategic Committee. Dr Shehmar advised that the Trust hoped the case would be put through as a priority in the next round of. Dr Odum advised that the lack of a respiratory support unit within the Trust was of great concern and needed to be resolved as without the service it would impact critical care services. Ms Allinson advised that whilst the Trust was awaiting the funding for the Respiratory Hub, it needed to encourage patients towards the respiratory virtual ward as capacity was very low. Dr Shehmar advised that in line with the Thirlwall Inquiry the Trust's perinatal mortality and still birth rates had been reported quarterly to the Trust's Mortality Review group for scrutiny. She said there had been an increase in the trends for perinatal mortality and stillbirth rates and the Trust would investigate negative trends as they were highlighted. Dr Shehmar reported that the Trust needed to review what, within the Walsall population, had caused the mortality rates to increase in the specific reported time frames. She advised that a recent report had highlighted a correlation between still birth rates and the cost of living crisis and the Trust needed to ensure the correct balance between the different pathways. She said that she had queried if the Trust had too many virtual antenatal clinics operating which did not allow clinicians the same opportunities to recognise the same safeguarding concerns in person as opposed to virtually. She said there was a high number of Did Not Attend (DNA) rates for virtual appointments and the Trust would review the whole antenatal care package to ensure there were enough face to face touch points. Ms Wright advised that continuity in antenatal care was a national drive as it was easier for clinicians to identify soft makers if they reviewed the same patient at every maternity appointment. Dr Shehmar reported that the Trust had established a pre pregnancy counselling clinic to review concerns around

	hypertension and diabetes. She advised that the Trust had developed a new app to ensure that the Trust had a higher number of patients who were booking below 10 weeks which was imperative in the intervention of reducing perinatal mortality and still birth rates for pre-eclampsia in later pregnancy. Dr Shehmar reported that the Trust had begun to see the clinical outcomes of the focus work surrounding colorectal cancer. She said the Trust's mortality rates and unplanned return to theatre rates had begun to decrease. Ms Rowe asked if the Trust could work closely with Walsall Together to help work with people within the communities to prevent deaths. **Resolved: that the Chief Medical Officer Report by Exception be received for information and assurance.**
641/23	**Group Director of Assurance Report – Verbal Update**
	Mr Bostock advised that the Trust was required to report on the Covid-19 National Inquiry. He said the Trust was subject to Module 3, the acute care module which had been paused until Module 2, the political decision making module went ahead in spring 2024. Mr Bostock reported that the Annual Health and Safety Report for 2022/23 was attached for information and advised that the Trust had received an inspection from NHS England surrounding sharps following which the Trust had received a contravention notice in January 2023 which had been actioned and closed in April 2023. Mr Bostock advised that the Trust had launched the beginnings of the implementation of the Patient Safety Incidents and Response Framework to replace the NHS England 2015 Serious Incident Framework as of 1 November 23. **Resolved: that the Group Director of Assurance Report – Verbal Update be received for information and assurance.**
642/23	**Chief Operating Officer Report**
	Mr Hobbs thanked Ms Webley Director of Operations for Surgery and the wider team for all the extensive preparatory work that had taken place to secure the Getting It Right First Time (GIRFT) Surgical Hub accreditation. He said the Trust's elective waiting list was incrementally decreasing against a national backdrop of steadily increasing patients awaiting elective care. Mr Hobbs advised that the Trust was within the upper quartile nationally for performance against the 62-day cancer General Practitioner (GP) referral to treatment standard. Mr Hobbs reported on the ongoing challenges the Trust had faced entering the winter period and highlighted that in October 2023 the Trust had noted the highest month of type 1 Emergency Department (ED) attendances on record. He said November 2023 had seen the highest number of intelligently conveyed ambulances to Walsall from other boroughs on record. Mr Hobbs advised that during the upcoming period of industrial action the clinical prioritisation of urgent and emergency care services would be maintained, which would unfortunately require further postponement of outpatient and elective surgical procedures. **Resolved: that the Chief Operating Officer Report be received for information and assurance.**
643/23	**Emergency Preparedness Self-Assessment Core Standards Report**
	Mr Hobbs advised that the Emergency Preparedness Self-Assessment Core Standards Report (EPRR) had been reviewed by the Finance and Productivity and Audit Committees and requested that the Board review and approve the post moderation self-assessment of non-compliance for the Trust. Mr Hobbs reported that the moderation process had included 2 levels of moderation and following the Trust's own self-assessment the Trust had received Integrated Care Board (ICB) moderation and NHS England Midlands regional level moderation. He said the Trust had initially self-assessed as partially compliant and as a result of NHS England's further scrutiny and moderation the Trust had ended up within the bracket of non-compliant. Mr Hobbs advised that there had been several contributory key factors and the level of evidence required to demonstrate compliance had become more strenuous which had resulted in some of the Trust's core standards becoming non-compliant.

	Mr Hobbs reported that the 4 key theme areas that the Trust need to strengthen were to ensure that the Trust's Major Incident Plan reflected the Trust's new arrangements with the newly opened Urgent and Emergency Care Centre, the non-compliance of the Trust's Data Protection and Security Toolkit had ultimately affected the EPRR core standards, ensure the strengthening of business continuity management arrangements particularly surrounding the monitoring processes and being able to demonstrate the assurance of those arrangements, and to ensure that the Trust's Chemical, Biological, Radiological and Nuclear Defence (CBRN) arrangements were resilient 24/7, 365 days a year within the Emergency Department and Ambulance Service. Mr Hobbs advised that Mr Ferris had joined the Trust as the Head of EPRR and he was confident that this substantive appointment would put the Trust in a stronger EPPR position for 2024. Mr Assinder welcomed Mr Ferris to the Trust. **Resolved: that the Emergency Preparedness Self-Assessment Core Standards Report be received and APPROVED.**
	SUPPORT OUR COLLEAGUES (SECTION HEADING)
644/23	**Board Level Metrics (Including Chair's Report from People Committee)**
	Mr Hemans advised that the Trust had commissioned a deep dive into the review of appraisals and would continue to monitor the appraisal process and ensure there were no compromises to increase the trajectory rate for appraisals. Mr Hemans reported that some of the funding that had been available to various work groups across the Black Country had been withdrawn and the Trust would continue to ensure that this would not impact the Trust's planning and being able to resource accordingly. He said the Trust did not want to see any impact on workforce as the Trust moved into a challenging financial year in 2024/25. Mr Hemans advised on the National campaign to review band 2 and band 3 Health Care Assistant (HCA) workers. He said the Trust was working collaboratively with The Royal Wolverhampton NHS Trust (RWT) to review the figures when available to understand what impact this would have on staffing from a financial point of view. **Resolved: that the Board Level Metrics (Including Chair's Report from People Committee) be received for information and assurance.**
645/23	**Group Chief People Officer Report**
	Mr Duffell reported that of the Trust's 6 key metrics, the retention and vacancy position showed a strong position. He said that turnover and mandatory training had been highlighted as amber and continued to improve and the 2 areas of concern were sickness absence and appraisals. Ms Bond reported that the Trust had conducted a deep dive into appraisals as commissioned by the People Committee. She said there was tight monitoring of the 4 clinical divisions through divisional performance reviews with divisions who had not performed receiving an escalated review to look at their trajectories. Ms Bond advised that the deep dive had highlighted a lack of progress within corporate areas and estates facilities. Ms Bond reported that the Trust was unable to provide assurance that the 90% target would be hit in 2023/24 and the Trust's current appraisal target rate was 79%. She said that as the escalation process continued there was assurance that the Trust would continue to increase to the 90% target. Mr Duffell reported that the British Medical Association had advised that a pay increase offer would be presented to Consultants and that they were reasonably comfortable that the offer would be accepted. He said that relationships had further broken down in relation to negotiations with the Government and junior doctors, who had a current mandate until mid-February 2024, following which any further industrial action after that date would require a further mandate. Mr Hobbs advised that due to industrial action, weekend days and bank holidays between the period of Wednesday 20 December 23 to Wednesday 3 January 24 (15 day), only 3 of these would be normal working days.

	He said this was the most challenging operational period of the year due to peak winter pressures and the Trust would take the relevant measures to mitigate risk during that period. Ms Muflahi noted that there were 26 open disciplinary cases and asked if the breakdown in banding professional ethnicity could be shared with Board members. Ms Bond advised that every quarter a detailed report around all aspects of employment relations was presented to the People Committee and this provided a breakdown of demographics, ethnicity, age and banding. Ms Bond reported that the final staff survey response results had been received and the Trust had a confirmed response rate of just over 46% which was just below the 47% the Trust had received in 2022. Ms Bond advised that Walsall Healthcare NHS Trust (WHT) had the highest response rate of the four acute Trusts within the Black Country and this was a reflection of the hard work and active leadership support from Board Members and Senior leaders in the Trust. Mr Hobbs congratulated Ms Bond and fellow leaders across the Trust for the strong response rate against what had been a challenging year with industrial action which may have affected NHS colleagues across the Country not wanting to participate in staff surveys. **Resolved: that the Group Chief People Officer Report by Exception be received for information and assurance.**
646/23	**Off Framework Agency**
	Mr Duffell advised that the Off Framework Agency paper was a part of a national ask that had come out to all provider organisations in relation to the 3 key areas, which were reducing the Trust's agency spend, the Trust remaining with the price cap, and ensuring the Trust eliminated and reduced Off Framework agency. Mr Duffell reported that the Trust predominately used agency staff to ensure services remained safe, activity was increased and reduce backlogs that had built up as result of industrial action. He advised that the Trust had been required to respond to range of questions by 31 October 23. He said the Trust had responded and met the requirements. Mr Duffell reported that a key area within the report detailed that the Trust did not exceed 3.7% of the total pay bill and the Trust had been recorded at 3.4%. He advised that part of the National ask required Trust Boards to receive a regular review of the Trust's position in relation to Off Framework Agency spend. He said the intention would be to present the Board with a public overview of where the Trust was against trajectory to reduce agency spend, at future Trust Board meetings. Mr Duffell advised that the Trust had been required to deliver against various actions and since the report had been produced, actions 1, 5 and 6 had been. He said action 4 was in progress as the intention was to delegate the executive group to make decisions on the escalation progress. Mr Duffell reported that the new escalation process had received executive sign off. Mr Assinder congratulated Mr Hobbs on the appointment as the Lead Director responsible for agency override. **Resolved: that the Off Framework Agency Report be received for information and assurance.**
647/23	**Any Other Business**
	Mr Loughton thanked Ms Wilson Joint Staffside Lead who was retiring from her post within the Trust. He thanked her for all her work at the Trust and said that she had been instrumental in helping create a working partnership relationship with trade unions. Mr Assinder said that Ms Wilson would be greatly missed. **Resolved: that Any Other Business be received and noted.**
648/23	**Resolution**
	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.**
649/23	**Date and Time of Next Meeting: Wednesday 14 February 2024**
	Mr Assinder confirmed the date and time of the next meeting as Wednesday 14 February 24. He wished colleagues a Merry Christmas and peaceful 2024.

ENC 5

Walsall Healthcare
NHS Trust
30 January 2024 08:24

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board Meeting to be held in Public 13/12/2023 7.2 PACK A: Freedom to Speak Up				
1020.	ACTION: Future Freedom to Speak Up Reports to include the outcomes of raised concerns and how these are communicated back to wider staff groups.	Bond , Clair	14/02/2024	Pending
Trust Board Meeting to be held in Public 13/12/2023 9.3 PACK A: Group Director of Place Report				
1018.	ACTION: Ms Cartwright to include within future Director of Place Reports an update surrounding the ongoing challenges of recruitment of Health Visiting Staff.	Cartwright , Stephanie	14/02/2024	Completed
	Explanation Cartwright , Stephanie Group Director of Place report has been updated to include the ongoing challenges associated with recruitment to the Health Visiting Team.			
1019.	ACTION: Ms Cartwright to include within future Director of Place Reports the actions underway to ensure fuller utilisation of Virtual Wards.	Cartwright , Stephanie	14/02/2024	Completed
	Explanation Cartwright , Stephanie The Group Director of Place report has been updated to include actions underway to increase usage of virtual wards.			
Trust Board Meeting to be held in Public 07/06/2023 12.2 7 Day Audit				
839.	Minute Ref - 547/23 _Dr Shehmar and Mr Stringer to provide an update to the Trust Board on the implementation timeline of Electronic Patient Records	Shehmar, Manjeet Stringer , Kevin	14/02/2024	Pending

	Explanation action item Mr Stringer advised there had been delays due to national money which for computer development in the NHS being used for other projects. He said the Trust was awaiting confirmation as to whether the money would be reconstituted from the 1 April 24. It was agreed that this action be extended until the Trust Board Meeting 14 February 24.			
Trust Board Meeting to be held in Public 13/12/2023 10.5 PACK A: Director of Midwifery Report				
1021.	ACTION: Ms Wright to arrange for the internationally educated midwives to attend a future Trust Board Meeting to discuss their roles and journey with Trust Board Members.	Wright, Jo	14/02/2024	Completed
	Explanation action item It has been agreed with Ms Wright for the internationally educated midwives to attend the Trust Board meeting to be held in September 2024.			
Trust Board Meeting to be held in Public 2023/24 11/10/2023 9.1 Pack A. People Committee - Chair's Report				
966.	Min ref: 598/23: Mr Duffell to provide an update report at the December 23 Board Meeting detailing the results of the deep dive into mandatory training and appraisal rate compliance.	Duffell, Alan	13/12/2023	Completed
	Explanation action item Mr Duffell advised that a summary of the deep dive would be presented within his Chief People Officer report. It was agreed that this action be closed.			
	Explanation Duffell, Alan Addressed within the public board meeting of the 13 Dec 2023			

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public on 14 February 2024		
Title of Report:	Chief Executive's Report	Enc No: 7
Author:	Gayle Nightingale, Directorate Manager to the Group Chief Executive	
Presenter/Exec Lead:	Prof David Loughton CBE, Group Chief Executive	

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

Recommendations:

The Board is asked to note the contents of the report.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☒ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	Risk Description: None Is Risk on Risk Register: Yes☐No☒ Risk Score (if applicable):		
Resource Implications:	Revenue: None Capital: None Workforce: None Funding Source: None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Well-led
	NHSE	Yes☐No☒	Details:
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☒No☐	Accountability through local influence and scrutiny
	Other	Yes☐No☒	Details:
CQC Domains	**Responsive: Well-led:**		

NHS
Walsall Healthcare
NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert
Assure Assurance relating to the appropriate activity of the Group Chief Executive Officer.
Advise None in this report.
Alert None this report.

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

Walsall Healthcare NHS Trust

Chief Executive's Report

Report to Trust Board Meeting to be held in Public on 14 February 2024

EXECUTIVE SUMMARY

This report indicates my involvement in local, regional and national meetings of significance and interest to the Board.

BACKGROUND INFORMATION

As follows.

RECOMMENDATIONS

To note the 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: **General Medicine and Upper Gastro-intestinal (GI)** Dr Muhammad Ali **Ear, Nose and Throat (ENT)** Dr Ramanathan Swaminathan
3.0	**Policies and Strategies**
	Policies for January 2024 • Policies, Procedures and Guidelines - Quarter 8 and 9 Report • IP1010 V6 – Blood Borne Virus (BBVss) Policy • IP011 V5 – Administration of Infection Prevention and Control within Walsall Healthcare NHS Trust Policy • IP012 V6 – Infection Prevention and Control Procedures for Deceased Patients Policy • OP1006 V1 – Non-medical Authorisation of Blood Components Policy • V8 – Covid 19 Vaccination Recipient Pre-screening and Consent Form 2023/24 • V4 – Management of Hyperkalaemia Guideline • V1 – Preparation and Administration of Spikevax XBB 1.5ml Syringes for Administration – Trust-wide Standard Operating Procedure
4.0	**Visits and Events**
	• Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • 20 November 2023 – chaired the inaugural Joint RWT and WHT Partnership Forum (HR) • 21 November 2023 - undertook a joint WHT and RWT Non-Executive Directors (NEDs) briefing

	• 27 November 2023 – participated in the National Institute of Healthcare Research (NIHR) Operations Director interviews • 28 November 2023 - met virtually with PA Consulting as part of the Black Country Integrated Care Board (ICB) Financial Improvement programme and attended a Research Thank you event • 4 December 2023 – filmed a Podcast for 'Voices of Care' for New Cross Healthcare Solutions • 5 December 2023 – participated in a virtual Black Country Integrated Care System (ICS), Provider Chief Executives meeting • 6 December 2023 – participated in a national and ICB financial planning meeting • 7 December 2023 – undertook a site visit for Emma Bennett, Chief Executive – Walsall Council as part of her induction programme and participated in a virtual Social Care and Health Overview and Scrutiny Committee • 13 December 2023 - met virtually with Mark Axcel, Chief Executive (ICS) and participated in a virtual ICS Productivity and Value Group meeting • 14 December 2023 – undertook a site visit of Modular Building – wards 1 to 4 and chaired a virtual Joint WHT and RWT staff briefing • 15 December 2023 - participated in a Joint RWT and WHT Board Development workshop and attended a Celebration event to mark the 100 orthopaedic case using the Mako Robot • 18 December 2023 – participated in a virtual national NHS Leadership event with Amanda Pritchard, Chief Executive (NHSE) • 19 December 2023 - undertook a joint RWT and WHT Non-Executive Directors (NEDs) briefing and virtually met with Kerrie Allward, Executive Director for Adult Social Care, Public Health and Hub, Walsall Council • 21 December 2023 - participated in a Joint Negotiating Committee (JNC) • 22 December 2023 - virtually met with Wendy Morton MP and Eddie Hughes MP • 2 January 2024 - met virtually with PA Consulting as part of the Black Country Integrated Care Board (ICB) Financial Improvement programme • 9 January 2024 – participated in a Joint WHT and RWT Board Development session • 11 January 2024 – participated in a virtual Local Negotiating Committee (LNC) • 12 January 2024 - participated in the virtual Black Country Joint Provider Committee • 16 January 2024 - undertook a joint virtual WHT and RWT Non-Executive Directors (NEDs) briefing and participated in a virtual ICB and Trust Chief Executives meeting • 17 January 2024 – participated in a virtual Black Country ICS System Review meeting with NHS England (NHSE) and attended a Walsall Proud Partnership meeting • 19 January 2024 - virtually met with Kerrie Allward, Executive Director for Adult Social Care, Public Health and Hub, Walsall Council, virtually met with Wendy Morton MP and Eddie Hughes MP and chaired the Joint WHT and RWT Partnership Forum (HR)
5.0	**Board Matters**
	There are no Board Matters to report on this month.

NHS
Walsall Healthcare
NHS Trust

Report for Public Trust Board – to be held in Public 14 February 2024		
Title of Report:	Freedom to Speak Up Quarter 3 Board Report	Enc No: 7.1
Author:	Sol Jeewa Tel 01922 721172 Ext 3066 suleman.jeewa@nhs.net	
Exec Lead:	Professor David Loughton, Group Chief Executive	
Presenter:	Sol Jeewa, Freedom to Speak Up Guardian	

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

Recommendations:

The Board is asked to note the report and continue to support the F2SU service to:

- Embedding Speaking Up as routine day-to-day practice.
- Ensure concerns are heard and responded to, supporting the guardians to seek the assurance that is required.
- Encourage Senior Leadership Team/ Executives and Non-Executives to complete F2SU *Follow Up* Training.
- Work towards Freedom to Speak Up Training to be provided as core training, as per the NGO guidance. https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/
- Undertake regular walk arounds by F2SU and Executives/ Non- Executives in underrepresented areas, to raise awareness of the service and how to speak up.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: 2489 *Trust-wide: Risk of staff not feeling safe and protected at work, due to potentially experiencing, bullying, discrimination and/or harassment in the workplace from members of staff / patients / public, resulting from an adverse impact on staff well-being, recruitment, retention, and performance, ultimately reducing the quality of care experienced by patients.* On Risk Register: Yes☒No☐ Risk Score (if applicable): 12 Moderate (Severity 4 x Likelihood 3)		
Changes to BAF Risk(s) & TRR Risk(s) agreed.	State None if None Risk Description Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	(if none, state 'none') Revenue: Capital: Workforce: Funding Source:		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☒No☐	Details: NHS People Promise
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	Black, Asian or minority ethnic employees often face more barriers than non BAME employees when raising concerns. The Freedom to Speak Up Guardians are all from a diverse background, it is hoped that colleagues will feel the Guardians may understand the barriers they may face to speaking up and this will encourage them to raise concerns. Currently, there are four FTSU Champion Team Members from three divisions, a recruitment drive is planned over the next month to encourage FTSU champions in each department. The data available is not yet sufficient to reliably determine and evidence equality and diversity impacts. This is being addressed through collecting concerns electronically through the incident reporting system, Safeguard and work being undertaken by the Equality, Diversity, and Inclusion Committee.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: People Committee 29.01.24
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- The Board can be assured that the F2SU service continues to operate in accordance with the National Guardian's Office and provides a safe space for colleagues to speak up about anything that concerns they may have.
- The F2SU ensures that data related to the key demographics of those raising concerns is recorded to understand key themes and where barriers may be encountered.
-

Advise

- The FTSU service supports colleagues to escalate patient and staff safety concerns which when appropriately addressed contribute to establishing a culture of openness and safety.
- This report provides an analysis of the number of concerns generated through Freedom to Speak Up from April 1st, 2023 – December 31st, 2023.
    - Within Q1 (April, May, and June 2023) 38 concerns were raised.
    - Within Q2 (July, August, and September 2023) 46 concerns were raised.
    - Within Q3 (October, November, and December 2023) 87 concerns were raised.
- F2SU data identifies that concerns raised by colleagues from a BAME background represent 42% in Q1 and 52% in Q2 and 17% in Q3 of the total concerns. This is an overall increase of colleagues from a BAME background raising concerns though the F2SU route.
- F2SU Training (as set by the National Guardians Office) is available for all colleagues to access via My Academy Walsall. As at the end of December 2023, 35.98% of all staff have completed the 'Speak Up' Training and 26% of all colleagues responsible for the line management of staff. See appendix 1.

Alert

- There is an inconsistency in the application of the Trust values which means in different ways and for different reasons some unacceptable behaviours and poor working practices have developed across the different services, which causes some staff to feel isolated, discriminated against, unsafe and undervalued.
- Over the last three years there has been a continual increase in the number of concerns raised to the F2SU. In 2021/22 a total of 110 concerns were raised compared to 144 concerns in 2022/23. Year to date for 2023/24 171 concerns have been raised.
- There has been an increase in the number of cases reported to relate to negative behaviours, bullying and harassment from 35% in 2021/22 to 48% in 2022/23. Of the 171 cases raised in Q1, Q2 and Q3 of 2023/23, 60% are related to negative behaviours, bullying and harassment. It is anticipated the numbers will higher by the end of Q4 March 2024.
- PALS complaints relating to staff attitude and inappropriate behaviours:

- April 2023 to October 2023 47 complaints
- October 2023 to December 2023 33 complaints
- 45 Formal complaints

- It is evident that the volume of internal concerns recorded through the Freedom to Speak Up service has increased quarter on quarter, and we need to be keen to understand and learn about, in detail, what areas of good and poor culture exist across the organisation. This will then enable any concerns to be identified and fully addressed, the sharing and dissemination of positive practice, the opportunity to move forward collectively and individually, as well as the continued fostering of positive working relationships.

- The trust is committed to tackling this and the FTSU team are seeking the independent review and triangulation of a range of cultural indicators.

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

Walsall Healthcare NHS Trust

Freedom to Speak Up Quarterly Report (Q3 23/24)

EXECUTIVE SUMMARY

This is a report of the concerns raised to through Freedom to Speak Up (FTSU) at Walsall Healthcare NHS Trust for the period 1st of October 2023 to 31st December 2024, Q3 for 2023/24.

The report offers comparative data that can be used to assess the FTSU activity from April 2023 to December 2023.

BACKGROUND INFORMATION

All NHS trusts and providers of NHS care subject to the NHS standard contract are required to appoint a Freedom to Speak Up (FTSU) Guardian and follow the National Guardians Office (NGO)'s guidance on speaking up.

The NGO supports the healthcare system in England on Speaking Up Through leading, training and supporting an expanding network of FTSU Guardians. FTSU guardians support workers to speak up. They also proactively work with organisations to tackle barriers to speaking up.

Workers voices' form one of the pillars of the NHS People Plan. Guardians are key in ensuring workers are heard, particularly those groups of workers facing barriers to speaking up.

FTSUGs are one of many routes through which workers may raise concerns. Information about the speaking up cases raised with Freedom to Speak Up (FTSU) forms part of a bigger picture of an organisation's speaking up culture and arrangements.

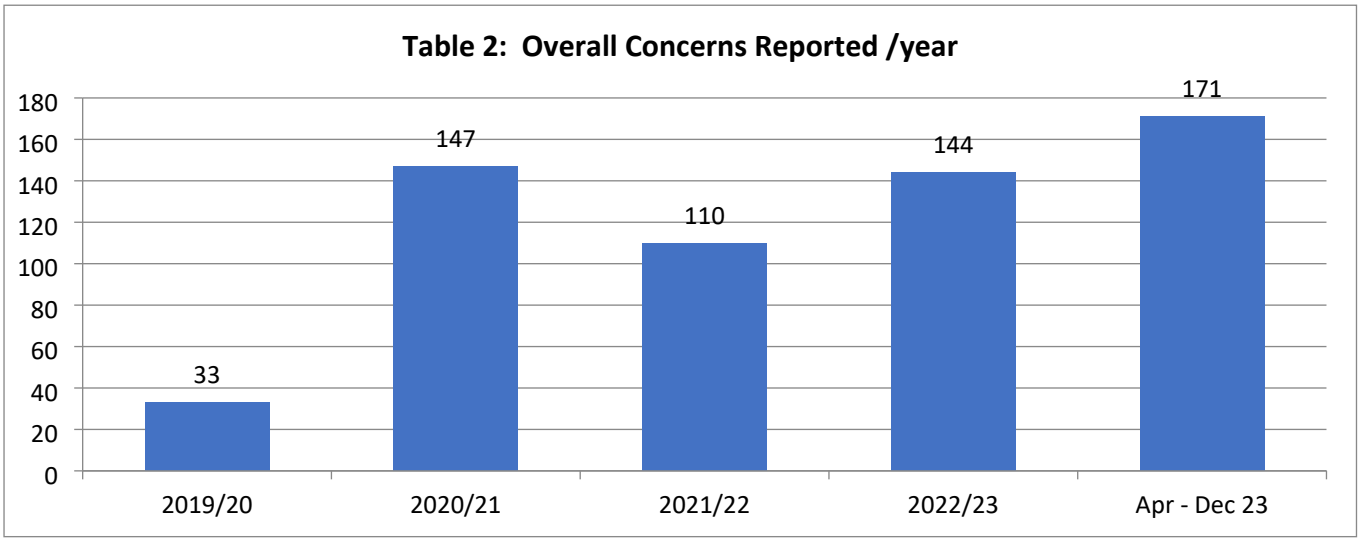
Data from each trust is reported to the NGO on a quarterly basis and incudes the professional background and grade of those who Speak Up.

Demographic data such as gender, age, ethnicity, sexuality, and any other protected characteristics (those included in the 2010 Equality Act) can be reported at the discretion of each individual trust. This information will help to understand the FTSU Guardian's 'reach' across the organisation and identify groups which may be using the FTSU route more or less frequently.

DETAILS

Within Q3, 87 Concerns were raised contributing to a total of 171 cases raised between 1st April 2023 - 31st December 2023. This is a significant increase compared to 144 cases raised in the previous year (between 1 from April 2022 to 31 March 2023) and 110 cases raised between 1 April 2021 and 31 March 2022. It is a positive sign that staff are feeling more confident about raising concerns. Table 1 denotes the number of concerns raised each month over Q3 and table 2 sets out the total number of concern raised over 4 years.

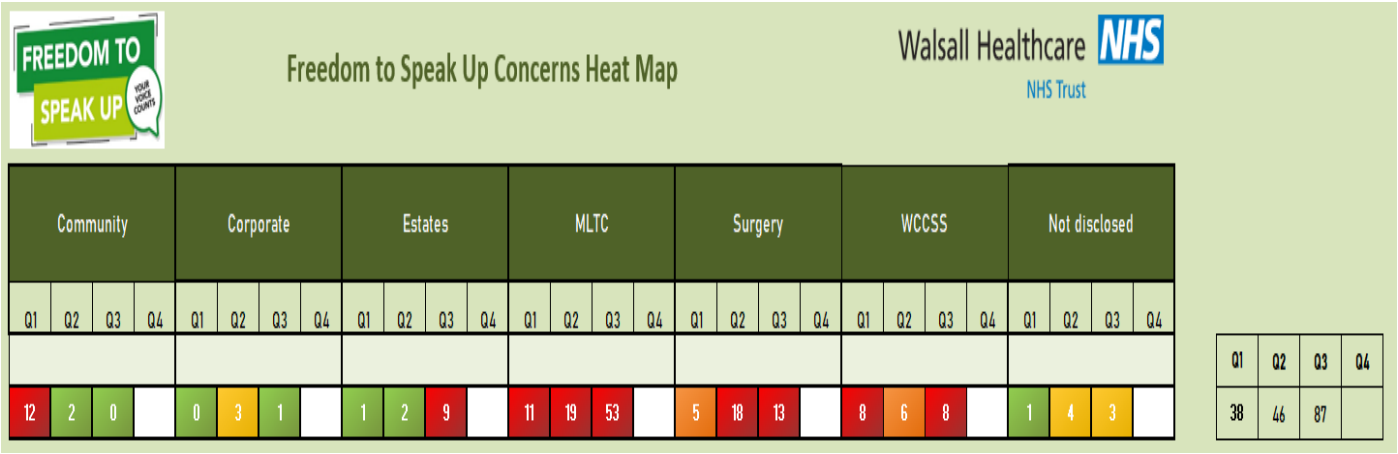
Table 1



Divisional analysis of concerns raised.

The division of Medicine and Long-term Conditions (MLTC) has the highest number of concerns reported through this route between April 2023 and December 2023. In quarter 3, Community has seen a decrease in the numbers of concerns raised, and MLTC quarter on quarter increase in concerns raised.

A number of concerns have been raised anonymously by internationally educated colleagues providing feedback that they feel unsupported and experience inappropriate behaviours. Regular meetings are being held with the clinical divisional leadership teams and the Chief Nurse. Our team have compared data with 7 other Trusts, similar size to ours and the data is not consistent with the other Trusts. There is a commitment from all senior leaders to encourage all staff to attend the Civility and Respect training.



Themes

At the national level, the NGO reported for Q1, 19.3% of cases raised included an element of patient safety/quality, up from 18.8% 2022/23. At Walsall Healthcare NHS Trust, the number of cases including an element of concern for patient safety quality amounted to 3% in Q1 and 4% in Q2 and 11% in Q3.

Nationally, the NGO report that poor behaviour remains a cause for concern, with the highest proportion of cases, over a third (31.3%) including an element of behaviours, such as bullying/harassment across all trusts. This is reflected in Walsall, year to date, where in 60% of cases Q1 and 52% of cases in Q2 and 60% in Q3

included an element of bullying and harassment. At Walsall Healthcare NHS Trust, inappropriate behaviour, bullying and harassment continues to go on the upwards trend. May 2023 figures for the element of bullying and harassment was 29%, please note there is a marked increase. Please note from the data below and from the previous year's data, quarter-on-quarter increases in the number of cases relating to behaviours, including bullying and harassment/ inappropriate behaviours. Staff negative attitude towards patients is also reflected in the complaints PALS are receiving.

Themes 2023/24	Analysis of concerns raised Q1	Analysis of concerns raised Q2	Analysis of concerns raised Q3
Attitudes & Behaviours	60%	52%	60%
Equipment & Maintenance	•	31%	•
Patient Experience	•	•	•
Performance Capability	5%	•	•
Policies, Procedures, Processes	11%	•	22%
Quality & Safety	3%	4%	11%
Service Changes	•	7%	•
Staffing Levels	3%	2%	•
Other	•	4%	7%

National Guardians Office Elements

The National Guardian's Office (NGO) guidelines introduced in April 2022 state that each concern must be broken down and recorded to show any element of bullying, harassment, worker safety/wellbeing etc. although there was a total of 263 concerns raised during quarter one, two and three, when broken down into the new elements the number will always be higher than the number of concerns raised.

The data when drilled down further shows the nature of these concerns by elements (see below). Please note that worker safety/wellbeing, bullying or harassment and inappropriate behaviours make up most concerns elements.

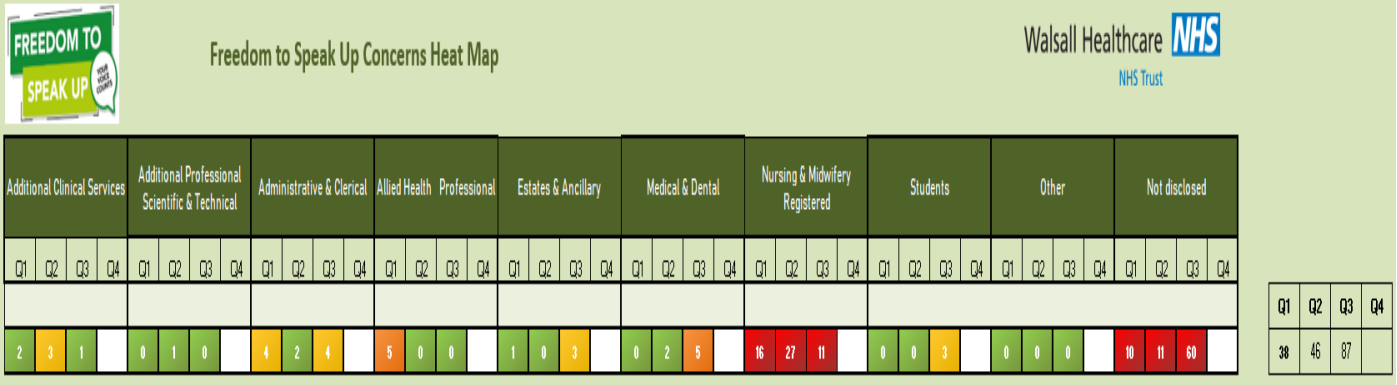
Quarter 3 Element 2023/24	Total
Patient safety/quality	44
Worker safety or wellbeing	82
Bullying or harassment	43
Other inappropriate attitudes or behaviours	64
All other cases	30
Total number of reportable elements	**263**

Professional Staff Groups

The graph below illustrates that there are staff of most groups whose concerns are presented in the data. It is also evident that Nursing & Midwifery staff group are the highest reporters, there are still many staff groups that are under-reporting. Plans are already in place and commenced for the FTSU team to attend ward managers and Matrons forums and have organised regular drop-in sessions. 69% of the professional staff group in Q3 not disclosed, relates to the staff that report anonymously, therefore no data is available relating to the professional staff group they belong to.

To address the under-reporting groups, F2SU team have organised targeted drop-in sessions, Matron's and ward managers drop-in sessions have already commenced. The team will be working with comms to publicise bi-weekly drop-in sessions targeted to specific professional groups and departments for the rest of this year.

The ward manager's and Matron's sessions held have been successful, the team will duplicate these sessions for all areas and departments across Walsall Hospitals NHS Trust. Pop-up stands will be organised in different areas of the Trust, including all the community bases, outside specific departments to target the under-reporting staff groups.



Ethnicity Profile of individuals raising concerns

The percentage of Black and Minority Ethnic (BAME) employees who work for WHT is 38%.

F2SU data compared to the previous year identifies that concerns from colleagues from a BAME background represent 42% in quarter 1 and 52% in quarter 2 and 17% in Q3 of the total concerns. This is a slight over representation of colleagues from a non-BAME background raising concerns though the F2SU route. The high number of non-disclosed ethnicity is due to anonymous reporting, where we have no information of the reporter.

Colleagues are aware that that Speaking Up ensures escalation as all concerns are logged by Guardians and followed up. The guardians will always thank colleagues for raising concerns and work with the organisation to address issues. The role of the guardian is to challenge and hold the organisation to account to effectively support colleagues. This action by the guardians empowers BAME employees who are statistically more likely to face more barriers and be taken less seriously than their white colleagues.

Ethnicity 2023/24	Analysis of concerns raised Q1	Analysis of concerns raised Q2	Analysis of concerns raised Q3
BAME	42%	52%	17%
Non-BAME	32%	24%	14%
Not disclosed	26%	24%	69%

FTSU Training

The National Guardian office guidelines are that FTSU training to be provided as core training. Speak Up training for all staff to complete, trust wide is currently 35.98%, Listen Up training for all line managers is currently 26%. The national target being 90%.
FTSU team will seek the support of all senior managers through team meetings, divisional quality boards to highlight the training and look at ways to improve the training figures.

Listen Up Training (Line Managers) - Dec 2023

Organisation	Staff count	Compliant	Not compliant	% Target = 90
Walsall Healthcare NHS Trust	461	120	341	26.03%
Chief Executive Directorate	5	2	3	40%
Community	99	32	67	32.32%
Digital Services	18	5	13	27.78%
Directorate of Transformation & Strategy	6	2	4	33.33%
Estates and Facilities	25	8	17	32%
Finance Directorate	10	2	8	20%
Governance Directorate	11	3	8	27.27%
Medical Directorate	15	5	10	33.33%
MLTC	90	17	73	18.89%
Nurse Directorate	17	3	14	17.65%
Operations Directorate	4	1	3	25%
People & Culture Directorate	28	10	18	35.71%
Surgery	61	16	45	26.23%
Walsall Together	4	1	3	25%
WCCSS	66	11	55	16.67%

Speak Up Training (all staff) - Dec 2023

Organisation	Staff count	Compliant	Not compliant	% Target = 90
Walsall Healthcare NHS Trust	4861	1749	3112	35.98%
Chief Executive Directorate	11	4	7	36.36%
Community	936	403	533	43.06%
Digital Services	126	59	67	46.83%
Directorate of Transformation & Strategy	16	8	8	50%
Estates and Facilities	346	73	273	21.10%
Finance Directorate	65	17	48	26.15%
Governance Directorate	40	19	21	47.50%
Medical Directorate	107	46	61	43%
MLTC	1137	403	734	35.44%
Nurse Directorate	91	37	54	40.66%
Operations Directorate	34	16	18	47.06%
People & Culture Directorate	82	41	41	50%
Surgery	946	364	582	38.48%
Walsall Together	12	1	11	8.33%
WCCSS	910	257	653	28.24%

RECOMMENDATIONS

The Board is asked to note the report and continue to support the F2SU service to:

- Embedding Speaking Up as routine day-to-day practice.
- Ensure concerns are heard and responded to, supporting the guardians to seek the assurance that is required.
- Encourage Senior Leadership Team/ Executives and Non-Executives to complete F2SU *Follow Up* Training via My Academy.
- Work towards Freedom to Speak Up Training to be provided as core training, as per the NGO guidance. https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/
- Undertake regular walk arounds by F2SU and Executives/ Non- Executives in underrepresented areas, to raise awareness of the service and how to speak up.
- There is an inconsistency in the application of the Trust values which means in different ways and for different reasons some unacceptable behaviours and poor working practices have developed across the different services, which causes some staff to feel isolated, discriminated against, unsafe and undervalued.
- It is evident that the volume of internal concerns recorded through the Freedom to Speak Up service has increased quarter on quarter, and we need to be keen to understand and learn about, in detail, what areas of good and poor culture exist across the organisation. This will then enable any concerns to be identified and fully addressed, the sharing and dissemination of positive practice, the opportunity to move forward collectively and individually, as well as the continued fostering of positive working relationships.
- The trust is committed to tackling this and FTSU team are seeking the independent review and triangulation of a range of cultural indicators.

F2SU Next Steps

The Board are advised that the Freedom to Speak Up team will be focusing attention on the following activities.

- Proactive session to raise awareness, FTSU regular stands from January.
- Recruit FTSU champions in each area/department, recruitment drive to start in January.
- Champion sessions on Compassionate Leadership/Civility Saves Lives in senior leadership/ ward managers/matrons meetings.
- Focus on areas reluctant to raise concerns, Estates, facilities etc.
- Bi-weekly drop-in sessions scheduled over the next three months, each session will be allocated to different areas and departments, including all the community bases.
- Additional drop-in sessions for ward managers and matrons.

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public on 14 February 2024		
Title of Report:	Chair's report of the Trust Management Committee (TMC) held on 25 January 2024 – to note this was a virtual meeting	Enc No: 7.2
Author:	Gayle Nightingale, Executive Assistant to the Group Chief Executive	
Presenter/Exec Lead:	Ned Hobbs, Chief Operating Officer/ Deputy Chief Executive	

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

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

NHS
Walsall Healthcare
NHS Trust

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 23 November 2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- In October 2023 TMC reviewed the annual report detailing the activity and impact of the Schwartz Rounds which have continued to be take place across the Trust having been introduced in 2022. The monthly programme provides an opportunity for staff to engage in reflection of the emotional and wellbeing impact of work and help to improve culture of compassionate care towards colleagues and patients. Over the last reporting period 98.5% of attended have recommended colleagues attend and shared through evaluation the benefits experienced from attending such as developing different understandings and valuing the safe space created. TMC supported the recommendation to continue to support Schwartz Rounds into 2024/25 with an additional commitment to provide active support of the programme.
- The Trust's total elective waiting list has decreased by 12.9% since April 2023
- The Trust is delivering upper quartile 4-hour Emergency access standard performance nationally and delivered the second best ambulance handover performance (<30mins) in the West Midlands in December 2023.
- The Trust is delivering upper quartile 62-day (combined) Cancer referral to treatment performance.
- The most recently published SHMI and HSMR mortality rates are within expected range for Walsall Manor Hospital.

Advise

Matters discussed and reviewed at the most recent Trust Management Committee (TMC) are set out in detail within the report below.

Alert

- Month 9 Finance report shows an adverse YTD variance to plan of £14.6m
- The Trust has had 71 C Diff cases YTD at month 9
- Access to Endoscopy and Non-Obstetric Ultrasound diagnostic tests remains challenging, pending implementation of the approved business case expansion.
- TMC received a report to address stronger assurance on the issuing of outpatient clinic letters following clinic appointments, with a task and finish group being established to oversee the work.
- Work to manufacture chemotherapy in the Trust's on site Aseptic Suite is currently suspended, pending remedial actions. Mitigation plans are in place to source chemotherapy treatments externally.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care

	• Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Walsall Healthcare NHS Trust

Chair's report of the Trust Management Committee (TMC)

Report to Trust Board Meeting to be held in Public on 14 February 2024

EXECUTIVE SUMMARY

Chair's report of the Trust Management Committee (TMC) held on 25 January 2024 – to note this was a virtual meeting.

BACKGROUND INFORMATION

As per the below.

RECOMMENDATIONS

To note this report.

1	**Key Current Issues/Topic Areas/ Innovation Items:**
	• There were none this month.
2	**Exception Reports**
	• There were none this month.
3	**Items to Note – all of the following reports were reviewed and noted in the meeting**
	• Chief Nursing Officer Report • Midwifery Services Report • Infection Prevention Report • Divisional Quality and Governance Report – Medicines and Long-Term Conditions Report • Divisional Quality and Governance Report – Surgery Report • Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services Report • Divisional Quality and Governance Report – Community Services Report • Integrated Quality Performance Report (IQPR) • Trust Financial Position (Revenue and Capital) - Month 9 Report • Workforce Metrics Report • Walsall Together Report • Group Strategy Officer Report • Corporate Risk Register and Board Assurance Framework (BAF) Heat Map Report
4	**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**
	• Quarterly Pharmacy Report • Controlled Drugs Accountable Officer Report • Group Strategy Officer Report • Mental Health Report • Learning from Deaths Report • Research and Development Report • Patient Voice September – December 2023 Report • RSM Elective Audit Update Report

	• Freedom to Speak Up Report • Quality Improvement Team Update Report • Sustainability and Green Plan Update Report • Emergency Preparedness, Resilience and Response (EPRR) Assurance Progress Update Report • Contracting and Business Development Update Verbal Report
5	**Business Cases – approved**
	• Post Implementation Reviews (PIRs) of previously approved Business Case/ Improvement Group Update Report
6	**Policies approved**
	• Policies, Procedures and Guidelines - Quarter 8 and 9 Report • IP1010 V6 – Blood Borne Virus (BBVss) Policy • IP011 V5 – Administration of Infection Prevention and Control within Walsall Healthcare NHS Trust Policy • IP012 V6 – Infection Prevention and Control Procedures for Deceased Patients Policy • OP1006 V1 – Non-medical Authorisation of Blood Components Policy • V8 – Covid 19 Vaccination Recipient Pre-screening and Consent Form 2023/24 • V4 – Management of Hyperkalaemia Guideline • V1 – Preparation and Administration of Spikevax XBB 1.5ml Syringes for Administration – Trust-wide Standard Operating Procedure
7	**Other items discussed**
	• There were none this month.

References to Reading Room Enclosures

- **Research and Education Report (B Pack: Enc 7.2.1)**
- **Schwartz Round (B Pack: Enc 7.2.2)**

Walsall Healthcare NHS Trust

Public Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Research & Development Bi-Annual Report	Enc No: 7.2.1
Author:	Catherine Dexter, Research & Development Manager	
Presenter/Exec Lead:	Pauline Boyle, Managing Director of Research & Development Dr Manjeet Shehmar, Chief Medical Officer	

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

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

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

Summary of Key Issues using Assure, Advise and Alert

Assure

Research Activity across the Trust

- Recruitment by Specialty (**Table1**)
- Number of studies Opened, In Set-up an Pipeline **(Graph1)**
- Number of Trust own account research (Students/Staff) (**Table 2)**
- Number of studies recruited over previous 5 years **(Graph 2).**
- Commercial V Non Commercial research 2023-2024 (**Graph 3**)

Advise

- Research update -General
- Growth and development of Commercial Portfolio

Alert

Aseptic pharmacy support for research studies currently on hold, working in collaboration with the Director of Pharmacy to rectify this issue, non-aseptic pharmacy support has been rectified

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

Research & Development Bi-Annual Report

Report to Public Trust Board to be held on 14th February 2024

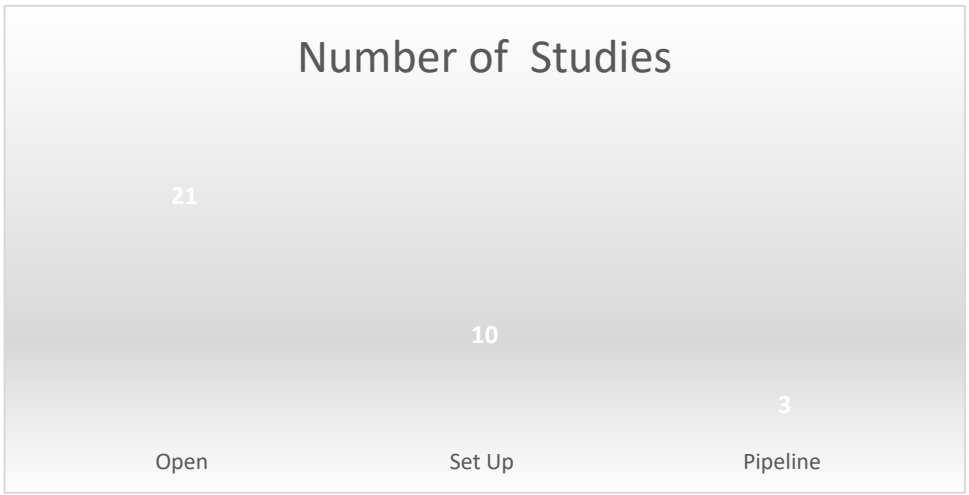
Table1: Recruitment by Speciality (counted to the end of November)

Ageing	0	0	0		
Anaesthesia, Perioperative Medicine and	0	3	0		-100%
Cancer	53	13	9	-83%	-31%
Cardiovascular Disease	0	7	11		57%
Children	41	9	1	-98%	-89%
Critical Care	0	6	0		-100%
Dementias and Neurodegeneration	0	0	0		
Dermatology	3	5	27	913%	440%
Diabetes	12	3	2	-83%	-33%
Ear, Nose and Throat	37	7	0	-100%	-100%
Gastroenterology	0	0	0		
Genetics	18	3	0	-100%	-100%
Haematology	0	0	0		
Health Services Research	99	20	5	-95%	-75%
Hepatology	0	0	0		
Infection	11	231	0	-100%	-100%
Mental Health	0	26	0		-100%
Metabolic and Endocrine Disorders	0	0	0		
Musculoskeletal Disorders	0	0	6		
Neurological Disorders	0	0	0		
Ophthalmology	0	0	0		
Oral and Dental Health	0	0	0		
Primary Care	1	0	0	-100%	
Public Health	0	0	0		
Renal Disorders	1	2	16	2300%	700%
Reproductive Health and Childbirth	59	82	56	-6%	-32%
Respiratory Disorders	14	3	4	-71%	33%
Stroke	4	0	0	-100%	
Surgery	0	0	0		
Trauma and Emergency Care	0	22	0		-100%

Advise

We currently have a good variation in specialities undertaking research. Diversity of studies now expanding with new Principle Investigators identified in Rhumatology, Urology and ENT.

Graph 1: Reflects the number of studies opened, in set up and in the pipeline



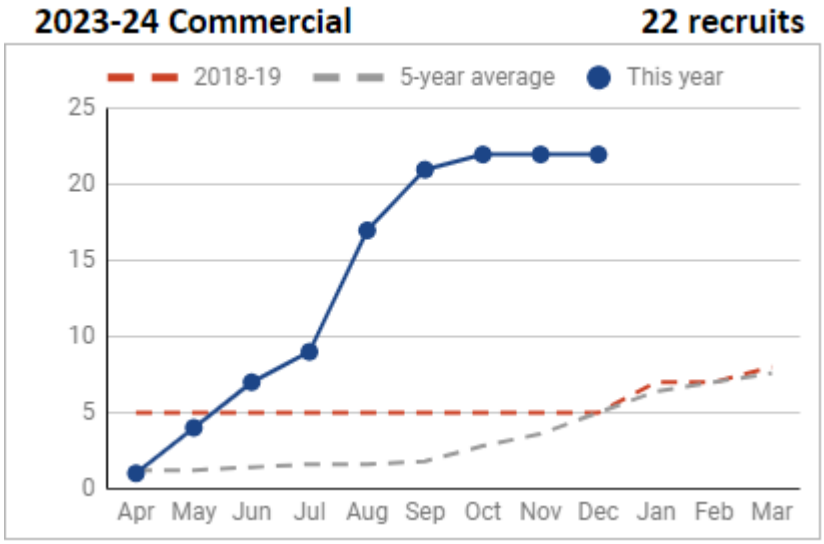
Own account research across the Trust (Table 2)

Approved 2023	17
Outstanding 2023	24

There has been an Influx of queries relating to staff undertaking academic courses and requiring help/support re projects. The team are currently supporting consultants with an invention looking at the development of a CPAP mask. This collaboration has been extended to Medilink Midlands.

Graph2:.

Graph3: Commercial V Non Commercial research 2023-2024

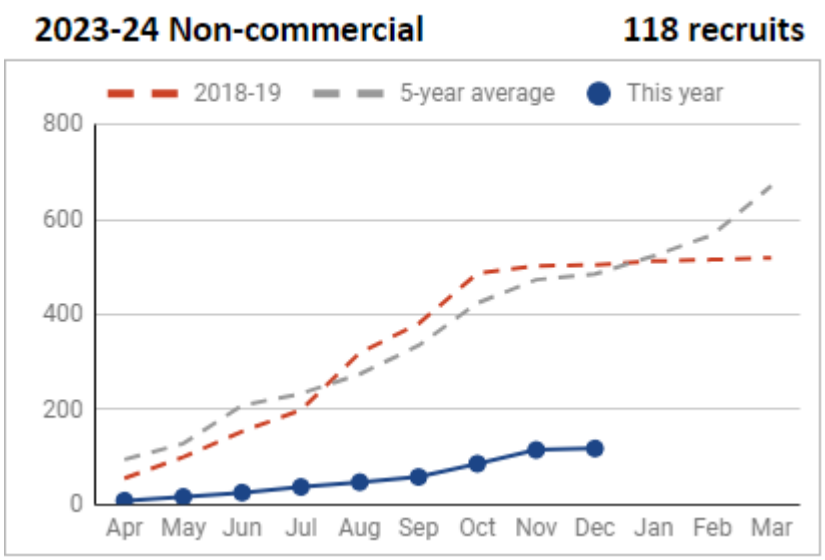


2018-19	8
5-year average	8

Pro rata to end of last month

340% ahead of 2018-19

511% ahead of 5 year average



16% commercial recruitment so far this year

2018-19	520
5-year average	672

Pro rata to end of last month

77% behind 2018-19

76% behind 5 year average

Alert

Ongoing issue with pharmacy regarding research sign off from pharmacy. Main issue relates Aseptics, flagged with Director of Pharmacy.

R&D Update-General

- R&D team received 2 awards at the recent CRN Award event 1.R&D team (commercial activity) and 2. Governance team.
- Research Patient Celebration event on the 28th of November proved very successful.
- BADBIR Study (Dermatology study) -Centre of the month for recruitment
- Successful in obtaining additional funding from the CRN to continue with the Hybrid Research Midwife post. This post has been extremely successful with excellent recruitment into non-commercial studies. The commercial portfolio in midwifery is very limited. Currently WHT have 3 Maternity studies opened.

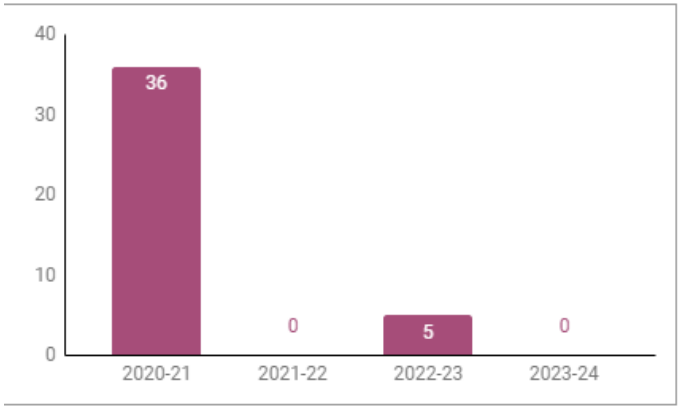
Walsall Healthcare NHS Trust

Report Detail and Appendices

1. Executive Summary (summarise/add context to issues/report items below including clinical implications/outcomes, resources required, any proposed risks for escalation, positive/negative impact of assurance given detail below e.g. CQC, NHSR, HSE, MHRA, other)

This report is to inform the Quality Committee of research activities across the Trust. The front sheet is expanded to focus on the main issues currently relating to research: recruitment, studies in set up and studies in the pipeline (**Graph 1**). It enables the reader to see the specialities (**table 1**) Walsall are research active it also highlights the potential areas missing out on research opportunities. **Graph 2 &3** shows over all recruitment from March 2023 to November 2023 for Commercial V Non-Commercial studies. The report informs the reader of current alert which impacts on research activity and is discussed below in more detail. **Indicator/standard monitoring undertaken e.g., from national audit/national guidance/legislation etc. (Each group/author to add own key for RAG status below):**

Assurance Theme	Indicator/Standard/ Question.	Target	R	A	G	Prev Rep	This Rep	Commentary
Increase research activity across the Trust and deliver within time and Target	In line with NIHR CRN High Level Objectives (HLOs) 2023/24 as follows: 2023/24 NIHR CRN High Level Objectives (HLOs) Efficient Study Delivery Deliver NIHR CRN Portfolio studies to recruitment target (Ambition 80%). Sustain or grow commercial contract research (CRN target75%) Lord O'Shaughnessy report 2023 and development of Innovation strategy and Research Strategy.							Aim to work in collaboration with research teams, support services and sponsors to achieve effective study set up and delivery of studies currently active or in set up at WHT. Currently WHT have **24** studies opened of those **24** studies, **1** is a commercial contract study. In line with the NIHR HLO for effective study delivery of the **24** studies, **2** have hit their target. **7** of the studies opened have recruited more than **50%** of their target with time left to recruit agreed targets agreed. Studies which are proving difficult to recruit into are monitored weekly, strategies to increase recruitment discussed and actioned (i.e., using the CRN to support PIC - Patient information Centres within the community). Studies monitored closely by sponsors with onsite visits frequent. Growing Commercial research in line with NIHR HLO's, WHT have commercial contract studies in set up (**5**) and potential (**5**) in the pipeline. Recurring business with known Sponsors i.e**., MSD, LEO, GSK and AstraZeneca,** we continue to stride to open studies in a timely fashion.

	Commercial clinical trials in the UK: the Lord O'Shaughnessy review - final report Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery. Participants responding to the Participant Research Experience Survey (PRES),							Overall Walsall have been poor in reporting on the Patients experience of taking part in research questionnaire Survey (CRN), 2022/23 saw **5** responses to the survey, the WM's had a total response rate of **1,654.** **PRES Responses**  **PRES report for WHT:** https://lookerstudio.google.com/s/trozEflFKSE WHT Lead Research nurse attends monthly PRES meetings (Patient in Research Experience Survey) we are working closely with the CRN PRES team to increase our response to the PRES Survey. WHT R&D team held a Research Participant thank you event on the 28TH of November in which **20** participants involved in research studies attended, moving forward the team will hold a yearly event celebrating the impact research has on people's lives and their families. The team will work closely with the Patient Relations & Experience service leads moving forward.

This requires the group/individual to be specific in terms of the standard/indicator that is/has been monitored – the target is usually set either by the Trust, Policy, Legislation, Standard, national audit, national guidance, external review - etc. – be clear what has been reviewed. In the commentary – include the analysis of finding (e.g. is a particular risk for our trust shown and any rationale about the indicator e.g. H&S we have a high number of claims for slips trips and falls so you would expect to see an indicator that demonstrates whether or not we've improved this outcome.

2. **Emerging issues/themes (summarise issues or information which is impacting on the area/compliance) Where** there are areas of low/non-compliance with a standard/target/outcome in the above table – is it clear how you have identified that issue - do we need to act if not – why not - what is the rationale?

Assurance Theme	**Specific Item Reviewed (Data source)**	**Information you have used to make the judgement of assurance** (inc independent assurance – indicate timeliness by completing next column)		**IA *** (use key below)	**Emerging Issue/Outcome and any on-going risk (So what factor)**	**Action required**	**Lead**	**Action due date**
		Positive	**Negative**					
Increase research activity across the Trust and deliver within time and Target	Pharmacy -	-	- Issue relating to Aseptic support within Pharmacy (Director of Pharmacy aware of the issue) .	3	<u>Emerging issue</u> Unable to take on any Clinical Trials which support Aseptic review and sign off. Currently have **1** study on hold which requires aseptic support, risk is unable to offer this study treatment to potential participants therefor could have an impact on their quality of life. <u>Emerging Risks</u> Increase of bias being introduced as to how R&D scope for studies relating to Cancer in particular, many studies (clinical Trials) would require aseptic pharmacy involvement. This reduces the opportunities for our patients to have access to new/novel treatments and prolong life in some instances. There is also the risk that consultants may lose interest in undertaking research active at WHT due to this ongoing issue.	Identify pharmacist who will support aseptic review and sign off.	Director of Pharmacy working in collaboration with MD of Research &Development	July 2023 December 2023

Assurance Theme	Specific Item Reviewed (Data source)	Information you have used to make the judgement of assurance (inc independent assurance – indicate timeliness by completing next column)		IA * (use key below)	Emerging Issue/Outcome and any on-going risk (So what factor)	Action required	Lead	Action due date
		Positive	Negative					

Any independent assurance provided in the above table is time limited – please indicate (x) the overall level of independent assurance based on descriptions below (where applicable in the IA* column above).

If you have included any independent assurance in the above – it is important to be clear in terms of the reliance the Trust can place on it – identify using the table below.

3 ***	Recent (less than one year old) independent assurance.
2 **	Less Recent (more than one less than two years old) independent assurance.
1 *	Historical (more than two years old) independent assurance.

3. Risk identified (new or existing risks identified from report issues):

What (if any) are the risks you have identified from the report – do any of the actions mitigate existing risks (trust or local level) – check your risk register. Add below those risks that are impacted by the work you have identified above or if there is a new risk that has been identified add the current risk rating

Key Risks being addressed:	Risk No	Risk level	Previously reported risk rating	Current Risk Rating (C x L) categorisation matrix	Target grade (date to be achieved by)
Pharmacy -Aseptic review and sign off			Director of Pharmacy	High -Unable to open studies requiring Aseptic pharmacy	July 2023 December 2023
Inappropriate storage of research data due to space and allocation of storage room potential breach of GDPR and MHRA Inspection regulations.	1816		3	3	This will continue as the space we have in Town Wharf is unsuitable for storing patient research data.

Walsall Healthcare NHS Trust

Report for Trust Management Committee Date: 26 October 2023	
Title of Report:	Schwart Round Annual Report
Author:	Nathalie Harris, Tracy Nicholls and Esther Waterhouse
Presenter/Exec Lead:	Clair Bond, Interim Director of HR and OD

Action Required of the Board/Committee/Group (AUTHORS Please tick box as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐
Recommendations: To inform and assure			

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

Walsall Healthcare NHS Trust

Equality and Diversity Impact	Schwartz round is an inclusive experience provided to all staff.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure Point of Care Schwartz rounds continue monthly. They provide a safe space for staff to attend, to listen to emotive stories and reflect upon what they have heard and how this may personally impact their own work or personal experiences. It is a positive intervention for mental and emotional wellbeing. A steering group is in place with monthly meetings to continue to guide the rounds forwards positively; work ongoing to recruit a member from every division for the steering group.
Advise Reports including the Schwartz round topics, attendance numbers, occupational groups, feedback and equality and diversity data, are sent to the Point of Care foundation six-monthly.
Alert None

Links to Trust Strategic Aims & Objectives (Authors to Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement
Support our Colleagues	• Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement
Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Progress joint working across Wolverhampton and Walsall

Walsall Healthcare NHS Trust

Schwartz Rounds

EXECUTIVE SUMMARY

Schwartz Rounds have been undertaken at Walsall Healthcare Trust on a monthly basis for the last 18 months.

The response to the rounds has been overwhelmingly positive (98.5% of attendees of the last 12 months would recommend Schwartz Rounds to colleagues), and therefore we would recommend that they continue.

E Waterhouse is the Clinical Lead and Nathalie Harris is the Administrator for the Schwartz Rounds.

BACKGROUND INFORMATION

Schwartz Rounds Purpose:

Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. 85% of staff who participate in Schwartz Rounds feel better able to care for patients. Stories shared in Schwartz Rounds have the ability to empower staff and their organisations. Staff can reconnect with their values and reaffirm their motivation to work in healthcare.

Evidence Base:

- Established in many countries. USA > 20 years.
- Schwartz Centre for Compassionate Healthcare research (Lown, 2010)- teamwork, less stress, participants more likely to attend to patients psychological and emotional needs, empathy, (also enhanced by increased attendance of Schwartz Rounds)
- UK evidence around compassionate care – Two pilot sites, (Goodrich, 2012).
- Qualitative evidence base is good. Around 270 NHS trusts and hospices in UK undertaking Rounds
- Longitudinal research study highlighted benefits.
    - *'Rounds have been shown to offer unique support compared to other interventions. Organisational level interventions for staff wellbeing are scarce and Rounds uniquely straddle both individual and organisational levels.*
    - *Providing high quality healthcare has an emotional impact on staff, which often goes unnoticed. Rounds offer a safe, reflective space for staff to share stories with their peers about their work and its impact on them. Attendance is associated with a statistically significant improvement in staff psychological wellbeing.*
    - *Reported outcomes included increased empathy and compassion for patients and colleagues and positive changes in practice'*

Walsall Healthcare Trust continues to have monthly Schwartz Rounds; to date eighteen rounds have been held. Please see figure 1 below:

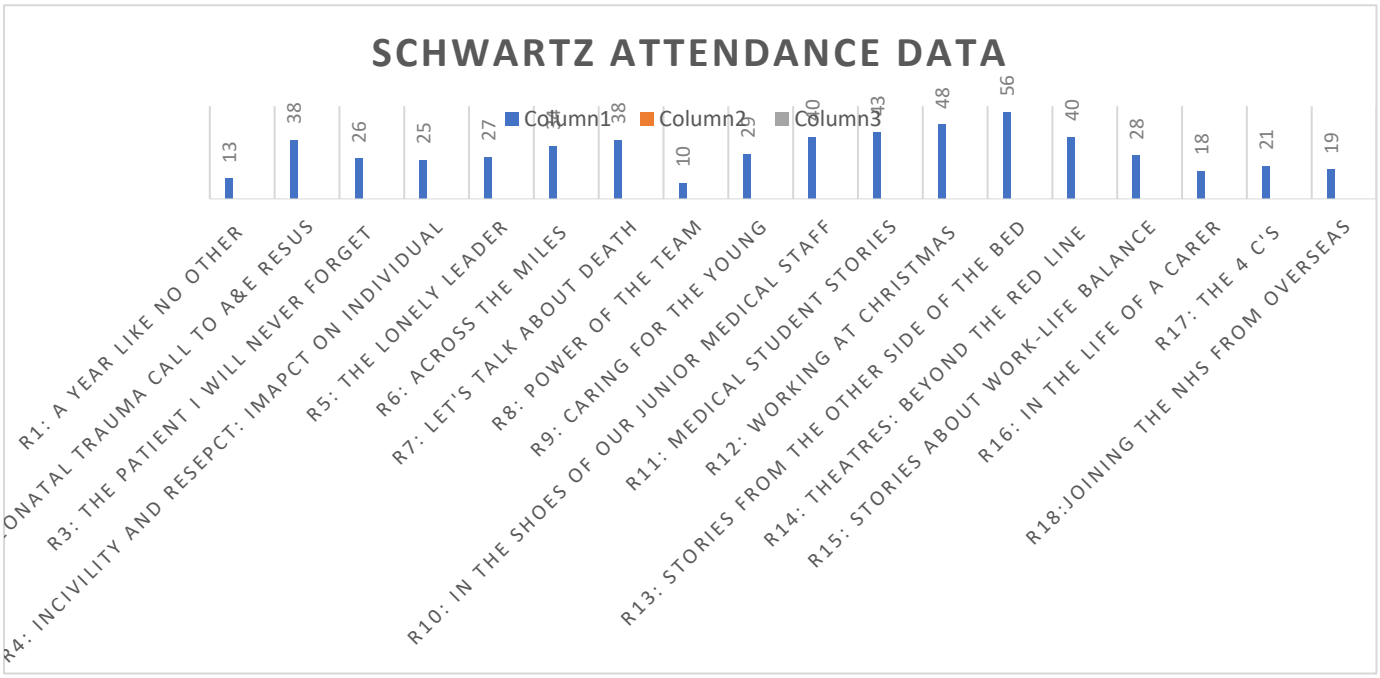


Figure 1. Schwartz attendance data

Of the three hundred and forty nine attendees from the last twelve months, the general themes from feedback have been:

- General positivity
- Insightful, relatable, promoted reflection
- Useful for future practice
- Emotional/moving/powerful
- New understanding (of self, of others)
- Safe space
- Bravery of speakers
- Suggestions for future rounds

To date, only two 'negative' responses have arisen from the rounds:

- Not for me
- Would be nice if the storytellers had more than 5 minutes to tell their stories, perhaps 10 minutes?

The table below illustrates the positive impact that Schwartz Rounds have had on attendees:

Figure 2. 18 month feedback themes data

Certification/CPD/Reflective practice:

- Each participant/panel member receives a CPD certificate.
- Reflective practice is actively encouraged by the facilitator during the introductory briefing at the start of the Round, and reflective templates are available.

Schwartz Rounds sustainability:

- Finances- estimated annual costs for contract and food = £3.5K- a small investment given the staff benefits and staff feedback from Rounds
- Active membership of Schwartz Round Steering Group to ensure positive engagement.
- Multiple sites – engagement. This has been explored through the Steering Group.
- Sustaining quality through peer review
    - Point of Care Foundation receive our feedback data every 6 months.
- Annual report to TMC/Trust Board - to sustain Board engagement.
- Learn from other organisations- feedback from other organisations is that organisational support is high initially, but long-term sustainable support can be a challenge (especially around financial support and embedding Rounds)

RECOMMENDATIONS

Due to the overwhelmingly positive feedback of staff attending Schwartz Rounds, we would recommend that the Trust continues undertaking the monthly Rounds.

Any Cross-References to Reading Room Information/Enclosures:

NHS
Walsall Healthcare
NHS Trust

Paper for Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Trust Board Metrics Report – Excel in the Delivery of Care	Enc No: 8.1
Author:	Author - Amanda Cater, Head of Performance Responsible Directors – Dr Manjeet Shehmar, Chief Medical Officer, Lisa Carroll, Chief Nursing Officer, Ned Hobbs, Chief Operating Officer and Deputy Chief Executive, Dan Mortiboys, Operational Director of Finance; Kevin Stringer, Group Chief Financial Officer and Group Deputy Chief Executive	
Presenter/Exec Lead:	Dan Mortiboys - Operational Director of Finance	

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

Recommendations:

Board members are asked to note the contents of the report and note that metrics included in the report maybe reported in further detail within other subcommittee papers.
Areas for focus are included within subcommittee highlight reports.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☐ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) : Any risks associated with individual metrics within the report will be noted within the appropriate sub-committee papers.		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State: **None**		
Resource Implications:	(if none, state 'none') Revenue: **None** Capital: **None** Workforce: implications associated with the capture and reporting of performance data. Funding Source: **None**		
Report Data Caveats	This is a standard report using the previous months or most recent data. It may be subject to cleansing and revision. The report relies on timely and accurate data recording in corporate systems and, for data provided outside of corporate systems, timely provision of the data to the Performance Team for incorporation into the report		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Effective, Caring, Responsive, Well-led
	NHSE	Yes☒No☐	Details: Publication PRN00196 Elective care prioritise 2023/24
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:

Walsall Healthcare
NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert

Introduction

'Board Level Metrics' are a rationalised set of priority metrics for the Board to focus on. The metrics align against our four strategic objectives (Care, Colleagues, Collaboration and Communities) and our Vision. Whilst this is a rationalised set of metrics to generate higher quality discussions and assurance, we also monitor a considerable number of metrics within subcommittee papers. Highlight reports from each committee are included for Board focus. This report includes data in Statistical Process Control (SPC) charts using the NHS 'Make Data Count' style of reporting. Further detail on how to interpret SPC charts icons is explained in the final page of this report. This is the second time this new report has been produced; the content will evolve over time. This report replaces the previous IQPR – Integrated Quality and Performance Report.

Please refer to subcommittee highlight reports for areas of Assure, Advise and Alert

Trust Board Metrics - Key Objectives

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L		Cancer - No. of patients waiting 63+ Days for treatment (CARE) MSFD - Average number of Medically Fit for Discharge Patients in WMH (COMMUNITIES)	18 Weeks RTT - Number of 78 Week Breaches (excluding patient choice) (CARE)	
		Urgent Crisis Response (UCR) - 2 Hour Response Rate (CARE) Vacancy Rates - Overall (COLLEAGUES) Virtual Ward - Total Referrals (COLLABORATION)	18 Weeks RTT - Number of 65 Week Breaches (CARE)	
H / L		ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival (CARE)		

Dashboard metrics for the below Objectives do not contain enough data points to populate the above matrix - Please see exception page for further detail

- Carbon Footprint - 5% reduction in the carbon footprint (COMMUNITIES)
- R&D - Number of Recruits - Commercial (COLLABORATION)
- R&D - Number of Recruits - Non Commercial (COLLABORATION)

Dashboard metrics for the below Objectives are currently in development

- 10% increase on previous year in the percentage of staff responding positively in the annual staff survey when asked if they are able to suggest and make improvements in their area (CARE)
- Delivery of the agreed financial plan (CARE)
- Deliver an improvement on 2022/23 in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing by March 2024 (COLLEAGUES)
- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged (COLLEAGUES)
- Deliver an improvement on 2022/23 in Workforce Equality Standard performance by March 2024 (COLLEAGUES)
- Identify, implement and report on a agreed set of outcome measures for each of the projects within the provider colloborative programme (COLLABORATION)
- Develop and implement a Health Inequalities Strategy with measurable outcomes in 2023/24 (COMMUNITIES)

NHS
Walsall Healthcare
NHS Trust

Trust Board Metrics - CARE Dashboard

KPI	Latest month	Measure	Trajectory	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
18 Weeks RTT - % Within 18 Weeks – Incomplete	Dec 23	56.69%	56.45%	92%	F	L	61.51%	58.94%	64.07%
18 Weeks RTT - Number of 52 Week Breaches	Dec 23	1161	1257	1000		H	1070	830	1309
18 Weeks RTT - Number of 65 Week Breaches	Dec 23	304	257	0	F	?	315	176	455
18 Weeks RTT - Number of 78 Week Breaches	Dec 23	0	0	0	F	L	77	32	122
Ambulance Handover - % of Handovers completed within 30mins of Arrival	Dec 23	83.04%	95.00%	95%		?	91.52%	82.55%	100.48%
Cancer - 28 Day Faster Diagnosis - % Compliance – Overall	Nov 23	26.42%		85%	F	?	37.23%	-2.76%	77.22%
Cancer - 31 Day Diagnosis to Treatment - % Compliance - Combined Standard	Nov 23	97.73%	96.00%	96%		H	95.84%	89.07%	102.61%
Cancer - 62 Day Referral to Treatment - % Compliance - Combined Standard	Nov 23	77.99%	85.00%	85%		?	74.90%	59.11%	90.69%
Cancer - No. of patients waiting 63+ Days for treatment	Nov 23	34	84	39		L	76	33	119
Clostridium Difficile - Number of Cases	Dec 23	7	3	2		H	5	-3	12
MRSA - Number of Cases	Dec 23	0	0	0		?	0	-1	1
Diagnostics - % of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	Dec 23	27.17%	1.00%	1%	F	H	14.03%	7.58%	20.47%
ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival	Dec 23	72.31%	76.00%	76%		L	76.93%	70.99%	82.88%
ED - ED Attendances Admitted, Transferred or Discharged within 12 hours of Arrival	Dec 23	8.17%	6.00%	2%		H	4.68%	-0.38%	9.73%
Falls - Number resulting in severe harm or death	Dec 23	0	0	0		?	1	-2	4
Incidents - Never Events	Dec 23	0	0	0		L	0	-1	1
Incidents - Serious Incidents Hospital	Dec 23	0		0		L	7	-4	18
Incidents - Serious Incidents Community	Dec 23	0		0		?	0	-1	2
Maternity - Midwife to Birth Ratio - (1 to)	Dec 23	26.9	28	28		?	29	22	36
Pressure Ulcers: Cat 2, 3, 4 Incidents Hospital	Dec 23	9		0	F	?	14	1	26
Pressure Ulcers: Cat 2, 3, 4 Incidents Community	Dec 23	11		0	F	?	14	2	26
Sepsis - % of patients screened who received anitbiotics within 1 hour - ED (E-Sepsis Module)	Dec 23	79.59%	90.00%	90%	F	H	71.3%	63.2%	79.5%
VTE Risk Assessment	Dec 23	89.13%	95.00%	95%	F	?	91.1%	87.8%	94.5%

Footnotes

* The Variation SPC icon is based off the target column. The monthly trajectory column has been added for information only

** Targets are sourced from Trust Board approved targets / constitutional standard targets / local expectations

*** The target for C Difficile is cumulative but the metric is reported monthly, therefore the year target has been divided by 12 in order to populate the Variation SPC icon

Care Colleagues
Collaboration Communities

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**).

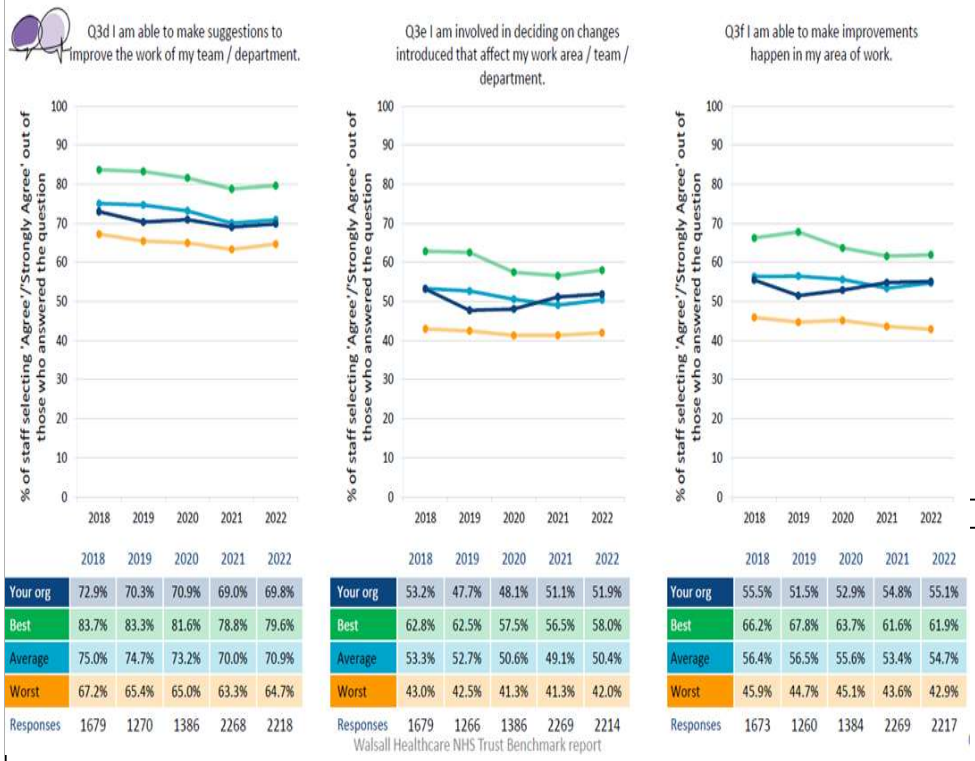
Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator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

Strategic Aim: CARE

Strategic Objective: **We will embed a culture of learning and continuous improvement at all levels of the organisation**

Board Level Metric(s): **10% increase on previous year in the percentage of staff responding positively in the annual staff survey when asked if they are able to suggest and make improvements in their area**



	Q3d 2018	Q3d 2019	Q3d 2020	Q3d 2021	Q3d 2022
Your org	72.9%	70.3%	70.9%	69.0%	69.8%
Best	83.7%	83.3%	81.6%	78.8%	79.6%
Average	75.0%	74.7%	73.2%	70.0%	70.9%
Worst	67.2%	65.4%	65.0%	63.3%	64.7%
Responses	1679	1270	1386	2268	2218

	Q3e 2018	Q3e 2019	Q3e 2020	Q3e 2021	Q3e 2022
Your org	53.2%	47.7%	48.1%	51.1%	51.9%
Best	62.8%	62.5%	57.5%	56.5%	58.0%
Average	53.3%	52.7%	50.6%	49.1%	50.4%
Worst	43.0%	42.5%	41.3%	41.3%	42.0%
Responses	1679	1266	1386	2269	2214

	Q3f 2018	Q3f 2019	Q3f 2020	Q3f 2021	Q3f 2022
Your org	55.5%	51.5%	52.9%	54.8%	55.1%
Best	66.2%	67.8%	63.7%	61.6%	61.9%
Average	56.4%	56.5%	55.6%	53.4%	54.7%
Worst	45.9%	44.7%	45.1%	43.6%	42.9%
Responses	1673	1260	1384	2269	2217

Supporting Information

Q3d – I am able to make suggestions to improve the work of my team/department – 2022 score 69.8%.
Q3e – I am involved in deciding on changes introduced that affect my work /area/team/department – 2022 score 51.9%%.
Q3f – I am able to make improvements happen in my area of work – 2022 score 55.1%.
Annual staff survey results – Due February 2024.

Analyst Narrative:

Benchmark data available from 2018. Scores for each Question have broadly remained the same, although an increase of 2% from 2020 for Q3f.

Updated data will be available Feb 2024.

Executive Narrative:

Executive Director Lead: Simon Evans

Executive Narrative: Although this specific metric is in relation to the annual staff survey, questions within the quarterly pulse survey include the following: 1. I am able to make suggestions to improve the work of my team/department, 2. I am able to make improvements happen in my area of work. 3. There are frequent opportunities for me to show initiative in my role. Proposal to track these results quarterly (Q3 pulse survey is replaced with the annual staff survey) which will provide more meaningful and timely data.

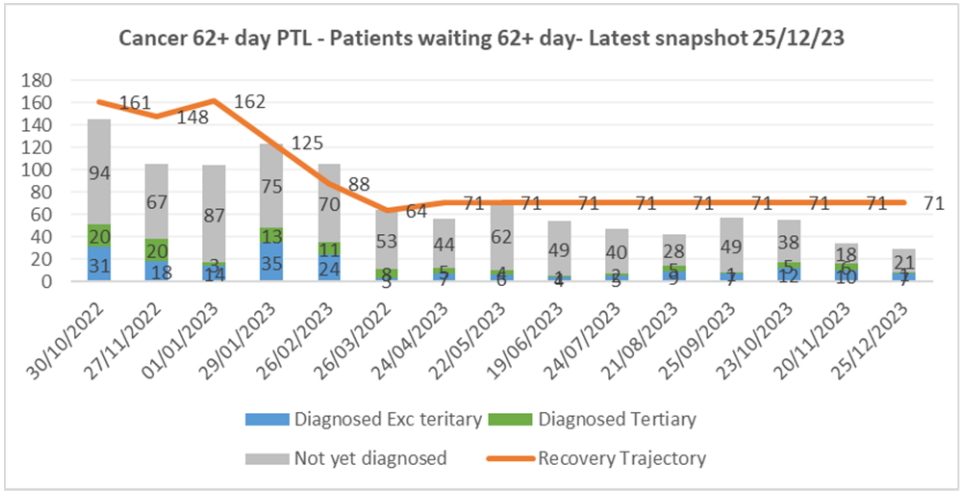
ACTION	BY WHO	BY WHEN
Agreement to include (or replace) with the quarterly pulse survey results to track this metric.	Simon Evans	Feb-24

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

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



Analyst Narrative:

The number of patients waiting over 62 days continues to reduce, as at the snapshot 25th December 2023, there were 29 patients on the PTL over 62 days. This is ahead of the submitted trajectory.

Submitted forecast for patients waiting 62 days +:

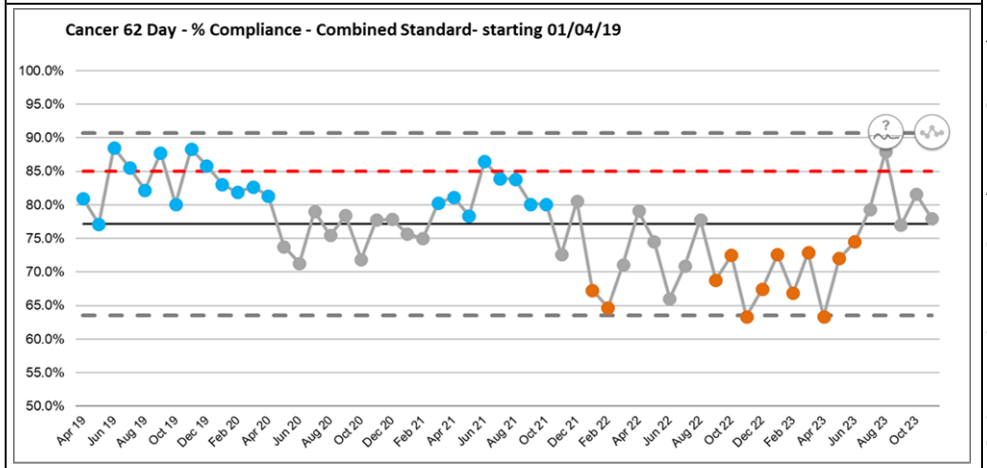
Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
123	117	111	106	100	95	89	84	78	72	67	61

part of the new 62-day combined performance indicator. There has been no statistical variation for the last 5 months however performance has been on or above mean average. This places the Trust in the upper quartile of performance nationally, at 18th best performing Trust out of 119 reporting general acute Trusts.

The trusts national ranking for 62 day referral to treatment of all cancers (old metric) was 27th nationally and 1st out of 20 trust regionally. This places the Trust in the upper quartile of performance nationally out of 119 reporting Trusts.

The Trust met the new 28 day faster diagnosis standard in October, ranked 9th out of 119 Trusts nationally and continue to perform positively against this standard. (Early diagnosis supports achieving the 62 day standard).

SUPPORTING METRICS



Executive Narrative:

Issues:

The core risks to delivery are currently timely endoscopy access (specifically for colonoscopy) and urgent histopathology results, as delivered by the Black Country Pathology Service. Work continues to reduce colorectal waiting times, as this is a significant contributor to the number of patients waiting over 62-days.

Dermatology continues to be challenged to keep booking days under 14 days (old cancer metric 2 week waits).

Mutual aid between RWT & WHT continues for Dermatology, which is supporting reduced booking days.

Actions:

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

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

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

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

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

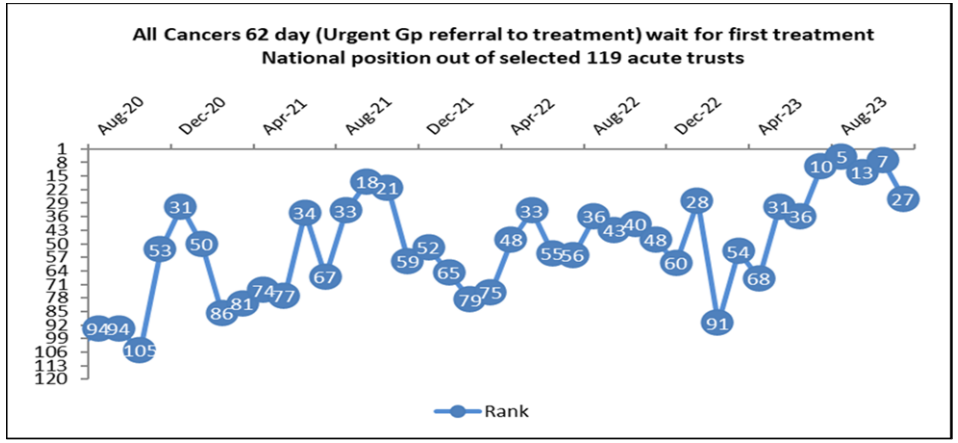
Due to recent challenges with 2ww capacity, the cancer team have implemented a 6 week forward look of available capacity for 2ww appointments against predicted demand with an agreed escalation process to the care group and the Deputy Divisional Director of Operations

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

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



ACTION	BY WHO	BY WHEN
Endoscopy expansion business case	Director of Ops MLTC	From Oct 23 - into 24/25
BCPS recovery plan - At Walsall we have set up a working group to look at the various workstreams to support the improvement	Interim Director of WC&CSS (support services)	Ongoing
Request to SWBH to increase radiology capacity clinics and support an additional rapid access clinic per week. (breast)	Interim Director of WC&CSS (support	Apr-24
consultant led triage of breast referrals to commence in January	Care Group Manager	Jan-24
Introduction of Breast pain clinics run by a Surgical Care Practitioner	Care Group Manager	Feb-24
Update to Cancer Access Policy	Deputy Director Division of Surgery	Mar-24

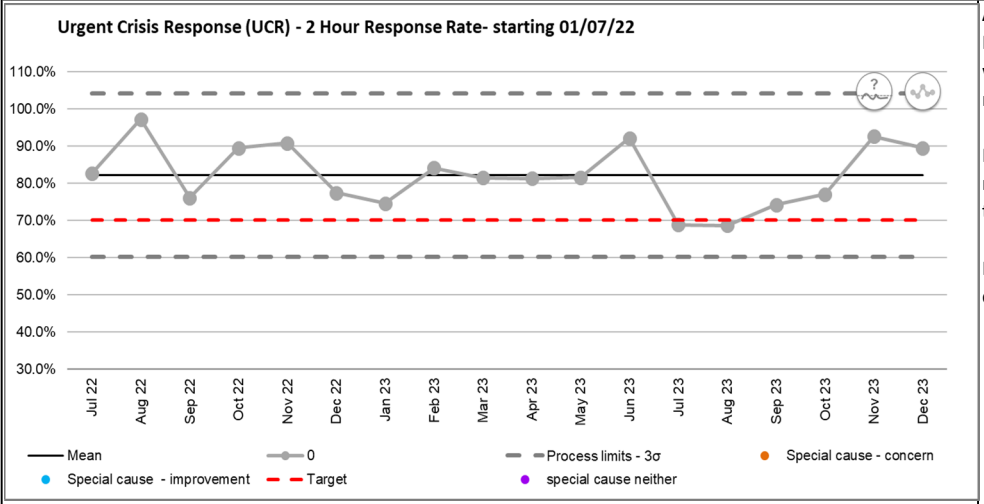
above ranking chart reflects the old cancer metric for 62 day Gp referral to treatment and not the new combined metric.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

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



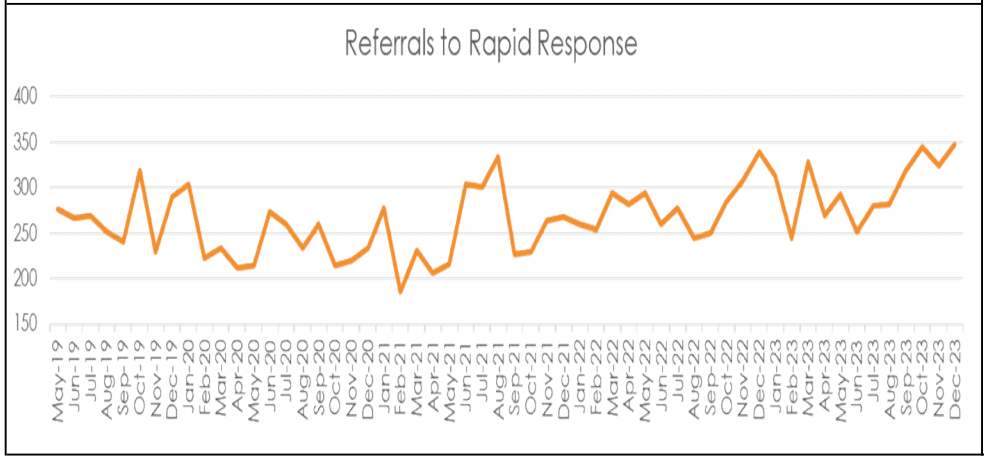
Analyst Narrative:

Performance against the national constitutional standards for response rates within 2 hours continues to be within normal statistical variation. December reported 89.49% above the target of 70% (for the 4th consecutive month).

Rapid Response received 365 referrals in December. These are patient with acute exacerbation of symptoms requiring an urgent intervention to potentially prevent a hospital admission. Rapid Response intervention led to 91% of patients avoiding an admission (332).

Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non-clinical referrals.

SUPPORTING METRICS



Executive Narrative:

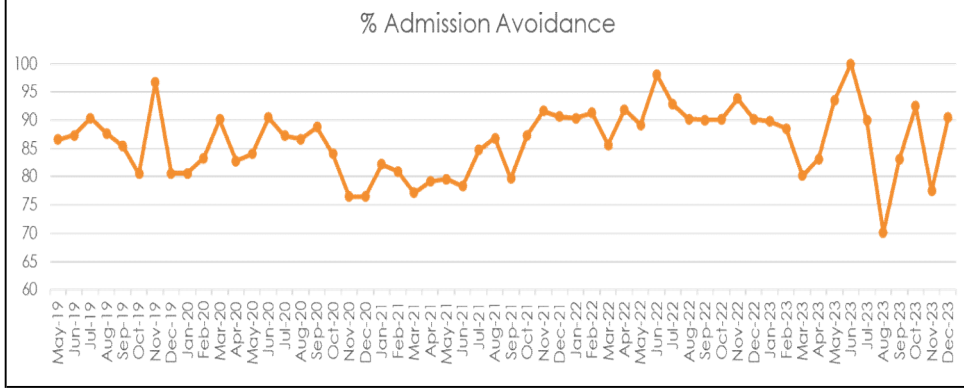
The continuing expansion of our collaboration with WMAS and subsequent increases in referrals has necessitated a review of the operational hour of Rapid Response. It has been established that the service would benefit from moving to a 24/7 model. A project has therefore commenced to merge UCR teams with Rapid Response to expand the operational hours. This project will be completed by the end of the financial year.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

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



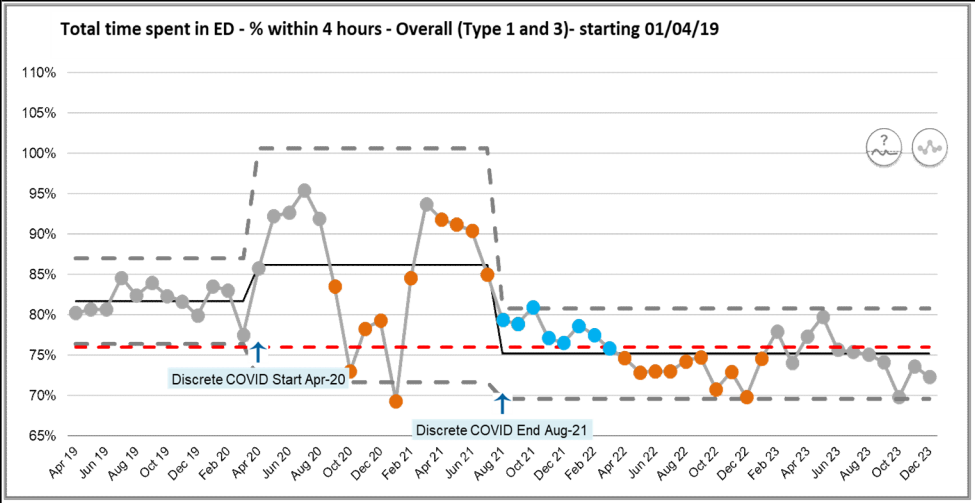
ACTION	BY WHO	BY WHEN
Merge of UCR & Rapid Response	Community Leadership Team	Mar-24

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

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



Analyst Narrative:

From April 2023 the national constitutional target changed to 76% for Percentage of Accident & Emergency attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival.

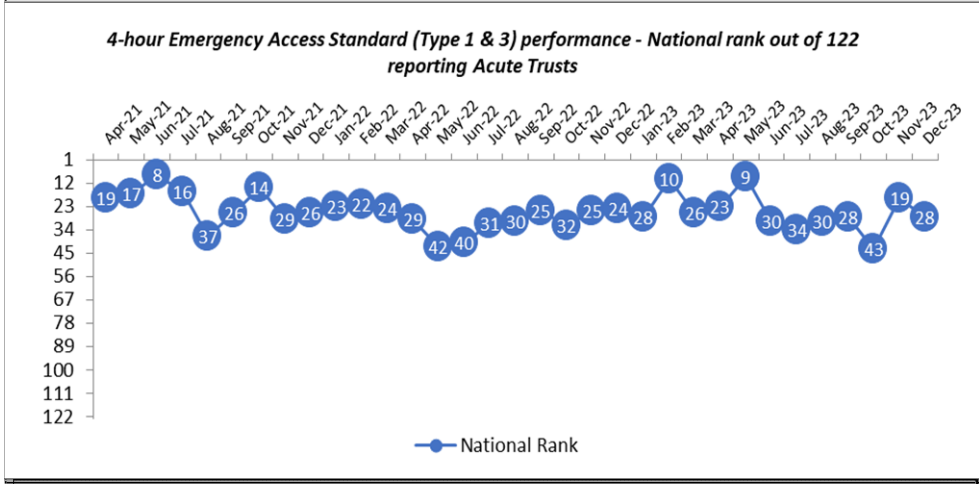
In December the Trust fell short of this target with a performance of 72.3%, this is showing no statistical change to the 4-hour performance percentage, with 11 data points showing normal variation (noting the application of stepped change on the chart for the Covid period).

December was the second highest month of Type 1 ED attendances received on record, and significant Exit Block for patients requiring admission from ED was experienced.

WHT's national ranking is 28th best Trust out of 122 reporting Acute Trusts in December 2023, remaining upper quartile. Regional ranking is 3rd out of 21 Trusts.

The Trust remains in the 2nd best quartile for the percentage of ED attendances spending 12 hours in ED from time of arrival compared to the national position.

SUPPORTING METRICS



Executive narrative:

Issues: December 2023 was the second highest month of type 1 attendances in ED on record and the second highest month of net importing of Intelligently Conveyed ambulances to Walsall Manor hospital on record, with 212 ambulances conveyed to Walsall Manor, and 24 conveyed away, representing a net import of 188 ambulances. This is a reflection of the extent of pressure at neighbouring organisations and poses a risk to the Trust's ability to maintain timely access to emergency care locally, and also poses a significant financial risk too.

Challenges continue in the:

ability to improve Non Admitted pathway, ability to effectively manage the increase in Mental Health presenting patients to ED., appropriate streaming of GP referrals and delays in accessing imaging (particularly CT).

Actions:

New Ambulatory Emergency Care Unit with expansion in Assessment rooms to take both returning AEC patients and GP referrals streamed from ED. The new Unit opened January 2024..

Introduction of a new Hot Imaging Suite, located adjacent to the new ED to open in Spring 2024.

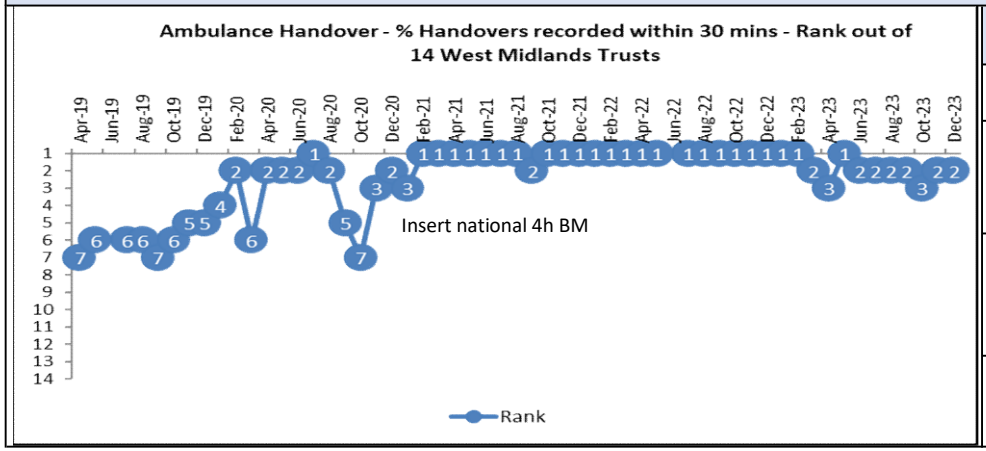
21 Winter Plan general medical beds are open and have been throughout December.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

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



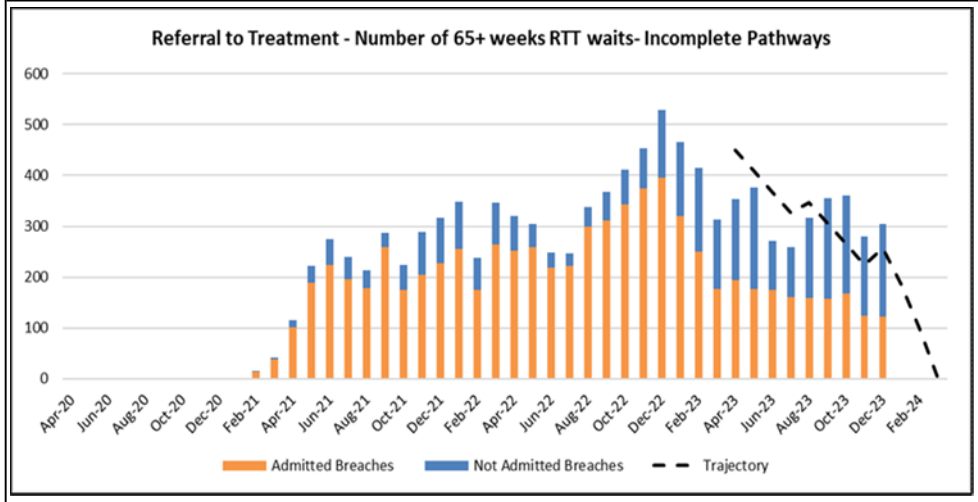
ACTION	BY WHO	BY WHEN
New Medical SDEC, expanding assessment spaces to 15 and streaming all GP referrals away from ED.	MLTC Divisional Team	Jan-24
Introduction of a decision-support module within AskEarl (the referral system utilised in ED and Acute Medicine)	MLTC Divisional Team	Jan-24
Introduction of a new Hot Imaging Suite, located adjacent to the new ED. The Suite will provide dedicated imaging support for both CT and Ultrasound	MLTC Divisional Team / Imaging Care Goup Manager	May-24

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

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



Analyst Narrative:

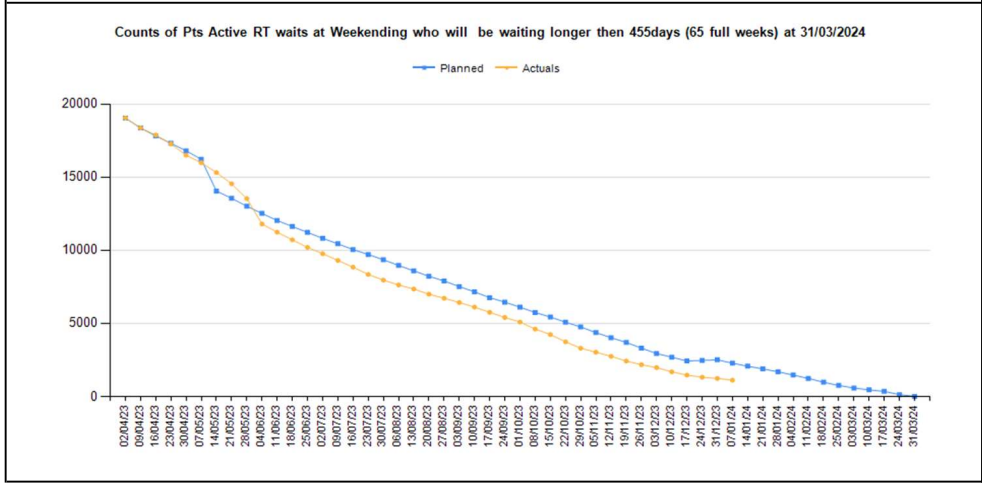
The Trust delivered the national standard to have no patients waiting in excess of 78 weeks as of the end of December 2023 (excluding patient choice), for the 10th consecutive month.

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

The Trust's 65-week waiting time (as a % of total PTL) is in the 2nd best quartile at 55th nationally (out of 120 trusts) and 8th regionally in the Midlands out of 21 Trusts. (third chart)

In December, the RTT performance was 56.69%, slightly below the forecast of 57%. The Trust's ranking position for RTT is demonstrating incremental improvement this financial year and critically the number of patients on the Trust's total elective waiting list is now falling from a peak of 35,882 in April 2023 to 31,255 in December 2023 (12.9% reduction).

SUPPORTING METRICS



Executive Narrative:

Issues: The Trust postponed 304 outpatient and 22 elective procedures due to industrial action in December 2023 (although lost elective surgical capacity was far greater than this as bookings into theatre lists on strike days were suspended once the strike dates were announced). December shows a decrease in sessions undertaken and a decrease % usage from the previous month with 262 out of a potential 305 session utilised - (86% of sessions utilised) compared to Nov 330/341 (97% of sessions in Nov). 30 sessions given up due to Junior Doctor strike action. Despite this, Walsall Healthcare Trust remain in the top Quartile (4) for capped theatre utilisation with an average of 90.3%.

Actions: An additional 6.5 theatre sessions were established from 23rd October 2023 following approval of a business case for theatre expansion to support elective recovery, meaning that November saw the highest number of cases through theatres post-COVID.

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

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

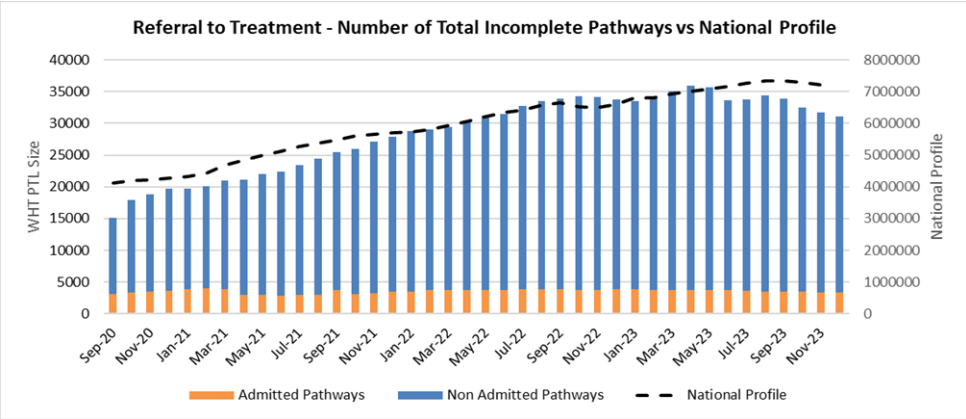
Plans have been put in place to support challenged specialties with achieving no patients wating at 31st March 2024 over 65 weeks, with additional clinics and theatre capacity.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: CARE

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

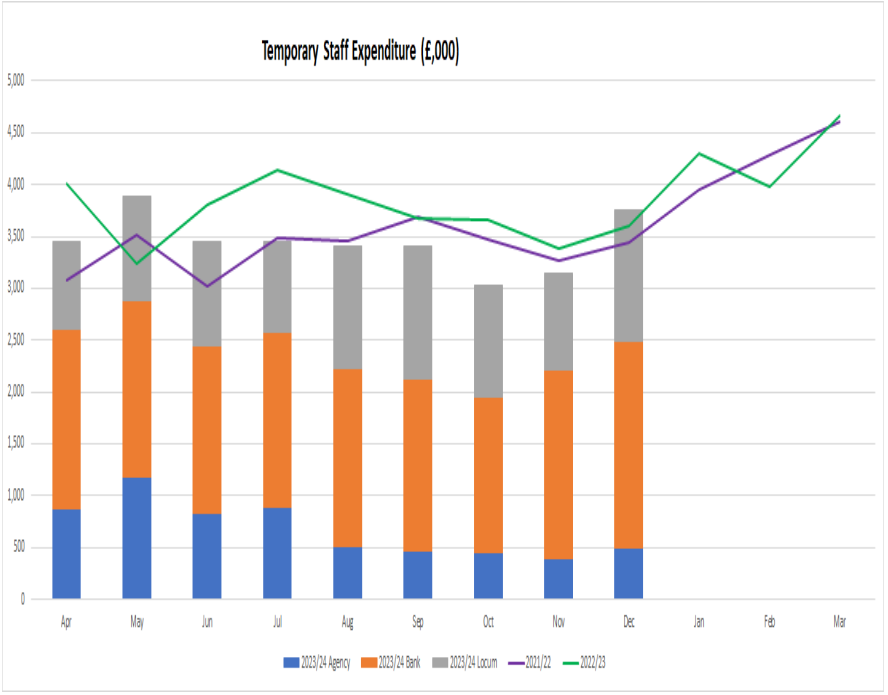
Board Level Metric(s): **Eliminate 78 weeks by the end of June 2023 (excluding patient choice) / Eliminate 65 weeks by the end of March 24 (excluding patient choice)**



ACTION	BY WHO	BY WHEN
Participating in NHSE Further Faster Programme	Lead Div Director Ops DoS	Q4
Implementing PIDMAS Patient initiated digital mutual aid system)	Lead Div Director Ops DoS	Sep-24
Outpatients transformation Project (Internal)	Lead Div Director Ops DoS	Q3
Capital Funding for the refurbishment of Main Theatres has been agreed,	Lead Div Director Ops DoS	Dec-24

Financial Performance to December 2023 (Month 9)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Subtotal Income	286,655	290,400	3,745
Subtotal Pay Expenditure	(195,906)	(204,919)	(9,013)
Subtotal Non Pay Expenditure	(95,031)	(103,608)	(8,577)
Subtotal Finance Costs	(9,623)	(10,440)	(817)
Total Surplus / (Deficit)	**(13,905)**	**(28,566)**	**(14,661)**
Plan Re-Profile	4,138	0	(4,138)
Adjusted Surplus / (Deficit)	**(9,767)**	**(28,566)**	**(18,799)**



Financial Performance

- The Trust has submitted a deficit plan of £14.05m for 2023/24
- The Trust has reprofiled the submitted deficit plan
- The financial settlement offered to the Trust for 2023/24 has a considerable decrease in revenue. Trust plans show a higher % reduction in income than other acute providers in the system.
- The income movements following Covid-19 rescinding and changes to IPC guidelines has resulted in reduced income allocations for the 2023/24 financial year. It will be important the Trust moves quickly into financial recovery and more 'normal' operational performance
- The Trust has delivered a deficit of £28.566m at Month 9, this is £14.661 above the planned deficit of £13.905m.
- Income was £3.745m above plan (this includes £2.612m over performance against the ERF target) Staffing costs were £9.013m above plan and non-pay costs were £8.577m above plan.

Capital

- Trust Board approved a level of capital expenditure of £25m for the 2023/24 financial year. This includes £2.5m of PDC funding for digital aspirant schemes and £12.6m grant funding for decarbonisation projects.
- The capital plan in 2023/24 is not fully funded and projects need to be prioritised to live within the available envelope.
- Year to Date Capital expenditure for Month 9 was £5.992m against a plan of £20.866m.

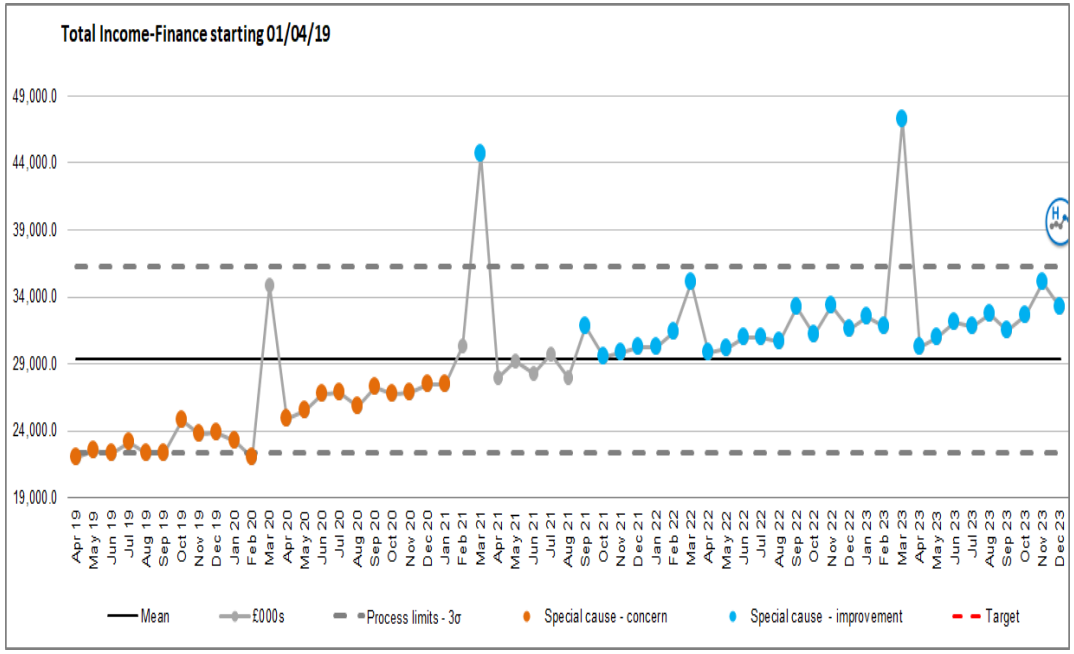
Cash

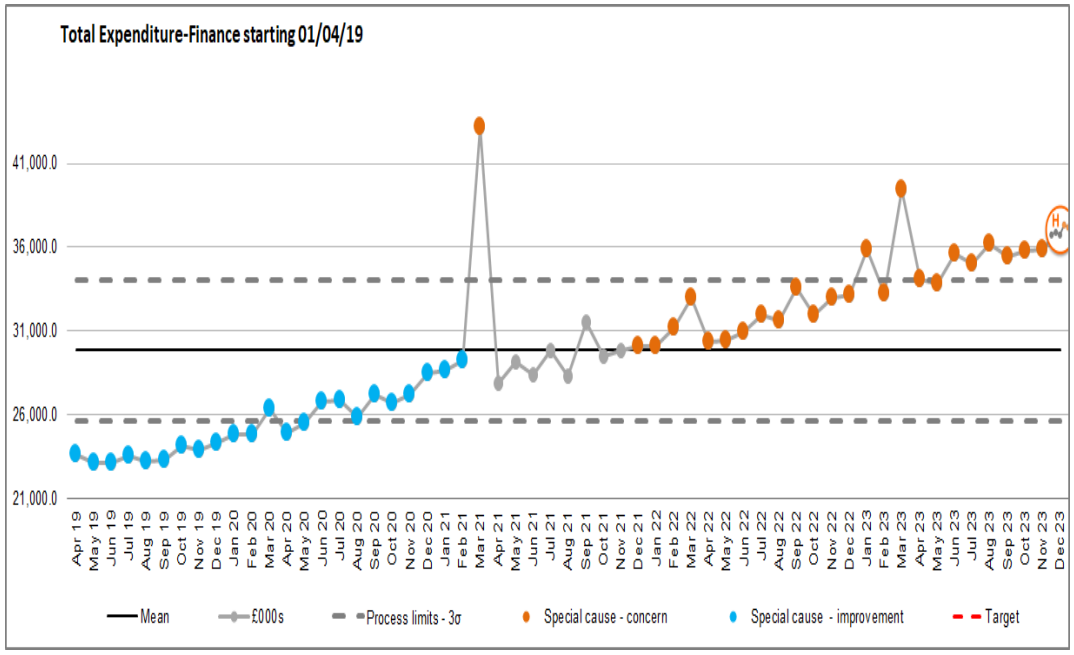
- The Trust currently holds a healthy cash position, however the forecast deficit results in the need for borrowing in future months. The trust is seeking cash support from the ICB during Q3.

Efficiency attainment

- Traditional CIP plans (£17.2m Divisional Target) are currently at 81% achievement (64% Recurrent & 36% Non- Recurrent)
- FOT delivers 65.3% of the £26.45m stretch original planned savings
- FOT savings of £17.3m of which £2.8m are high risk (£0.5m still to be identified) and £4.6m are medium risk schemes (including £3.3m of technical adjustments).

Income and expenditure run rate charts





Income additional information

- Income spiked in March 2023 due to the 23/24 pay award non-consolidated retrospective payment funding
- Income has reduced in 2023/24 due to covid allocation reductions, WHT losing more income proportionally compared to other providers in the system
- January and February 2020 income reduced as the Trust moved away from plan, losing central income from the Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) during these months
- March 2020 saw the Trust move back on plan and receive the quarters FRF and PSF in month accordingly.
- April's income reflects the emergency budget income allocation (increasing monthly to reflect the increase in the top up of funding received).
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.
- In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment.
- The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears.

Expenditure additional information

- Expenditure spiked in March 2023 due to a provision for the 23/24 pay award non-consolidated retrospective, as the funding was received in that month
- March 2020 costs increased to reflect the Maternity theatre impairment £1m & Covid-19 expenditure
- Costs increased in support of COVID-19, with June and July seeing these costs increase further for elective restart and provision for EPR, Clinical Excellence Awards impacts on cost base, noting a reduction in expenditure in August due to the non recurrent nature of these. Spend increased again in September due to back dated Medical Pay Award, increased elective activity and non recurrent consultancy spend and increased further in Q4 20/21 driven by the additional pressures of a second wave of COVID activity.
- March 21 spend includes non recurrent items such as Annual leave accrual, adjustments for Push stock, and non recurrent spend on the Digital Aspirant Programme offset by income.
- In September 2021 the back dated pay award was paid to staff, increasing in month spend by £2.5m

Walsall Healthcare NHS Trust

Trust Board Meeting - to be held in Public
14 February 2024

Title of Report	Performance & Finance Committee Chair's Report	ENC 8.2
Author:	Paul Assinder	
Presenter:	Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	24th January 2024	

Action Required of Committee/Group			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☒	Yes☒No☐	Yes☐No☒	Yes☒No☐

Recommendations:

The Board are asked to note the increased risk to the achievement of the 2023/24 Financial Plan

ALERT

Financial Performance 2023/24 Year to date

1. The Trust is currently working to an agreed deficit plan for 2023/24 of £14.5m.
2. The reported Month 9 (31st December 2023) deficit position is £28.6m (prev month £24.7m), which is c£14.7m worse than period plan.
3. Key drivers of the Month 9 position are:
    a. Excess Inflation c£4.4m
    b. Cost of Industrial Action c£2.0m
    c. Additional staffing in ED & Paediatrics c£5.2m
    d. Unidentified CIP of £6m

4. Cash remains a concern to the Committee, with a projected need for external loan funding of c£18.5m, required in March.

5. The Committee is extremely concerned about the robustness of the Trust's 2023/24 Annual Financial Plan:
    a. At Month 9 only £14.5m of required £17.2m efficiency opportunities have been identified to date, 84.4%. Although some additional ERF generation opportunity is possible.
    b. Temporary workforce spending continues in some areas above plan.
    c. The costs of industrial action is not factored into plans or funded.

6. The Black Country ICS remains off plan for the period, by c£19m, with a forecast of £102m deficit.

The Board should note that A&E attendances in December were c15% higher than in 2022 and Non Elective 0LoS attendances up 13%. Further the Trust had a net importation of ambulance attendances of 188 in the month.

Endoscopy & Non Obstetric Ultrasound

These modalities are the biggest waiting issue in December. The departments' mitigation plans have proved successful but the Committee is closely monitoring the position.

Cancer Care

Some 81.6% of referrals met the 62 days wait target in December. The Board has previously been alerted to mitigation plans for delays in 2 weeks wait standards for Breast and skin, which remain issues.

Industrial Action

Cancellations to date for industrial action are 2,610 out patient appointments and 202 surgical procedures.

Financial Recovery Plan 2024/25 to 2028/29

The Committee considered a presentation by PA Consulting Ltd on the detail of the Black Country Financial Recovery Plan. This identifies a underlying deficit of c£267m for the wider system and c£50m in Walsall. It identifies potential efficiency opportunities of c£149 over a 5 year period and assumes an additional routine efficiency contribution of 4% per annum by all trusts over this period. The Committee expressed the need for much further work to be done on detail and FRP governance before these plans are presented to boards.

ADVISE

Urgent & Emergency Care

The Manor 'imported' over 230 ambulances from neighbouring systems in December – a monthly record, as was November.

Business Cases

The Committee endorsed 2 business cases which generate a net surplus (based upon current ERF reimbursement regimes):

1) Utilisation of New Lead-lined Procedure Room
2) Respiratory Care Expansion Case

These cases now require board consideration

ASSURE

Urgent & Emergency Care

The Trust continues to perform well against local and national peers for emergency care. Ambulance handovers 72% under 30 minutes and 74% under 4 hours in ED.

Elective & Planned Care

The Trust continues to hit the 78 weeks waiting target for planned care and the 28-day faster diagnostics standard.

Walsall Healthcare NHS Trust

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable):		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led Standards
	NHSE	Yes☒No☐	Details: Well-led Standards
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	NHS Constitution	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	Other	Yes☐No☒	Details:

Summary of Key Issues:
As noted above

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Report	Working/Executive	Yes☐No☒	Date:

Journey/Destination Significant follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Group		
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

Walsall Healthcare NHS Trust

EXCEPTION REPORT FROM PERFORMANCE & FINANCE COMMITTEE CHAIR

MATTERS FOR THE BOARD's ATTENTION **Information, issues et.al that either require bringing to the Board's attention or that Board may need to deal with, any matters requiring Board delegation** **As above**
ACTIVITY SUMMARY
Matters presented for information or noting As above
Chair's comments on the effectiveness of the meeting:

Walsall Healthcare NHS Trust

Trust Board Meeting - to be held in Public
14 February 2024

Title of Report	Finance and Productivity Committee Chair's Report	Enc 8.2
Author:	Paul Assinder	
Presenter:	Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	3rd January 2024	

Action Required of Committee/Group			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☒	Yes☒No☐	Yes☐No☒	Yes☒No☐

Recommendations:

The Board are asked to note the increased risk to the achievement of the 2023/24 Financial Plan

ALERT

Financial Performance 2023/24 Year to date

1. The Trust is currently working to an agreed deficit plan for 2023/24 of £14.5m.
2. The reported Month 8 (30th November 2023) deficit position is £24.7m, which is c£10.2m worse than period plan.
3. Key drivers of the Month 8 position are:
    a. Excess Inflation c£3.5m
    b. Cost of Industrial Action c£1.7m
    c. Additional staffing in ED & Paediatrics c£3.8m
4. Cash remains a concern to the Committee (£18.6m balance at Month 8), with a projected need for external loan funding of c£17.4m, required in Q4.
5. The Committee is extremely concerned about the robustness of the Trust's Annual Financial Plan:
    a. At Month 8 only £14m of required £17.2m efficiency opportunities have been identified to date, 81%. Although some additional ERF generation opportunity is possible.
    b. Temporary workforce spending continues in some areas above plan.
    c. The costs of industrial action is not factored into plans or funded.
6. The Committee has requested a re-casting of the 2023/24 Financial Plan, which the Board may consider for re-submission to the ICB.
7. The Black Country ICS remains off plan for the period, by c£19m.

Endoscopy

Endoscopy services are the Trust's biggest diagnostics challenge with 1,700 patients waiting over 2 weeks for scans. This represents c90% of the total over 2 weeks waits in the Trust. The department's mitigation plans have proved successful but the Committee is closely monitoring the position.

Cancer Care

Some 81.6% of referrals met the 62 days wait target in November. The Board has previously been alerted to mitigation plans for delays in 2 weeks wait standards for Breast and skin.

Industrial Action

Cancellations to date for industrial action are 2,610 out patient appointments and 202 surgical procedures.

ADVISE

Urgent & Emergency Care

The Manor 'imported 245' ambulances from neighbouring systems in November – a record.

ASSURE

Urgent & Emergency Care

The Trust continues to perform well against local and national peers for emergency care. Ambulance handovers 89% under 30 minutes and 74% under 4 hours in ED.

Elective & Planned Care

The Trust continues to hit the 78 weeks waiting target for planned care. We marginally failed the 28-day faster diagnostics standard for October (73.7% v target 75%).

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	Note new risks to endoscopy waiting times and working capital. Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable):		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led Standards
	NHSE	Yes☒No☐	Details: Well-led Standards
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	NHS Constitution	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	Other	Yes☐No☒	Details:

Summary of Key Issues:
As noted above

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Report Journey/Destination Significant follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

Walsall Healthcare NHS Trust

EXCEPTION REPORT FROM PERFORMANCE & FINANCE COMMITTEE CHAIR

MATTERS FOR THE BOARD's ATTENTION **Information, issues et.al that either require bringing to the Board's attention or that Board may need to deal with, any matters requiring Board delegation** **As above**
ACTIVITY SUMMARY
Matters presented for information or noting As above
Chair's comments on the effectiveness of the meeting:

Walsall Healthcare NHS Trust

Trust Board Meeting to be held in Public
14th February 2024

Title of Report	Quality Committee	Enc No: 8.3
Author:	Dr Julian Parkes	
Presenter:	Dr Julian Parkes	
Date(s) of Committee/Group Meetings since last Board meeting:	26th January 2024	

Action Required of Committee/Group			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☒No☐
Recommendations: The Board is asked to note the contents of the report			

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	None if none. Risk Description Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: All domains
	NHSE	Yes☒No☐	Details:
	Health & Safety	Yes☒No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☒No☐	Details:
	Other	Yes☐No☐	Details:

Summary of Key Issues:
Please see Alert, Advise and Assure sections

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Report Journey/ follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date
	Other	Yes☐No☐	Date:
Any Changes to Workplan to be noted	Yes☐No☐		Date:

Walsall Healthcare NHS Trust

EXCEPTION REPORT FROM QUALITY COMMITTEE CHAIR

ALERT

- Endoscopy access remains a challenge but now recruitment is in place and there is trajectory to clear the backlog by the end of June 2024. Non obstetric ultrasound also remains a challenge
- 7 cases of C Diff were reported in December 2023 and 4 of these were deemed avoidable
- VTE compliance was 88.47% in December 2023
- Level 3 safeguarding remains below Trust target but it is now improving
- 102 incidents initially graded as moderate harm, severe harm or death are being investigated
- Only 50% of reports issued by the National Audit Office are being reviewed
- Medical records filing remains a significant problem for WHT. Includes an increasing problem with loose filing not being completed and a huge backlog, case note tracking not in place leading to missing records and lack of staff responsibility for the handling of records. Current working conditions are inadequate and relocation to a new Portakabin facility is due to be operational in April 2024. This service is currently managing 4 trust wide risks

ADVISE

- The Trusts 18 week RTT performance has 56.7% waiting under 18 weeks and a national position of 61/121, the Trusts highest ranking in 2 years
- Adult virtual wards continue to offer 80 beds and usage went up in December 2023 but numbers remain below service capacity
- For adult inpatients 73.6% received antibiotics in the first hour, in ED the rate was 79.86% in December 2023
- The nursing and midwifery vacancy rate has risen slightly to 6% from 4% in October 2023
- Occupational Health are offering measles vaccine to those staff who are not immunized
- Midwife Support Worker recruitment has been generally successful, leaving a small number of roles to be filled
- The complex case review of upper limb patients has been completed. It has led to an area of concern with hand and wrist surgery and it is suggested that a second phase of investigation is performed in this area

ASSURE

- Goscote Hospice has achieved the Trusts first Sapphire clinical accreditation review rating
- The Trust continues to deliver some of the best ambulance handover times in West Midlands with 83.04% of patients handed over in 30 minutes in December 2023
- 72.3% of patients were managed in ED within the 4 hour window against the revised national target of 76%. It remains in the upper quartile of reporting Acute Trusts
- 78% of patients with confirmed cancer were treated within 62 days, placing the Trust in the upper decile nationally.
- The Trusts RTT incomplete waiting list shows incremental reductions, falling from a peak of 35,882 to 31,255.
- All appropriate Health Visitor contacts are being completed face to face.
- There has been a high level of demand for the Care Navigation Centre, Rapid Response team and Front Door Service
- Falls per 1000 bed days remains low at 3.30 in December.
- Timeliness of observations as 87.01% in December and 91.28% excluding ED
- The latest SHMI is 0.9933 which is within the expected range for Aug 2022 to July 2023

MATTERS FOR THE BOARD's ATTENTION
Information, issues et.al that either require bringing to the Board's attention or that Board may need to deal with, any matters requiring Board delegation

- The Board is asked to note the high risks associated with the issues described with regard to record availability and large amounts of outstanding loose filing centrally and also at ward level
- The Board is asked to note the proposed opening of a second phase of work looking at more hand and wrist patients who have undergone surgery within the complex case review
-

ACTIVITY SUMMARY
Presentations/Reports of note received including those Approved

Constitutional Standards and acute service restoration and recovery report
Performance Constitutional Standards report for Community.
Safe high quality care report
Maternity Services Update
Serious Incident update
Corporate risk register Quality
Clinical Audit and effectiveness update
Information Governance Steering Group
Health Records Improvement Plan
Learning from Deaths report
Complex Case recall project

Matters presented for information or noting

104 day harm update
Mental Health update
Research and development report
Medicines safety Officer report
Quarter 2 CQUIN report

Chair's comments on the effectiveness of the meeting:

Walsall Healthcare NHS Trust

Chairs Summary Log for xxx Committee, date of Log xx/yy/zz

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Health Records availability and filing	• Phase 2 of hand and wrist recall project
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Goscote Hospice attaining Sapphire clinical accreditation	

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14 February 2024		
Title of Report:	Group Chief Finance Officer Report	Enc No: 8.5
Author:	Dan Mortiboys, Operational Director of Finance	
Presenter/Exec Lead:	Kevin Stringer, Group Chief Finance Officer	

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

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Risks 2081 and 2082 deal with the risk of deficit in year and the financial sustainability of the Trust respectively. On Risk Register: Yes☒No☐		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	The Report summarises the overall financial position of the Trust at Month 3		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☐No☒	Details:
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains			

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☒No☐	Date: 26 July 2023 PF Committee

or matters that may have been referred to other Board Committees	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure
Advise
Alert ThThe Trust is reporting a YTD deficit of £28.568m at the end of Month 9. This is £14.661m adverse to the (revised) submitted plan and £18.799m adverse to the original plan submitted to NHS England. All Trusts were asked by NHSE nationally to provide a full year 2023/24 outturn forecast in November. The Trust engaged with the ICB and a forecast of £27.95m was agreed. NHSE have now advised that this forecast can be altered by the impact of industrial action in December and January, allowing for a current forecast of £30.99m deficit. The forecast includes a £4.5m stretch target which the Trust continues to find a route to achieving. Excluding technical adjustments, there remains a £3.2m shortfall in CIP plans. CIP (including technical adjustments) was £5.973m behind plan at Month 9 The Trust is carrying significant financial risks in 2023/24 and is working on all possible mitigations.

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

ENC 8.5.1

Report of the Group CFO

for the month of December 2023 (Month 9)

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

Care Colleagues
Collaboration Communities

Summary

Overview of Financial Performance

The Trust is reporting a YTD deficit of £28.568m at the end of Month 9. This is £14.661m adverse to the (revised) submitted plan and £18.799m adverse to the original plan submitted to NHS England.

Income is positive to plan by £3.745m due largely to , £2.305m of Education & Training income (offset by costs) and additional income as the Trust is ahead of elective recovery targets.

Pay is overspent by £9.013m. The Trust has incurred extra costs providing cover for junior doctor and consultant strikes (£1.923m). While substantive pay is underspent due to vacancies, this underspend is more than offset by temporary staffing costs.

For non pay drugs are overspent by £1.404m. Clinical supplies and services overspend is being driven by increased usage of hearing aids in audiology, YMS Endoscopy outsourcing and wheelchairs. Non Clinical Supplies and other non pay overspend is driven by various inflationary pressures, adhoc / unfunded costs linked to security, small works etc in addition to cost pressures from insourcing and outsourcing to maintain diagnostic performance.

System Updates

The ICB has a YTD deficit of £80.7m, £16.8m adverse to plan with 5 out of 8 organisations off plan.

Capital

The 23/24 Trust capital programme is £24.403m. The constituent parts of the programme are £9.053m of Capital Resource Limit (CRL) from Black Country ICB, £12.6m of Public Sector Decarbonisation Scheme (PSDS) and £2.75m from NHSE for Front Line Digitisation. YTD expenditure on the programme is £5.992m. Programmes are suffering from differing delays. The Trust now plans for the theatres modernisation programme to commence in March and be completed in the autumn. The expenditure will be part funded by PSDS. For clinical purposes it has been proposed that works in the Old ED to develop hot imaging have a higher clinical priority than develop the ED Shell Space (beds for AMU). The Trust continues to forecast all funds received from the ICB being deployed in the financial year and PSDS deployed as possible within the terms of the agreement.

Cash

The increased deficit has meant that the Trust has had to request cash from NHSE to support the revenue position. The request is for £18.5m of support in March 2024. Written confirmation of this funding is still awaited.

Risks

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

Care Colleagues Collaboration Communities

YTD I&E Performance – Walsall Healthcare Trust

	Plan £000s	Actual £000s	Variance £000s
Income			
Healthcare Income	272,911	273,641	**730**
Other Income (Education&Training)	5,910	8,215	**2,305**
Other Income (Other)	7,835	8,545	**710**
Subtotal Income	**286,655**	**290,400**	**3,745**
Pay Expenditure			
Substantive Salaries	(186,184)	(173,975)	**12,209**
Temporary Nursing	(7,850)	(14,103)	**(6,253)**
Temporary Medical	(1,449)	(11,019)	**(9,570)**
Temporary Other	(423)	(5,822)	**(5,399)**
Subtotal Pay Expenditure	**(195,906)**	**(204,919)**	**(9,013)**
Non Pay Expenditure			
Drugs	(17,571)	(18,975)	**(1,404)**
Clinical Supplies and Services	(14,212)	(17,020)	**(2,808)**
Non-Clinical Supplies and Services	(22,212)	(25,208)	**(2,996)**
Other Non Pay	(30,641)	(32,592)	**(1,951)**
Depreciation	(10,394)	(9,812)	**582**
Subtotal Non Pay Expenditure	**(95,031)**	**(103,608)**	**(8,577)**
Interest Payable	(9,623)	(10,440)	**(817)**
Subtotal Finance Costs	**(9,623)**	**(10,440)**	**(817)**
Total Surplus / (Deficit)	**(13,905)**	**(28,566)**	**(14,661)**
Plan Re-profile	4,138		**(4,138)**
Submitted Plan Profile	**(9,767)**	**(28,566)**	**(18,799)**

Care Colleagues
Collaboration Communities

I&E Performance – Drivers of the Overspend YTD Month 9 – National Pressures

Drivers of the Deficit	YTD M9 £000's
Excess Inflationary Pressures	
Drugs (incl volume)	**1,404**
Energy (incl contracts and leases)	**1,858**
Business Rates	**302**
Provisions	**513**
RPI linked contracts (non PFI)	**255**
Excess Inflationary Pressures - sub total	**4,332**
Other Funding Pressures	
Pay award - 23/24	**200**
Other Funding Pressures - sub total	**200**
Drivers outside WHT Control	
Dr Strike - Acting Down	**1,655**
Dr Strike - Temp Costs	**661**
Dr Strike - Deductions	**(393)**
Drivers outside WHT Control - sub total	**1,923**
Subtotal National Pressures	**6,455**

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

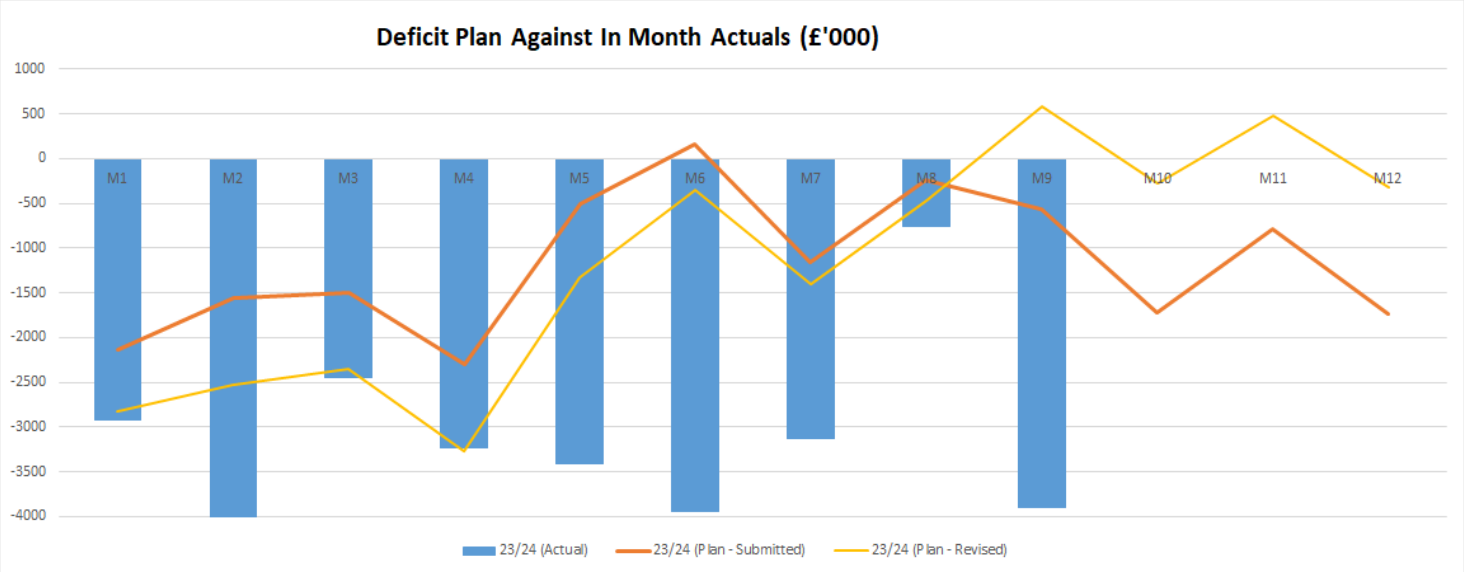
Care Colleagues
Collaboration Communities

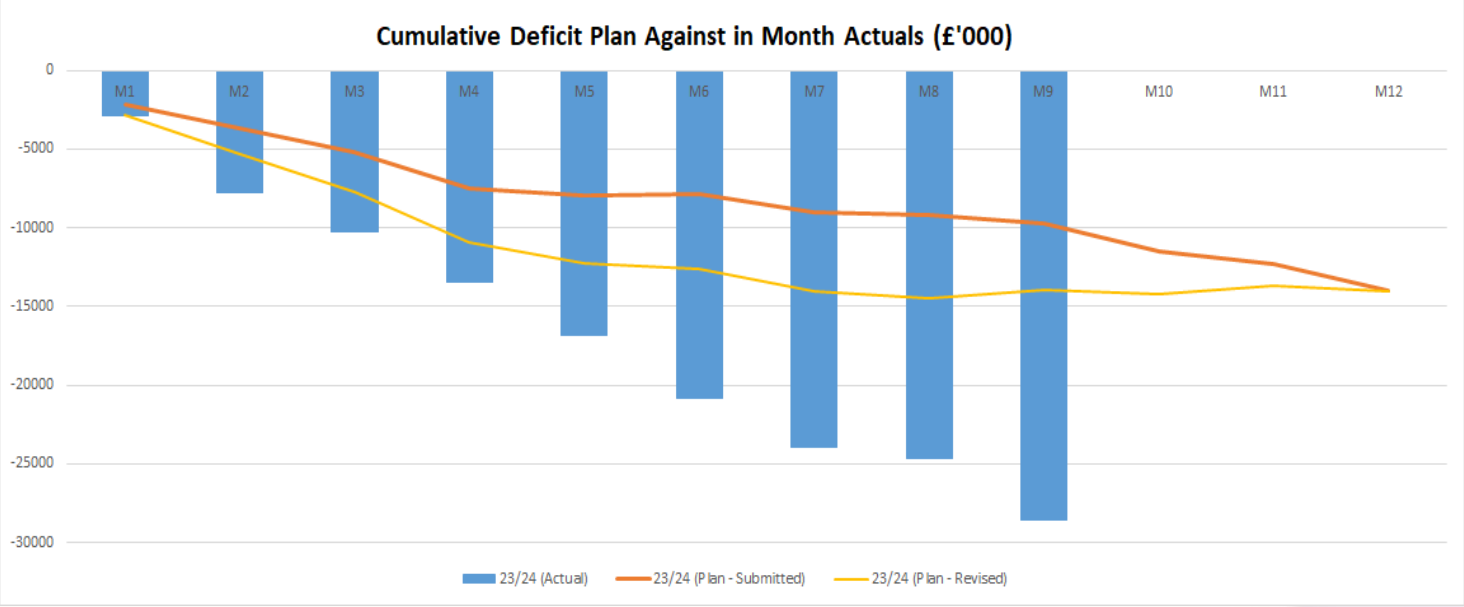
I&E Performance – Drivers of the Overspend YTD Month 9 – Other Pressures

Drivers of the Deficit	YTD M9 £000's
Subtotal National Pressures	**6,455**
Other Drivers	
CIP	**5,973**
ERF Over-performance (Included in CIP from Month 7)	**0**
Healthcare Income overperformance (Drugs and Devices)	**(730)**
Overperformance on Education and Training Income	**(2,305)**
Interest and Other Non Recurrent Income	**(710)**
Anaesthetics Consultant Locums	**1,095**
General Surgery Medical Staff	**1,145**
Paediatric Unfunded Rotas (Nursing and Medical)	**2,026**
Emergency Department Staffing	**2,041**
Gastroenterology Staffing	**508**
Elderly Care Staffing	**720**
Vacancy Underspends	**(5,125)**
Clinical Consumables	**2,372**
Patient Appliances	**389**
Imaging Outsourcing + Mobile MRI	**736**
Other	**71**
Other Drivers - sub total	**8,206**
Total variance to plan	**14,661**

Care Colleagues Collaboration Communities

I&E Performance – Walsall Healthcare Trust





- Revised Plan is for a deficit of £13.905m at Month 9. YTD actual shows an adverse variance to plan of £14.661m

- Important to note that NHSE did not allow WHT to update the financial plan profile and therefore are seeing a variance of £18.799m YTD in external reporting

Care Colleagues Collaboration Communities

Statement of Financial Position

STATEMENT OF FINANCIAL POSITION			
Statement of Financial Position for the month ending December 2023	Balance as at 31/03/23	Balance as at 31/12/2023	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Property, plant & Equipment	242,431	239,417	(3,014)
Intangible Fixed Assets	6,012	5,496	(516)
Receivables greater than one year	693	1,224	531
Total Non-Current Assets	**249,136**	**246,137**	**(2,999)**
Current Assets			
Receivables & pre-payments less than one Year	27,929	31,111	3,182
Cash (Citi and Other)	38,358	18,930	(19,428)
Inventories	3,629	3,813	184
Total Current Assets	69,916	53,854	(16,062)
Current Liabilities			
NHS & Trade Payables less than one year	(62,290)	(63,161)	(871)
Other Liabilities	(711)	(13,788)	(13,077)
Borrowings less than one year	(6,527)	(4,894)	1,633
Provisions less than one year	(183)	(183)	-
Total Current Liabilities	(69,711)	(82,026)	(12,315)
Net Current Assets less Liabilities	**205**	**(28,172)**	**(28,377)**
Non-current liabilities			
Borrowings greater than one year	(120,584)	(117,999)	2,585
Total Assets less Total Liabilities	128,757	99,966	(28,791)
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	252,913	252,912	(1)
Revaluation	65,284	65,284	-
Income and Expenditure	(162,566)	(189,442)	(26,876)
In Year Income & Expenditure	(26,874)	(28,788)	(1,914)
Total TAXPAYERS' EQUITY	128,757	99,966	(28,791)

Working Capital

As the Trust financial position deteriorates it is important to understand and assess the
movement in working balances, to ensure cash is available to service:

- Payments to our staff
- Payments to our suppliers of goods and services
- Payment for capital works and repayment of loan liabilities (PFI)

The Trust has maintained a positive cash balance, the reduction centring upon the movement in working balances and cash outflow to service trade and capital creditors. The cash position remains positive, though at planned deficit levels (noting also balance sheet flexibility release will not provide cash to service increased costs above I&E outturn) the Trust needs to carefully manage and project cashflows to maintain payment terms for suppliers (in addition to staff).

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

Further analysis of the Statement of Financial Position on later slides

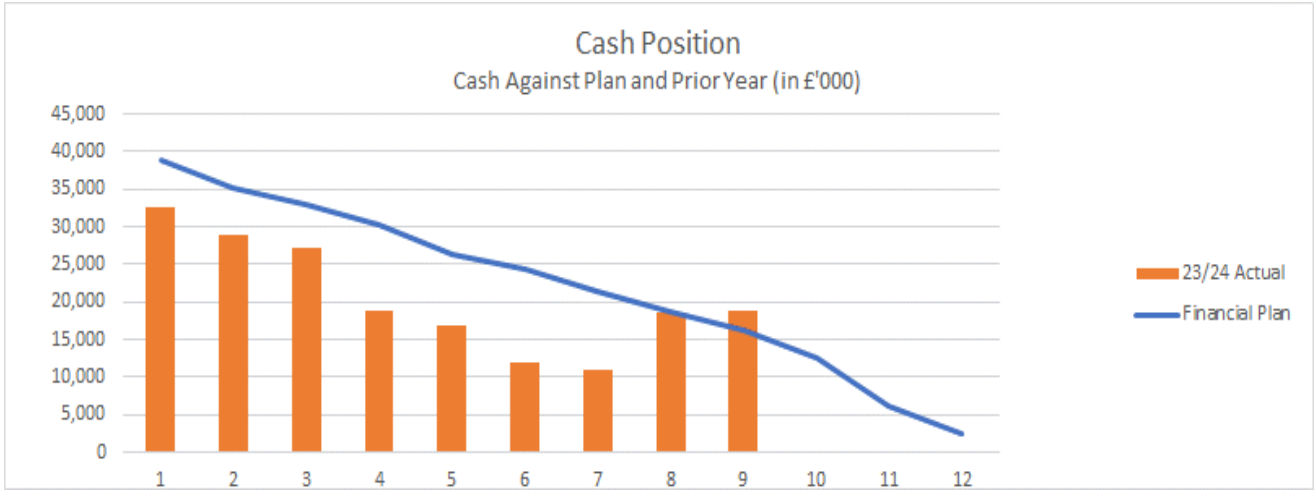
Trade payables/accruals have reduced from March 23 by £11m due to the payment of invoices and release of balance sheet provisions within the plan. This is also reflective of the current cash balance movements

Care Colleagues Collaboration Communities

Cashflow

CASHFLOW STATEMENT Statement of Cash Flows for the month ending December'23	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(19,377)
Depreciation and Amortisation	10,034
Donated Assets Received credited to revenue but non-cash	0
Fixed Asset Impairments	0
(Increase)/Decrease in Trade and Other Receivables	(4,040)
Increase/(Decrease) in Trade and Other Payables	19,275
Increase/(Decrease) in Other Liabilities	0
Increase/(Decrease) in Stock	(180)
Increase/(Decrease) in Provisions	0
Other movements in operating cash flows	0
Interest Paid	(7,953)
Dividend Paid	(1,418)
Net Cash Inflow/(Outflow) from Operating Activities	**(3,658)**
Cash Flows from Investing Activities	
Interest received	**1,029**
(Payments) for Property, Plant and Equipment	**(13,748)**
Initial Indirect costs in respect of new right of use assets	**0**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(12,719)**
Net Cash Inflow/(Outflow) before Financing	**(16,377)**
Cash Flows from Financing Activities	(3,051)
Net Increase/(Decrease) in Cash	**(19,428)**
Cash at the Beginning of the Year 2023/24	38,358
Cash at the End of the December	**18,930**

- The cash balance as at 31 December 2023 is £18.9m, a £0.3m increase on the previous month and an increase of £2.8m on financial plan.
- The cash balance has moved by £19.4m (decrease) on the closing balance at March 2023 of £38.4m.



Income	£m	
	31.5	Block Payments
	2.7	Non-NHS, including £2m from Walsall MBC
	1.1	VAT Income
	0.1	Interest
	35.4	

Expenditure	£m	
	(22.3)	Pay related costs including Tax, NI and Pension costs
	(8.8)	Non Pay
	(2.7)	Unitary
	(1.2)	NHS LA
	(0.1)	Other Expenditure
	(35.1)	
	0.3	

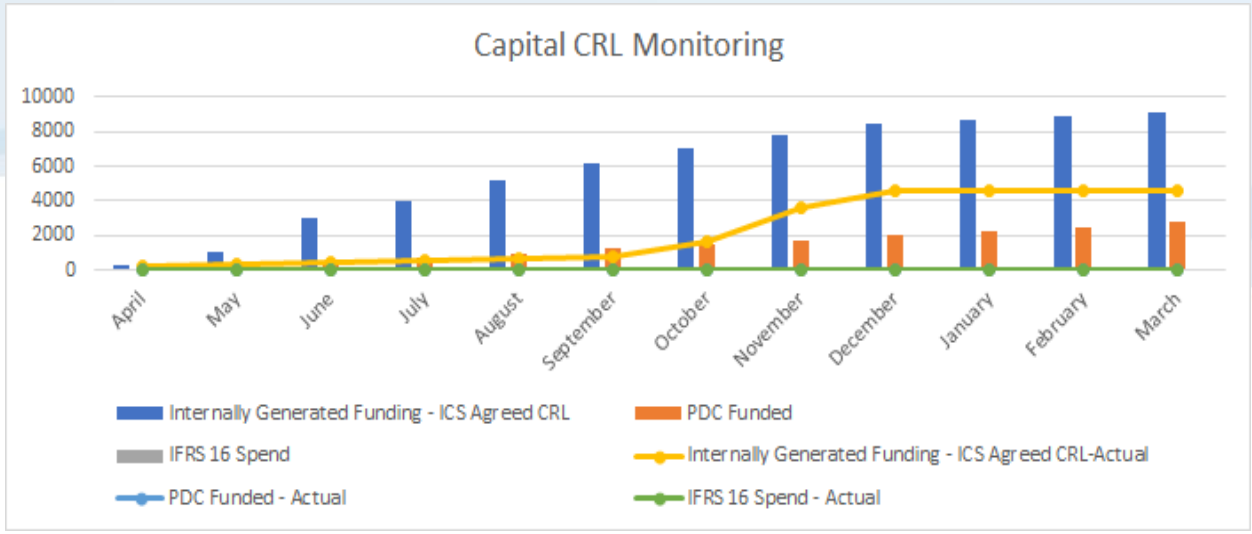
Care Colleagues Collaboration Communities

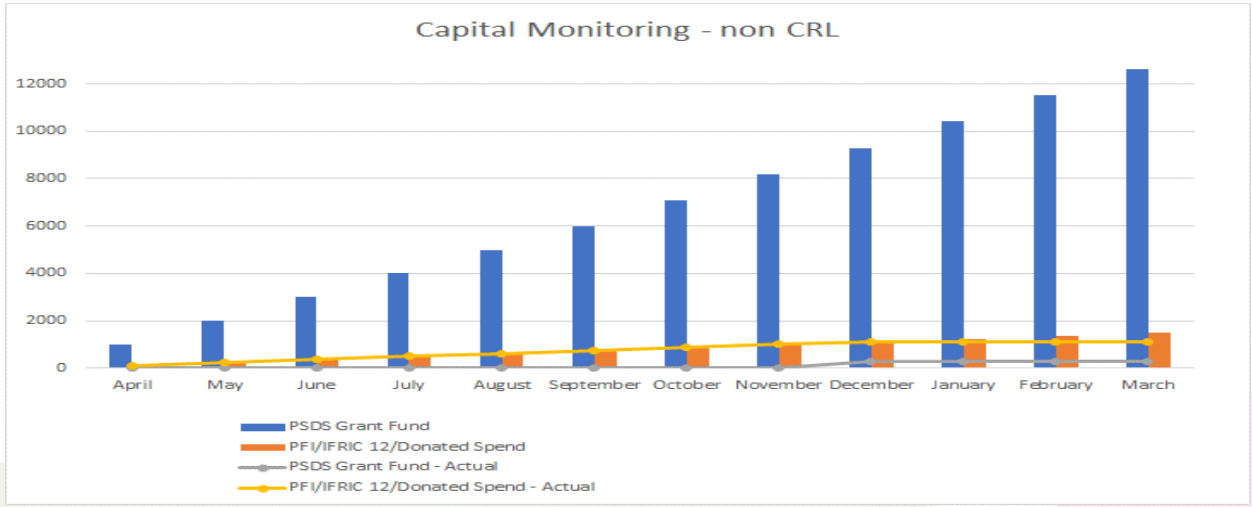
Capital

The trust has spent £6.0m of Capital YTD to 31st December 2023, which is an underspend of £14.9m against planned YTD Capital of £20.9m. Of the £6.0m YTD Spend:

- £4.6m relates to capital spend which the ICS is measured against, which is an underspend of £6.2m vs plan due to timing of orders. No PDC Funding YTD spend leading to a variance of £2m vs plan YTD due to approvals in progress. The trust expects to meet the CRL plan of £11.8m at the end of the year.
- The balance of the YTD Capital spend of £1.4m relates to PFI/IFRIC 12 capital while PSDS grant funds has a variance of £6.7m vs plan
- BCPS request to transfer CRL allocation of £53k to support high priority replacement schemes.

Scheme	M9 YTD Budget £'000s	M9 YTD Spend £'000s
Estates:		
PFI Lifecycle:	1,116	1,135
Old ED works	4,000	2,231
Lead Lined Room & Theatre Refurb	3,620	1,075
Estates Lifecycle & Health Records	1,730	811
New Build-Non Clinical (PSDS Match Funding)	7,000	286
Estates Total	**17,466**	**5537**
Medical Equipment:		
Medical Equipment	700	300
Medical Equipment Total	**700**	**300**
Information Management & Technology:		
IT Equipment	700	154
Information Management & Technology Total	**700**	**154**
PDC Funding		
IM&T PDC Funding	2,000	-
PDC Funding Total	**2,000**	**-**
Grand Total	**20,866**	**5,992**





Care Colleagues Collaboration Communities

Efficiencies Plan Overview

	CIP Plan Submitted to NHSE £'m	Plans at Month 9 £'m	% Achievement	Recurrent	Non Recurrent
Traditional' CIP (including ERF)	17.2	14.0	81%	64%	36%
Technical Adjustment requested	7.2	3.28	43%	0%	100%
Stretch Requested	2.05	0	0%		
Total	26.45	17.28	65.3%	51%	49%

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

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

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

Care Colleagues Collaboration Communities

Efficiencies FOT by Division

Division	Target	Green	Amber	Red	Total
MLTC	3,908	157	549	2,111	**2,817**
DoS	3,474	681	200		**881**
WCCSS	3,882	1,112	2,332	29	**3,473**
Community	2,621	21	1,301		**1,322**
Estates	1,250	204	38		**242**
Corp (IMT)	444	380	65		**445**
Corp (HR)	242	150	82		**232**
Corp (Fin)	360	3,008			**3,008**
Corp (Nurs)	314	238	6		**244**
Corp (Comms)	21	21			**21**
Corp (COO)	188	100			**100**
Corp (Med)	253	173			**173**
Corp (Govern)	173	51			**51**
Corp (Improv)	70	323			**323**
Procurement (Divisional)				209	**209**
Unidentified/ Stretch	7,200			462	**462**
Balance Sheet	2,050	3,276			**3,276**
Total	**26,450**	**9,895**	**4,572**	**2,810**	**17,277**

FOT divisional savings of £17.3m of which £2.8m are high risk (including £0.5m still to be identified) and £4.6m are medium risk schemes.

There are £3.3m of technical adjustments identified to support the delivery of CIP.

Care Colleagues Collaboration Communities

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public On 14 February 2024		
Title of Report:	Approval of Revised Standing Orders and Standing Financial Instructions	Enc No: 8.5.2
Author:	Dan Mortiboys, Operational Director of Finance	
Presenter/Exec Lead:	Kevin Stringer, Group CFO Keith Wilshere, Group Company Secretary	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☒No☐	Yes☐No☐	Yes☐No☐
Recommendations: Members of the Committee are asked to: Approve the revised Standing Orders and Standing Financial Instructions of the Trust			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☒ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	Revenue: none Capital: none Workforce: none Funding Source: none		
Report Data Caveats	None		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☒No☐	Details: The Trust has the breakeven duty and SFI form part of the framework to achieve that
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: SFI and SO are a requirement
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

NHS
Walsall Healthcare
NHS Trust

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: Audit Committee 12 Dec 2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- The Trust is updating its Standing Orders (SO) and Standing Financial Instructions (SFI). While this is good practice, it also allows additional controls to be included within Trust governance to support financial recovery and in line with requests from regulators
- Before completing the SFI, comparison has been made with SFI at RWT to ensure consistency where it is both appropriate and possible to do so.
- Audit Committee has endorsed the report at its December meeting

Advise

- The vast majority of changes within the report reflect changes to committee structure and changes linked to legislation or guidance (e.g. IFRS16, IR35). All changes are tracked changes for transparency.
- The Trust has mirrored changes made by RWT to allow the Operational Director of Finance the same authorization levels as the CFO.
- Controls in relation to agency staff authorization and non purchase order no pay have been included within SFI for the first time to allow for clarity for staff.

Alert

- Once authorised, the revised SFI will form part of training for bespoke budget managers, senior leaders and key information shared with new starters.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement Deliver improvement against the Workforce Equality Standards
Improve the	• Develop a health inequalities strategy

Healthcare of our Communities	• Reduction in the carbon footprint of clinical services by 1 April 2025 Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall Facilitate research that improves the quality of care

WHT-GI02 V5~~5~~

WALSALL HEALTHCARE NHS TRUST

Standing Orders,

~~February 2022~~January 2024
Version 5~~4~~

Document Title
STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS AND STANDING FINANCIAL INSTRUCTIONS

Document Description	
Document Type	Corporate Governance Documentation
Service Application	All Staff
Version	54

Lead Author(s)	
Name	Job Title
~~Russell Caldicott~~Kevin Stringer	Group Chief Financial Officer
Keith Wilshere	Group Company Secretary
Dan Mortiboys	Operational Director of Finance
Alan Lakin	Head of Financial Governance

Executive Director / Director / Manager			
If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date below:			
Name	~~Russell Caldicott~~Kevin Stringer, Chief Financial Officer	Date	~~22nd August 2022~~1st December 2023

Change History		
Version	Date	Comments
2	4.2.2016	1. Introduction of version control 2. Amendment of Standing Orders and Scheme of Delegation to reference People and Organisation Development Committee 3. Amendment to Scheme of Delegation and Standing Financial Instructions to reference responsibility of the Charitable Funds Committee to authorise Charitable funds expenditure.

2.3	9.10.18	4. A full review to ensure that the SFIs and Scheme of Delegation reflect current organisational responsibilities and current guidance and legislation
2.4	11.2019	Minor changes to the policy

2.4.2	2.2022	Minor changes to the policy
3	8.2021	Major changes to the policy
4	2.2022	Major changes to the policy
5	10,2023	Minor revisions to the Policy in the light of organisational change, revised national guidelines and local policy requirements

Links with External Standards	
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	
https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf	

Key Dates	DATE
Ratification Date	~~25th October 2022~~ 382/22
Review Date	~~25th October 2023~~

Executive Summary Sheet		
Document Title:	Standing Orders, Standing Financial Instructions, Scheme of Delegation, ~~Standing Orders~~	
Please Tick (□) **as appropriate**	This is a new document within the Trust	
	This is a revised Document within the Trust	✓
What is the purpose of this document?		
1. Standing Orders set out the statutory framework within which the Trust operates. This includes how the Trust Board and governance arrangements operate. 2. The Scheme of Delegation defines the control framework for committing resources. It identifies which functions the Chief Executive shall perform personally and those which have been delegated to other Directors or Officers. 3. The Standing Financial Instructions provide a business and financial framework within which all Board Members and employees of the Trust will be expected to work.		
How and when will this document be reviewed?		
The documents will be reviewed annually by the Group Company Secretary and the Group Chief Financial Officer.		

Circulated to the following for consultation

Name / Committee / Group
Executive Committee Audit Committee ~~2nd September~~ ~~2022~~December 2023 Trust Board
Policy Core Management Group ~~11th October 2022~~November 2023
Trust Management Committee ~~25th October 2022~~November 2023

Version Control Summary

Version	Date	Changes	Author
2	4.2.2016	5. Introduction of version control 6. Amendment of Standing Orders and Scheme of Delegation to reference People and Organisation Development Committee 1. Amendment to Scheme of Delegation and Standing Financial Instructions to reference responsibility of the Charitable Funds Committee to authorise Charitable funds expenditure.	

2.3	9.10.18	7. A full review to ensure that the SFIs and Scheme of Delegation reflect current organisational responsibilities and current guidance and legislation	
2.4	9.11.19	2. A full review to ensure that the SFIs and Scheme of Delegation reflect current organisational responsibilities and current guidance and legislation	Interim TrustSecretary Chief Financial Officer Director ofGovernance
2.4.2	2.2022	Minor Changes	Author
3	8.2021	Major Changes to the policy	Author
4	2.2022	Major Changes to the policy	Keith Wilshere
5	10.2023	Minor revisions to the policy	Keith Wilshere Dan Mortiboys

CONTENTS

SECTION A

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

SECTION B

STANDING ORDERS

Checklist for the Review and Approval of Procedural Documents

Equality Impact Assessment Form

FOREWORD

1. These Standing Orders and associated documents are extremely important. This document isThey designed to describe how the Trust operates i.e. how it is structured, how it takes decisions, and where authority and accountability is held.

1.2. For effective governance the Trust Board must have in place arrangements to ensure that there is clarity about how and where decisions are made, and who makes them.

3. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

2.4. The Standing Orders, Standing Financial Instructions, procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staffstaff, and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

3.5. The Trust Board has a responsibility to ensureis responsible for ensuring that staff at all levels of the organisation confidently understand what delegated authority they have to make decisions, anddecisions and are clear what to do when they do not have authority. The Scheme of Delegation sets out who has the authority to make decisions within the Trust.

4.6. Additional documents, which form part of these "extended" Standing Orders are:

- Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
- Schedule of Decisions Reserved to the Board of the Trust
- Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility, including a brief outline of the role and purpose of the respective Board Committees.

5.7. All Executive and Non-Executive Directors and senior staff are expected and required to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

SECTION A - INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Group Chief Executive or Group Company Secretary).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service (including but not limited to the Health and Social Care Acts 2012, 2022) or in the Financial Directions made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

"**Accountable Officer**" means the NHS officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Group Chief Executive.

"**Trust**" means Walsall Healthcare NHS Trust.

"**Board**" means the Chair, Executive and Non-Executive members of the Trust collectively as a body.

"**Budget**" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, ~~any~~any, or all of the functions of the Trust.

"**Budget holder**" means the director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.

"**Chair of the Board (or Trust)**" is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the ~~Vice-~~Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"**Chief Executive**" means the chief officer of the Trust.

"**Commissioning**" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"**Committee**" means a committee or sub-committee created and appointed by the Trust.

"**Committee members**" means persons formally appointed by the Board to sit on or to chair specific committees.

"Group **Chief Financial Officer** " means the group chief financial officer of the Trust.

"**Funds held on trust**" shall mean those funds which the Trust holds ~~a~~on 1st April 1996 or date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

"**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice.

"**Member**" means Executive or Non-Executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.

"**Associate Member**" means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

"Group Company Secretary" means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health and Social Care guidance.

"**Membership and Procedure Regulations**" means the National Health Service (Membership and Procedure) Regulations (SI 1990 No. 2024) and subsequent amendments.

"**Nominated officer**" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"**Non-Executive Director**" means a member of the Trust who is not an Executive of the Trust and is not to be treated as an Executive by virtue of the Membership and Procedure Regulations.

"**Officer**" (or staff) means employee of the Trust or any other person holding a paid appointment or office with the Trust. In certain circumstances, "officer" may include a person who is employed by another authority or by Third Party contracted to the Trust who carries out functions on behalf of the Trust.

"**Executive Director**" means is a member of the Trust who appointed in accordance with the Membership and Procedure Regulations

"**SFIs**" means Standing Financial Instructions.

"**SOs**" means Standing Orders.

"**~~Vice-~~Deputy Chair**" means the Non-Executive Director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

"**Associate Board Member**" – means a person appointed to a post in the Trust, which qualifies the holder for Executive membership, however that person shall be deemed a non-voting member.

"**Motion**" means a formal proposition to be discussed and voted on ~~during the course of~~during a

meeting.

"**~~NHSE/I~~NHSE**" means NHS England and Improvement

Wherever the title Group Chief Executive, Group Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1. Statutory Framework

1.1.1. The Walsall Healthcare NHS Trust (the Trust) is a statutory body which came into existence on 1st April 2011 under The Walsall Healthcare National Health Service Trust (Establishment) Amendment Order 2011 no 791"Establishment Order". This was amended on 11th February 2013 by way of the Walsall Hospitals National Health Service Trust (Establishment) Amendment Order 2013 No. 59, amending article 4 of the Establishment Order by increasing the number of directors of the trust.

1.1.2. The principal place of business of the Trust is Moat Road, Walsall, West Midlands, WS29PS.

1.1.3. NHS Trusts are governed by Acts of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act1990) as amended by the Health Authorities Act 1995 and the Health Act 1999 and the Health and Social Care Acts 2012, 2022.

1.1.4. The functions of the Trust are conferred by this legislation.

1.1.5. As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.1.6. The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999 and now contained in the NHS Act 2006, to fund projects jointly planned with local authorities, voluntary ~~organisations~~organisations, and other bodies.

1.1.7. The ~~Code of Accountability~~Code of Governance requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.8. The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2. NHS Framework

1.2.1. In addition to the statutory requirements the Secretary of State for Health and Social Care, through the Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.2.2. The ~~Code of Accountability~~Code of Governance ~~-~~Governance requires that, inter alia, Boards draw up a schedule of decisions reserved to the ~~Board, and~~Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Trust's Conflicts of Interest Policy, these Standing Orders and Codes of Conduct make various requirements concerning possible conflicts of interest of Board members.

1.2.3. The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS and should be considered in conjunction with the Freedom of Information Act 2000.

1.3. Delegation of Powers

The Trust has powers to delegate and ~~make arrangements~~decide ~~for~~ delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State for Health and Social Care may direct". Delegated Powers are covered in a separate document entitled 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4. Integrated Governance & Quality

Trust Boards are now encouraged to ~~move away from silo governance and~~ develop integrated governance ~~that will~~ leading to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, ~~quality~~quality, and financial objectives.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1. Composition of the Membership of the Trust Board

2.1.1. The voting membership of the Trust Board shall comprise the Chair and six Non-Executive Directors, together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent Non-Executive Directors.

2.1.2. The Executive Directors with voting rights shall include:

(a) Group Chief Executive
(b) Group Chief Financial Officer
(c) Chief Medical ~~Director~~Officer
(d) Chief Nurse Officer, or equivalent
(e) Chief Operating Officer

2.1.3. The Board may appoint additional Executive Directors, in crucial roles in the Trust, to be non-voting members of the Trust Board. They include:

~~(a) Director of Nursing~~
~~(b)~~(a) Group Director of Assurance
(b) Group Chief People~~Officer~~r

~~Director of People and Culture~~

(c) Group Chief Strategy Officer

(d) Group Director of Place

~~(c)~~ Additionally other appointees include

~~(d)~~(e) Group Director of Communications and Stake-holder engagement
~~(e)~~(f) Director of Maternity Services
~~(f) Director of Integration (Community Services)~~

This is not an exhaustive list as the composition of additional posts will change over time in relation to the requirements of the organisation.

2.1.4. The Board may appoint lay persons to the Trust Board and confer the title Associate Non-Executive Director on these individuals as an indication of their corporate responsibility. These individuals are entitled to attend meetings of the Trust Board but are not Board Members for the purpose of Membership and Procedure Regulations and as such they have no voting rights.

2.1.5. The Trust Board shall have not more than 13 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and Social Care, and set out in the Trust's Establishment Order or such other communication from the Secretary of State for Health and Social Care).

2.2. Appointment of Chair and Members of the Trust

2.2.1. Paragraph 3 of Schedule 3 to the NHS 2006 Act, provides that the Chair is appointed by the Secretary of State for Health and Social Care, but otherwise the appointment and tenure of office of the Chair and members are set out in the Membership and Procedure Regulations and terms and conditions as set out by the ~~NHSE/I~~NHSE.

2.3. Terms of Office of the Chair and Members

2.3.1. The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in regulations 7 to 9 of the Membership and Procedure Regulations.

2.4. Appointment and Powers of ~~Vice-Chair~~Deputy Chair

2.4.1. Subject to Standing Order 2.4.2 below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Executive Director, to be ~~Vice-~~Deputy Chair, for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

2.4.2. Any member so appointed may at any time resign from the office of ~~Vice-Chair~~Deputy Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice- Chair in accordance with the provisions of Standing Order 2.4.1.

2.4.3. Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice- Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the ~~Vice-Chair~~Deputy Chair.

2.5. Appointment of the Senior Independent Director

2.5.1. Subject to Standing Order 2.5.2 below, the Chair and members of the Trust should appoint one of their numbers, who is not also an Executive Director, to be the Senior Independent Director for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

2.5.2. Any member so appointed may at any time resign from the role of Senior Independent Director giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Senior Independent Director in accordance with the provisions of Standing Order 2.5.1.

2.5.3. The Senior Independent Director supports the Chair, conducts their annual appraisal, is available to members of the Trust if they have concerns that contact through the usual channels of the Chair, the Chief Executive, the Company Secretary or the Secretary to the Board has failed to resolve or where it would be inappropriate to use such channels.

2.5.4. The Senior Independent Director shall not attend the renumeration committee so as to be available in the case of any dispute or appeal.

2.6. Joint Members

2.6.1. Where more than one person is appointed jointly to a post mentioned in regulation 6 of the

Membership and Procedure Regulations those persons shall count for the purpose of Standing Order 2.1 as one person. (Where more than one person is appointed jointly to a post in an NHS trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become or be appointed an executive director ~~jointly, and~~jointly and shall count for the purposes of regulation 2 as one person).

2.6.2. Where the office of a member of the Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the ~~Board;~~Board.
(b) if both are present at a ~~meeting~~meeting, they should cast one vote if they agree;
(c) in the case of ~~disagreements~~disagreements, no vote should be cast;
(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.7. Role of Members

2.7.1. The Board will function as a corporate decision-making body, Executive and Non- Executive Members will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(a) Chair

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the ~~NHSE/I~~NHSE over the appointment of voting Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance. The Chair (or nominated Deputy) will lead the recruitment of Associate Non-executives with NHSE and ICB involvement, define their portfolio's and duties, and undertake their appraisals and performance management.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

(b) Non-Executive Directors

The Non-Executive Directors shall not be ~~granted~~granted, nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(c) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(d) Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

2.8. The Unitary Board:

The Trust Board is designed as a unitary Board with decisions to be reached by discussion

and consensus, with all Executive Directors and Non-Executive Directors permitted to participate in all discussions. All members of the Trust Board are bound collectively to the decisions taken by the Board.

2.9. Corporate Role of the Board

2.9.1. All business shall be conducted in the name of the Trust.

2.9.2. All funds received in trust shall be held in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.9.3. The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 3.

2.9.4. The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State for Health and Social Care.

2.10. Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.11. Lead Roles for Board Members

The Chair will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health and Social Care, or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (~~e.g.~~e.g., appointing a lead Board Member with responsibilities for Infection Control, Freedom to Speak Up or ~~Child Protection Services~~Safeguarding etc.).

3. MEETINGS OF THE TRUST

3.1. Calling meetings

3.1.1. Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

3.1.2. The Chair of the Trust may call a meeting of the Board at any time.

3.1.3. One third or more Members of the Board may requisition a meeting in writing (~~e.g.~~e.g., via email) to the chair. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the Members signing the requisition may forthwith call a meeting.

3.2. Notice of Meetings and the business to be transacted

3.2.1. Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member. This information and subsequent materials will be provided on the Trust shared corporate papers system accessed remotely by board members. Papers will be available at least three days before the meeting. Want of service of such a notice on any member shall not affect the validity of a meeting.

3.2.2. In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be considered to be signed by those members.

3.2.3. No business shall be transacted at the meeting other than that specified on the agenda, or

emergency motions allowed under Standing Order 3.6.

3.2.4. A member desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

The Board may determine that certain matters shall appear on every agenda for a meeting of the Board either indefinitely or for a specified period.

3.2.5. Before each meeting of the Board a public notice on the trust website of the time and place of the meeting, and the public part of the agenda, shall be given. A public notice shall be displayed at the Trust's principal offices and on its website at least three clear days before the meeting (required by the Public Bodies (Admission to Meetings) Act 1960 s.1(4)).

3.3. Agenda and Supporting Papers

The ~~Agenda~~agenda will be sent to members three working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will otherwise be dispatched no later than three days before the meeting, save in emergency.

3.4. Petitions

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

3.5. Notice of Motion

3.5.1. Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

3.5.2. The notice shall be delivered at least ten days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6. Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.7. Motions: Procedure at and during a meeting

3.7.1. Who may propose

A Motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another Member.

3.7.2. Contents of Motions

The Chair may exclude from the debate at their discretion any such Motion of which notice was not given on the notice summoning the meeting other than a Motion relating to:

(a) the reception of a ~~report;~~report.
(b) consideration of any item of business before the Trust ~~Board;~~Board.
(c) the accuracy of ~~minutes;~~minutes.
(d) that the Board proceed to next ~~business;~~business.
(e) that the Board ~~adjourn;~~adjourn.
(f) that the question be now put.

3.7.3. Amendments to Motions

A Motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to Motions shall be moved relevant to the ~~Motion, and~~Motion and shall not have the effect of negating the Motion before the Board.

If there are ~~a number of~~several amendments, they shall be considered one at a time. When a Motion has been amended, the amended Motion shall become the substantive Motion before the meeting, upon which any further amendment may be moved.

3.7.4. Rights of reply to Motions

(a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original Motion, who shall have the right of reply at the close of debate on the ~~amendment, but~~amendment but may not otherwise speak on it.

(b) Substantive/original Motion

The member who proposed the substantive Motion shall have a right of reply at the close of any debate on the Motion.

3.7.5. Withdrawing a Motion

A Motion, or an amendment to a Motion, may be withdrawn.

3.7.6. Motions once under debate

When a Motion is under debate, no Motion may be moved other than:

(a) an amendment to the ~~Motion;~~Motion.
(b) the adjournment of the discussion, or the ~~meeting;~~meeting.
(c) that the meeting ~~proceed~~proceeds to the next business;
(d) that the question should be now ~~put;~~put.
(e) the appointment of an 'ad hoc' committee to deal with a specific item of ~~business;~~ business.
(f) that a member/director be not further ~~heard;~~heard.
(g) a Motion under Section 1 (2) or Section 1 (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 3.17).

In those cases where the Motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a Motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive Motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8. Motion to Rescind a Resolution

3.8.1. Notice of Motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2. When any such motion has been dealt with by the Trust Board it shall not be competent for any member other than the Chair to propose a Motion to the same effect within six months. This Standing Order shall not apply to Motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9. Chair of meeting

3.9.1. At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the ~~Vice-Chair~~Deputy Chair (if the Board has appointed one), if present, shall preside.

3.9.2. If the Chair and ~~Vice-Chair~~Deputy Chair are absent, such member (who is not also an Officer Member of the Trust) as the Members present shall choose shall preside. This provision is also applicable to Board Committee meetings.

3.10. Chair's ruling

The decision of the Chair of the meeting on questions of order, relevance~~,~~ and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11. Quorum

3.11.1. No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and Members, including at least one member who is also an Executive Director of the Trust and one member who is a Non-Executive Director, is present.

3.11.2. An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.11.3. If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12. Voting

3.12.1. Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and eligible to vote on the question. In the case of an equal vote, the person presiding (i.e.: the Chair of the meeting) shall have the casting vote.

3.12.2. At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot or an equivalent electronic ballot.

3.12.3. If at least one-third of the members present so request, the voting on any question may be recorded ~~so as to~~to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4. If a member so requests, their vote shall be recorded by name.

3.12.5. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6. An Officer who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

3.12.7. An Officer attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.12.8. For the voting rules relating to joint members see Standing Order2.6.

3.13. Suspension of Standing Orders

3.13.1. Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two- thirds of the whole number of the Members of the Board are present, including at least one member who is an Executive Director of the Trust and one Member who is a Non-Executive Director, and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

3.13.2. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

3.13.3. No formal business may be transacted while Standing Orders are suspended.

3.13.4. The Audit Committee shall review every decision to suspend Standing Orders.

3.14. Variation and amendment of Standing Orders

3.14.1. These Standing Orders shall not be varied except in the following circumstances:

(a) upon a notice of motion under Standing Order ~~3.5;~~3.5.
(b) upon a recommendation of the Chair or Chief Executive included on the agenda for the ~~meeting;~~meeting.
(c) Upon the approval by the board as recommended by the Chair or Chief Executive as part of the regularly review and updating of the standing orders.
(d) that two- thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment.~~;~~

(e) providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State for Health and Social Care.

3.15. Record of Attendance

The names of the Chair and Members present at the meeting shall be recorded.

3.16. Minutes

3.16.1. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding~~at it~~.

3.16.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

3.17. Admission of public and the press

3.17.1. Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960.

Guidance should be sought from the NHS Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

3.17.2. General disturbances

The Chair (or ~~Vice-Chair~~Deputy Chair if one has been appointed) or the person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

`That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

3.17.3. Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 3.17.1 and 3.17.2 above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

3.17.4. Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

For the purposes of the minutes taking and checking, the trust reserves the right to record the meeting giving notice of this at the start of the meeting. Once the relevant minutes have been drafted and approved by the board, the recordings shall be erased. The approved minutes remain the official meeting record.

3.18. Observers at Trust meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, ~~alter~~alter, or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1. Appointment of Committees

Subject to such directions as may be given by, or on behalf of, the Secretary of State for Health and Social Care, the Trust may, appoint Committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time. Minutes, or a representative summary of the issues ~~considered~~considered, and decisions taken, of any committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting.

Any matters raised requiring reporting only to the closed section of the board meeting shall be redacted from the minutes made publicly available and unredacted set provided to the confidential section of the board.

The Chair of the board committee will prove a summary of the matters to the next available board meeting providing a focus of the board on matters of substance from that committee.

4.2. Joint Committees

4.2.1. Joint committees may be appointed by the Trust by joining together with one Trust consisting of, wholly or partly of the Chair and Members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.2.2. Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State for Health and Social Care or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not Members of Walsall Healthcare NHS Trust.

4.3. Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as ~~appropriate~~appropriately apply to meetings and any committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other committees as the context permits, and the term "member" is to be read as a reference to a member of other committees also as the context permits. There is no requirement to hold meetings of committees established by the Trust in public.

4.4. Terms of Reference

Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State for Health and Social Care. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5. Delegation of powers by Committees to Board~~Sub~~-Committees

Where Committees are authorised to establish ~~sub~~-committees or groups they may not delegate executive powers to the ~~sub~~-committee or group unless expressly authorised by the Trust Board. Each Committee shall approve the Terms of Reference of each sub-committee reporting to it. Minutes, or a representative summary of the issues ~~considered~~considered, and decisions taken of any ~~sub-~~committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

4.6. Approval of Appointments to Committees

The Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State for Health and Social Care. The Board shall define the powers of such appointees in accordance where appropriate with national guidance.

4.7. Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State for Health and Social Care, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State for Health and Social Care.

4.8. Mandatory and Statutory Committees to be established by the Trust Board

The Committees to be established by the Trust will consist of statutory and ~~mandatory;~~mandatory, and non- mandatory committees.

4.9. Role of Audit Committee

4.9.1. The Trust Board shall appoint a committee to undertake the role of an audit committee. This role shall include providing the Trust Board with a means of independent and objective review of the financial systems and of general control systems that ensure that the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with law, regulations, ~~guidance~~guidance, and codes of conduct. This Committee will pay due regard to good practice guidance, including, in particular, the NHS Audit Committee Handbook**.** The role of the Audit Committee is also described in s.11 of the Standing Financial Instructions.

4.9.2. The terms of reference of the Audit Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

4.9.3. Membership of the Audit Committee shall accord with the Local Audit and Accountability Act 2014 with respect to independence.

4.10. Role of the Auditor Panel

4.10.1. The Trust Board shall nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

4.10.2. The Auditor panel shall advise the Trust Board on the selection and appointment of the external auditor.

4.10.3. The terms of reference of the Auditor Panel shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust

4.11. Role of Remuneration Committee

The Trust Board shall appoint a Committee to undertake the role of a remuneration committee. This role shall include providing advice to the Trust Board about the appointment and appropriate

remuneration and terms of service for the Chief Executive and other Executive Directors (Regulations 17-18, Membership and Procedure Regulations), as well as advising the Trust Board on the terms of service of other senior ~~officers, and~~officers and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently. The Remuneration Committee is further referred to in SFI 18.1.

4.11.1. The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

4.11.2. The terms of reference of the Remuneration Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

4.12. Role of the Charitable Funds Committee

4.12.1. The Trust Board, acting as Corporate Trustee, shall appoint a Committee to be known as the Charitable Funds Committee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies.

4.12.2. The terms of reference of the Charitable Funds Committee shall have effect as if incorporated into these Standing Orders and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

4.13. Non mandatory committees

4.13.1. The Trust Board shall appoint such additional non-mandatory Committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

4.13.2. The terms of reference of these Committees shall have effect as if incorporated into these Standing Orders. The approval of the terms of reference shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

4.13.3. The membership of these Committees may comprise Non-Executive Directors or Executive Directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the Committee and shall be subject to approval by the Board.

4.13.4. The current non-mandatory Committees in place are (at ~~July2021~~December 2023):

(a) Quality~~, Patient Experience and Safety~~ Committee
(b) Finance and ~~Performance~~ Productivity ~~and Finance~~ Committee
(c) People ~~& Organisational Development~~Committee
(d) Walsall Together Partnership ~~(Board~~Committee)~~Board~~
~~(d)~~(e) Black Country Joint Partnership Committee

These are subject to change at the discretion of the Trust Board. All ~~new, or~~new or amended non-~~-~~mandatory Committees will have the same standing and will be subject to the same Standing Orders**.**

4.14. Proceedings in Committee to be confidential

4.14.1. There is no requirement for meetings of Committees and sub-committees to be held in public, or for agenda or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act 2000, and there is no legal justification for non-disclosure.

4.14.2. Committee members should normally regard matters dealt ~~with, or~~with or brought before the Committee as being subject to disclosure, unless stated otherwise by the Chair of the Committee. The Chair shall determine whether specific matters should remain confidential until they are reported to the Board.

4.14.3. Where a matter requires the maintenance of confidentially for legitimate reasons any approved minutes shall have those items redacted and the full unredacted minutes will be provided to the confidential section of the board

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BYDELEGATION

5.1. Delegation of Functions to Committees, ~~Officers~~Officers, or other bodies

5.1.1. Subject to such directions as may be given by the Secretary of State for Health and Social Care, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a Committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2. Section 19 of the NHS Act 2006 allows for regulations to provide for the functions of Trust to be carried out by third parties. In accordance with the Membership and Procedure Regulations, the functions of the Trust may also be carried out in the following ways:

(a) by another Trust;
(b) jointly with any one or more of the following: NHS trusts, ~~NHSE/I~~NHSE or Integrated Care Bodies
(c) by arrangement with the appropriate Trust Commissioning body, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;
(d) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more ~~NHSE/I~~NHSE, NHS Trusts or Clinical Commissioning body.

5.1.3. Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, ~~i.e.~~i.e., delegation to committees, sub-committees/groups or officers, the Trust delegating the function retains full responsibility.

5.2. Emergency Powers and urgent decisions

5.2.1. The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.8) may, in emergency or for urgent decisions, be exercised by the Chief Executive and the Chair. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board for formal ratification.

5.2.2. In the event of an urgent decision being required by the ~~Performance and Finance~~Finance and Productivity Committee to respond to an opportunity or risk, the Chief Executive, the ~~Performance and Finance~~Finance and Productivity Committee or their deputies shall consult formally with the Chair of the Trust, the Chair of Finance and Productivity Committee and at least one other Non- Executive Director who will constitute a~~n~~ Committee of the Board for this purpose. The decision of this Committee will be reported to the next Finance and Productivity Committee. The urgency procedure should only be applied in circumstances where it is not possible to hold an urgent extraordinary Finance and Productivity Committee meeting.

5.3. Delegation to Committees

5.3.1. The Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, sub-committees, groups or ~~joint committees~~joint committees, which it has formally constituted in accordance with directions issued by the Secretary of State for Health and Social Care. The constitution and terms of reference of these committees, sub-committees, groups or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2. When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.3.3. Where a decision is required between board meetings, the board may formally delegate approval of specific contacts of business cases to a committee of the board. In such cases any matters approved will be reported to the next available board meeting. In line with the SFI's and the Scheme of Delegation no board committee has the power of approval without formal delegation of the board.

5.4. Delegation to Officers

5.4.1. Those functions of the Trust which have not been retained as reserved by the Board or delegated to other Committee or sub-committee or ~~joint committee~~joint committee shall be exercised on behalf of the ~~T~~rust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which the Chief Executive will still retain accountability to the Trust.

5.4.2. The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.5. Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

The arrangements made by the Board as set out in the Schedule of Matters Reserved to the Board and Scheme of Delegation of powers shall have effect as if incorporated in these Standing Orders.

5.6. Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1. Policy statements: general principles

6.1.1. The Trust Board will from time to time agree and approve policy statements/ procedures which will apply to ~~all~~all, or specific groups of staff employed by Walsall Healthcare NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.1.2. The policies listed below, and any other policies the Trust may resolve to approve from time to time, are reserved to the Trust Board for approval. The approval of other Trust wide policy documents is delegated to the Trust Management Committee:

(a) Conflict of InterestPolicy
(b) Risk ManagementPolicy
(c) Fit and Proper Person Requirements Policy
(d) Health and Safety at Work Policy

6.2. Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policies, which shall have effect as if incorporated in these Standing ~~Orders::~~Orders:

(a) Conflicts of Interest ~~Policy;~~Policy.
(b) Disciplinary and Appeals Procedures.

6.3. Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders, as will the Reservation of Powers to the Board and Delegation of Powers.

6.4. Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health and Social Care, including but not limited to:

(a) Caldicott Guardian 1997 (and all subsequent guidance~~);~~).
(b) Human Rights Act ~~1998;~~1998.
(c) Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1. Declaration of Interests

7.1.1. Requirements for Declaring Interests and applicability to Board Members

The "Managing Conflicts of Interest in the NHS: Guidance for staff and ~~organisations" issued~~organisations issued by ~~NHSE/I~~NHSE in 2017 requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board Members must declare such interests. Any Board members appointed subsequently should do so on appointment. All Board Members are required to confirm that they are a 'fit and proper person' within the meaning of the Health and Social Care Regulations.

7.1.2. Interests which are relevant and material

(a) Interests which should be regarded as "relevant and material" are:

(i) Directorships, including Non-Executive Directorships held in private companies or PLC~~l~~s (with the exception of those of dormant companies).~~;~~
(ii) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.~~;~~
(iii) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.~~;~~
(iv) A position of Authority in a charity or voluntary organisation in the field of health and social care.~~;~~
(v) Any connection with a voluntary or other organisation contracting for NHS services.~~;~~
(vi) Research funding/grants that may be received by an individual or their department.~~;~~
(vii) Interests in pooled funds that are under separate management.

(b) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare their interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3. Advice on Interests

If Board Members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Company Secretary.

Financial Reporting Standard No 8 (issued by the Financial Reporting Council) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4. Recording of Interests in Trust Board minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes. Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5. Publication of declared interests in Annual Report

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6. Conflicts of interest which arise during the course of a meeting

During the course of a Trust Board meeting, if a conflict of interest is identified or established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.1.7. Conflict of Interest Policy and Anti-Fraud Bribery and Corruption Policy

Any potential or actual conflicts of interest must be dealt with in line with the Trust's Conflict of Interest Policy and the Trust's Anti-Fraud, Bribery and Corruption Policy.

7.1.8 In line with the conflict of interest policy and the national contracultural stands declarations of decision makers (including reference to those who have not made any declaration must be published~~) .~~). (See 7.2.3 below)

7.2. Register of Interests

7.2.1. The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both Executive and Non-Executive Trust Board members.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3. The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicize arrangements for viewing it.

7.3. Exclusion of Chair and Members in proceedings on account of pecuniary interest

7.3.1. Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(b) "contract" shall include any proposed contract or other course of dealing.

(c) ~~" Pecuniary~~"Pecuniary interest" Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

(i) they, or a nominee of them, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(ii) they are a partner, ~~associate~~associate, or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

~~(ii)~~(d) The extended definitions lie within the Conflicts of Interest Policy, and these must be followed.

7.3.2. Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract ~~if:~~ if: -

(a) neither they nor any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or

(b) any interest that they or any person connected with they may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract, or

(c) those securities of any company in which they (or any person connected with him/her) has a beneficial interest do not exceed ~~£5,000 in~~a nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.3. Exclusion in proceedings of the Trust Board

(a) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(b) The Secretary of State for Health and Social Care may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

(c) The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed ~~contract~~contract, or other matter in which they have a pecuniary interest is under consideration.

(d) Any remuneration, ~~compensation~~compensation, or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 3 to the National Health Service Act 2006 shall not be treated

as a pecuniary interest for the purpose of this Standing Order.

(e) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not they are also a member of the Trust) as it applies to a member of the Trust.

7.3.4. Waiver of Standing Orders made by the Secretary of State for Health and Social Care

(a) Power of the Secretary of State for Health and Social Care to make waivers

Under regulation 20(1) of the Membership and Procedure Regulations there is a power for the Secretary of State for Health and Social Care to issue waivers if it appears to the Secretary of State for Health and Social Care in the interests of the health service that the disability in regulation 20 (which prevents a chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (b) to (d) below.

(b) Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant chair" is

(i) ~~—~~at a meeting of the Trust, the Chair of that Trust;
(iii) at a meeting of a ~~Committee~~committee –

- in a case where the member in question is the Chair of that Committee, the Chair of the ~~Trust;~~Trust.
- in the case of any other member, the Chair of that Committee.

(c) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to:

(i) A member of the Trust who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

- services under the National Health Service Act 2006; or
- services in connection with a pilot scheme under the National Health Service Act ~~2006;~~2006.

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which they are present:-

- arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those ~~persons;~~persons.
- has been declared by the relevant chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons ~~who: –~~who: –
  - are members of the same profession as the member in question,
  - are providing ~~or performing~~or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(d) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(i) the member must disclose their interest as soon as practicable after the commencement of the meeting and this must be recorded in the ~~minutes;~~minutes.

(ii) the relevant chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief ~~Executive;~~Executive.

(iii) in the case of a meeting of the Trust:

- the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome ~~recorded;~~recorded.
- may not vote on any question with respect to it.

(iv) in the case of a meeting of the Committee:

- the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome ~~recorded;~~recorded.
- may vote on any question with respect to it; but
- the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4. Standards of Business Conduct

7.4.1. Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Standards of Business Conduct and Conflicts of Interest Policy and the national guidance contained in:

Standards of Business Conduct Policy NHS England and NHS Improvement.
Document first published: 12 July 2017, Page updated: 15 February 2022
https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/

Managing Conflicts of Interest in the NHS: Guidance for staff and organisations
NHS England.
Document first published: 7 February 2017, Page updated: 22 August 2017
https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance- for-staff-and-organisations/

Bribery Act 2010
https://www.legislation.gov.uk/ukpga/2010/23/contents

Code of Governance for NHS Trusts (2022)

Revised Fit and Proper Persons Test Guidance (2023)

7.4.2. The Trust considers it to be a priority to maintain the confidence and continuing goodwill of its patients, public and fellow service providers. The Trust will ensure that all staff are aware of the standards expected of them and will provide guidance on their personal and professional behaviour.

7.4.3. The NHS Constitution 2016 identifies a number of key rights that all staff have and makes a number of further pledges to support staff in delivering NHS services. It goes on to set out the

legal duties and expectations of all NHS staff, including:

(a) to accept professional accountability and maintain the standards of professional practice as set out by the relevant regulatory ~~bodies;~~bodies.
(b) to act in accordance with the terms of contract of ~~employment;~~employment.
(c) not to act in a discriminatory ~~manner;~~manner.
(d) to protect ~~confidentiality;~~confidentiality.
(e) to be honest and truthful in their ~~work;~~work.

(f) to aim to maintain the highest standards of care ~~and service~~and ;service.
(g) to maintain training and personal development to contribute to improving services~~;~~.
(h) to raise any genuine concerns about risks, malpractice or wrongdoing at work at the earliest ~~opportunity;~~opportunity.
(i) to involve patients in decisions about their care and to be open and honest with them ~~and;~~and
(j) to contribute to a climate where the truth can be heard and learning from errors is encouraged.

7.4.4. The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life. These are:

Selflessness: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability: Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and example.

7.4.5. All staff are expected to conduct themselves in a manner that reflects positively on the Trust and not to act in a way that could reasonably be regarded as bringing their job or the Trust into disrepute. All staff must:

(a) act in the best interests of the Trust and adhere to its values and this code of ~~conduct;~~conduct.
(b) respect others and treat them with dignity and ~~fairness;~~fairness.
(c) seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social ~~inclusion;~~inclusion.
(d) be honest and act with integrity and ~~probity;~~probity.
(e) contribute to the workings of the Trust and its management and directors in order to help them to fulfil their role and ~~functions;~~functions.
(f) recognise that all staff are individually and collectively responsible for their contribution to the performance and reputation of the ~~Trust;~~Trust.
(g) raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate and~~;~~
(h) accept responsibility for their performance, learning and development.

7.4.6. All Directors must act in accordance with the Code of Governance (2022).~~Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England Professional Standards Authority 21 May 2013 https://www.professionalstandards.org.uk/publications/detail/standards-for-members-of-nhs-boards-and-clinical-commissioning-group-governing-bodies-in-england~~

7.4.7. Gifts and hospitality shall only be accepted in accordance with the Trust's Conflicts of Interest Policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any

rewards or gifts of significant value.

7.4.8. All gifts and hospitality, other than those that are of clearly minimal value (as determined by the Trust's Conflicts of Interest Policy), should be declared via the Electronic Staff Record. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act 2006 https://www.legislation.gov.uk/ukpga/2006/35/contents. Bribery Act 2010 https://www.legislation.gov.uk/ukpga/2010/23/contents

7.4.9. Interest of Officers in Contracts

(a) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Company Secretary as soon as practicable.

(b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of them, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

(c) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.10. Canvassing of and Recommendations by Members in Relation to Appointments

Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, ~~experience~~experience, or character for submission to the Trust.

7.4.11. Relatives of Members or Officers

(a) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

(b) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between themselves and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(c) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(d) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' 'Exclusion in proceedings of the Trust Board (SO7.3) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1. Custody of Seal

The common seal of the Trust shall be kept by the Chief ~~Executive~~Executive, or a manager nominated by them in a secure place.

8.2. Sealing of Documents

8.2.1. The common seal shall not be affixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers.

8.2.2. Where it is necessary that a document shall be sealed, it must be approved and signed by the Chief Financial Officer (or an officer nominated by them). The seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not from the originating department, and shall be attested by them.

8.3. Register of Sealing

8.3.1. The Chief Executive shall keep a register in which they, or another manager authorised by them, shall enter a record of the sealing of every document.

8.3.2. An entry of every sealing shall be made and numbered consecutively in a book provided for that ~~purpose, and~~purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust Board after each sealing. The report shall contain details of the seal number, the description of the document and date of sealing.

8.4. Signature of documents

8.4.1. Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

8.4.2. In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (~~e.g.~~e.g., sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS (see overlap with SFI No. 19.3)

9.1. Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 256 & 257 of the NHS Act 2006. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the ~~health related~~health-related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 256 & 257 of the NHS Act 2006.

See overlap with Standing Financial Instruction No. 19.3.

Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any procedural document that requires ratification

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**	YES	
	Is the title clear and unambiguous? It should not start with the word policy.	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated? This should be in the purpose section.	YES	UPDATE
3.	**Development Process**		
	Does the policy adhere to the Trust policy format?	YES	
	Is the method described in brief? This should be in the introduction or purpose.	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
	Are all terms clearly explained/defined?	YES	
5.	**Evidence Base**		
	Has a comprehensive literature search been conducted to identify best evidence to inform the policy?	YES	
	Have the literature search results been evaluated and key documents identified?	YES	
	Have the key documents been critically appraised?	YES	
	Are key documents cited within the policy?	YES	
	Are cited documents referenced?	YES	
6.	**Approval**		

	Title of document being reviewed:	Yes/No	Comments
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
	For Trust wide policies has the appropriate Executive lead approved the policy?	YES	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	YES	OVERARCHING FINANCIAL POLICY SO ELEMENTS ARE LINKED INTO ALL TRAINING
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	BREACHES TO BE REPORTED TO AUDIT COMMITTEE
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	ANNUAL BY COMPANY SECRETARY AND THE CHIEF FINANCE OFFICER
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	YES	POSTED ON INTRANET

Reviewer			
If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date it and forward to the Policy Management Officer.			
Name	Dan Mortiboys	Date Approving Committee/s	5th August 2021 Trust Board
Ratification Committee Approval			
TMC minute number: 382/22			

Equality Impact Assessment Form – Initial Assessment Stage 1

Walsall Healthcare NHS
NHS Trust

For each of the protected characteristics listed answer the questions below using Y to indicate Yes and N to indicate No	Sex	Age	Race	Disability	Religion & Belief	Sexual Orientation	Gender reassignment	Marriage and Civil Partnership	Pregnancy & Maternity	Carers rights	Human Rights	Please provide a summary below of any potential positive or negative impact
1.Does the policy/strategy/ project have the potential to affect individuals or communities differently or in a negative way?	No	No	No	No	No	No	No	No	No	No	No	This policy does not have any negative implications on any of the groups listed in the protected characteristics.
2.Is there potential for the policy/strategy /project to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.?	No	No	No	No	No	No	No	No	No	No	No	There is no opportunity for any negative impact if this policy is followed. There is equal opportunity and non-discriminatory processes in place for all financial issues Trust wide and ensuring that any employees raising concerns are treated fairly
3.In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	No	No	No	No	No	No	No	No	No	No	No	If yes: Please state how you are going to gather this information.

If you have answered yes to question 1 across any of the protected groups you must complete a stage 2 impact assessment

Name: Alan Lakin	Job title:	Division/department:	Date:	Senior Manager name/ Signature
Title of policy /project /service/ to be assessed Standing Orders, Reservations and Delegations of Powers	Head of Financial Governance	Finance Directorate	~~09/05/2022~~	Dan Mortiboys

WHT-GI02 V5.3

WALSALL HEALTHCARE NHS TRUST

Standing Financial Instructions and Scheme of Reservation and Delegation

November 2023
Version 5.3

CONTENTS

SECTION C

STANDING FINANCIAL INSTRUCTIONS

SECTION D

SCHEME OF RESERVATION AND DELEGATION

SECTION C - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1. **General**

10.1.1. These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2. These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the ~~Scheme of Delegation~~Scheme of Reservation and Delegation adopted by the Trust.

10.1.3. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust, Walsall Together and any constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Chief Financial Officer/Operational Director of Finance~~Chief Financial Officer~~.**

10.1.4. Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders (contained within the Trust Constitution), particularly in relation to tending and contracting procedures, which were previously contained within the Trust Constitution but are now reproduced within this document for ease of reference.

10.1.5. Failure to comply with Standing Financial Instructions and Standing Orders is a disciplinary matter that could result in dismissal.

10.1.6. **Overriding Standing Financial Instructions**

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance shall be reported to the Chief Financial Officer/Operational Director of Finance~~Chief Financial Officer~~, Company Secretary and escalated to the Audit Committee as appropriate for referring action or ratification. All members of the Trust Board and officers have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ as soon as possible.

10.1.7 All instances of non-compliance in relation to this Policy where there is a suspicion of fraud or bribery must be reported to the Local Counter Fraud Specialist (LCFS) for investigation in accordance with the Anti-Fraud, Bribery and Corruption Policy.

10.2. **Responsibilities and delegation**

10.2.1. **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy and agreeing the long term financial model;~~;~~
(b) requiring the submission and approval of budgets within approved allocations/overall

income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the ~~Scheme of Delegation~~Scheme of Reservation and Delegation document.

10.2.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Reservation and Delegation and SOs.~~'Reservation of Matters Reserved to the Board' section of this document. All other powers have been delegated to such other committees as the Trust has established~~. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Reservation and Delegation document adopted by the Trust.

10.2.3. **The Chief Executive and Chief Financial Officer/Operational Director of Finance**

The Chief Executive and Chief Financial Officer/Operational Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4. It is a duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and put in a position to understand their responsibilities within these SFIs.

10.2.5. **The Chief Financial Officer/Operational Director of Finance**

The Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ is responsible for:

(a) ensuring that the SFIs are maintained and regularly reviewed.

~~(a)~~(b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

~~(b)~~(c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

~~(c)~~(d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ include:

~~(d)~~(e) the provision of financial advice to other members of the Board and employees;

~~(e)~~(f) the design, implementation and supervision of systems of internal financial control;

~~(f)~~(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6. **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust

(b) avoiding loss

(c) exercising economy and efficiency in the use of resources

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation~~Scheme ofDelegation~~.

10.2.7. **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.8. For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer/Operational Director of Finance~~Chief Financial Officer~~.

10.2.9. It shall be the duty of any officer having evidence of, or reason to suspect, financial or other irregularities or impropriety in relation to these SFIs to report these suspicions without delay to the Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ and/or the Trust's Local Counter Fraud Specialist for further investigation and action as appropriate, in line with the Trust's 'Anti- Fraud, Bribery and Corruption Policy'.

11. AUDIT

11.1. **Audit Committee**

11.1.1. In accordance with Standing Orders, and following guidance from the NHS Audit Committee Handbook, the Board shall establish a committee of non-executive directors as an Audit~~, and Risk~~ Committee with formal terms of reference, approved by the Board, to perform such monitoring, reviewing and other functions as are appropriate to provide an independent and objective view of internal control.

11.1.2. The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

11.1.3. The Audit Committee will provide an independent and objective view of internal control by:

(a) overseeing audit arrangements, including strategic and annual audit plans for Internal and External Audit services on behalf of the Trust Board;
(b) reviewing financial information and systems and monitoring the integrity of the financial statements and reviewing significant reporting judgements, including the draft Annual Accounts;
(c) reviewing the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical);
(d) reviewing schedules of write-offs and Losses and Special Payments on behalf of the Board and reviewing all occasions on which the Trust Board waiver standing orders;
(e) ensuring that agreed actions and recommendations arising out of internal and external audit reports are appropriately progressed;
(f) monitoring compliance with SOs and SFIs;
(g) reviewing the work of other committees and other significant assurance providers, where relevant and appropriate;
(h) overseeing counter fraud arrangements provided by the Local Counter Fraud Specialist within the Trust; and is accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation; and
(i) ensuring that the function of the Audit Committee complies, as appropriate, with the latest Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook recommendations.

11.1.4. Where the Audit Committee considers there is evidence of ultra vires transactions, evidence

of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care (to the Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ in the first instance.)

11.1.5. It is the responsibility of the Chief Financial Officer/Operational Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2. **Chief Financial Officer/Operational Director of Finance**

11.2.1. The Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
(b) ensuring that the Internal Audit is adequate and meets the Public Sector Audit Standards (PSIAS);
(c) The Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ is accountable for the provision of strategic management of all counter fraud, bribery and corruption work within the organisation.
(d) The Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken.
(e) Deciding at what stage to involve ~~the~~ Security Management ~~Director~~ and the police in cases of misappropriation and other irregularities not involving fraud or corruption;
(f) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:
    (i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
    (ii) major internal financial control weaknesses discovered;
    (iii) progress on the implementation of internal audit recommendations;
    (iv) progress against plan over the previous year;
    (v) strategic audit plan covering the coming three years;
    (vi) a detailed plan for the coming year.

11.2.2. The Chief Financial Officer/Operational Director of Finance, designated auditors, Local Counter Fraud Specialist and Security Management ~~Director~~ are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
(c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
(d) explanations concerning any matter under investigation.

11.2.3. The Trust's Chief Executive and Chief Financial Officer/Operational Director of Finance are responsible for ensuring access rights are given to NHS Counter Fraud Authority (CFA) where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with NHS CFA Standards for NHS Providers.

11.3. **Internal Audit**

11.3.1. Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;
~~(c)~~(d) the efficient and effective use of resources
~~(d)~~(e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.
~~(iii)~~(iv) Any form of risk, especially business and financial risk, but not exclusively so.
(f) The adequacy of follow up actions to audit reports.
~~(e)~~(g) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care

11.3.2. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer ~~and~~ /Operational Director of Finance must be notified immediately.

11.3.3. The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

The Head of Internal Audit shall be accountable to the Chief Financial ~~Chief~~Officer/Operational Director of Finance. The reporting system for internal audit shall be agreed between the Chief Financial Officer/Operational Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the PSIAS. The reporting system shall be reviewed at least every three years.

11.4. External Audit

11.4.1. The Local Accountability and Audit Act 2014 and The Local Audit (Health Services Bodies Auditor Panel and Independence) Regulations 2015 require the Trust to appoint external auditors. Audit Committee will ensure the Trust appoints external auditors. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Trust Board if the issue cannot be resolved.

~~11.4.1.~~11.4.2. The External Auditor is appointed by the Audit Committee and paid for by the Trust. The Audit Committee must ensure that the Trust receives a cost-effective, efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Audit Commission if the issue cannot be resolved.

11.5. Fraud, Bribery and Corruption

11.5.1. In line with their responsibilities, the Chief Executive and Chief Financial Officer/Operational Director of Finance shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Requirements of the Government Functional Standards 013: Counter Fraud.

11.5.2. The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the Government Functional Standards 013: Counter Fraud.

11.5.3. The LCFS shall report to the Chief Financial Officer/Operational Director of Finance and shall work with staff in the NHS Counter Fraud Authority, in accordance with the Government Functional Standards 013: Counter Fraud, the Counter Fraud Manual and the NHS Counter Fraud Authority's Investigation Case File Toolkit.

11.5.4. The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust.

11.5.5. The Trust will report annually on how it has met the requirements of Government Functional Standards 013: Counter Fraud as set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the Chief Financial Officer/Operational Director of Finance –shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority. The Chief Financial Officer/Operational Director of Finance shall sign-off the annual Counter Fraud Functional Standard Return and submit it to the NHS Counter Fraud Authority.

11.5.6. The Trust will comply with relevant government standards including the NHS Requirements of the Government Functional Standard 013: Counter Fraud; this includes NHS Requirement 1B, which includes support of the role of the Counter Fraud Champion to promote awareness of fraud, bribery and corruption within the organisation.

11.6. **Security Management**

11.6.1. In line with his/her responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

11.6.2. The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS security management.

~~11.6.1. The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director.~~

12. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

12.1. **Preparation and Approval of Plans and Budgets**

12.1.1. The Chief Executive shall prepare at least every five years or more regularly as required, a statement of strategic direction for approval by the Board.

12.1.2. The Chief Executive will compile and submit to the Board an ~~A~~annual business ~~P~~plan, which takes into account financial targets and forecast limits of available resources. The annual business p~~P~~lan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

12.1.3. Prior to the start of the financial year (or in line with the internal reporting timetable) the Chief Financial Officer/Operational Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;
(b) accord with workload and manpower plans;
(c) be produced following discussion with appropriate budgetholders;
(d) be prepared within the limits of available funds;
(e) identify potential risks.

12.1.4. The Chief Financial Officer/Operational Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to ~~Performance~~ Finance & ~~Investment~~ Productivity Committee and the Board.

12.1.5. Officers shall provide the Chief Financial Officer/Operational Director of Finance with all financial, statistical and other relevant information as necessary, for the compilation of such budgets, plans, estimates and forecasts. and financial performance against budgets to be monitored.

12.1.6. All budget holders will sign up to their allocated budgets at the commencement of each financial year.

~~12.1.5.~~12.1.7. The Chief Financial Officer/Operational Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully, and the expectations for senior Budget Holders including assessment of financial risk and holding to account for delivery.~~.~~

~~12.1.6.~~12.1.8. Operating surpluses may be used to:

(a) spend on revenue;
(b) meet locally determined health needs;
(c) build up cash reserves for future investments;
(d) finance an investment or purchase; or
(e) make payments on a loan.

~~12.1.7.~~12.1.9. Operating surpluses may not be distributed to members.

12.2. **Budgetary Delegation**

12.2.1. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

12.2.2. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

12.2.3. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

12.2.4. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer/Operational Director of Finance.

12.3. **Budgetary Control and Reporting**

12.3.1. The Chief Financial Officer/Operational Director of Finance will devise and maintain systems of budgetary control. These will include:
(a) monthly financial reports to the Board in a form approved by the Board containing:
  (i) income and expenditure to date showing trends and forecast year-end position
  (ii) movements in working capital;
  (iii) summary cash flow and forecast year-end position;
  (iv) capital project spend and projected outturn against plan;
  (v) explanations of any material variances that explain any movements from the planned retained surplus/deficit position at the end of the current
  (vi) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer/Operational Director of Finance's view of whether such actions are sufficient to correct the situation;
(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
(c) investigation and reporting of variances from financial, workload and manpower budgets;
(d) monitoring of management action to correct variances; and
(e) arrangements for the authorisation of budget transfers.

12.3.2. The Chief Financial Officer/Operational Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

12.3.3. Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;
(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

12.3.4. The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

12.3.5. The Trust's business case procedure is to be followed by managers when proposing service changes.

12.3.6. ~~Performance and~~ Finance and Productivity Committee shall monitor and review performance against Business Cases and report to the Board. Business Cases will be reported to the Board by 'exception' where benefits have not been delivered as originally approved.

12.3.7. All major business cases must be subject to a benefits realisation process, which will be monitored by the ~~Performance and ,~~ Finance and Productivity ~~and Investment~~ Committee.

12.4. **Capital Expenditure**

The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contracting Procedures.

~~(The particular applications relating to capital are contained in the tendering and contracting procedures – section 17)~~.

12.5. **Performance Monitoring Returns**

12.5.1. The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the to the Independent Regulator and any other requisite monitoring organisation within the prescribed timescales; and also that:

(a) financial performance measures have been defined and are routinely monitored;
(b) reasonable targets have been identified for these measures;
(c) a robust system is in place for managing performance against the targets;
(d) reporting lines are in place to ensure that overall performance is managed effectively; and
(e) arrangements are in place to manage/respond to adverse performance.

13. ANNUAL ACCOUNTS, REPORTS AND QUALITY ACCOUNT

13.1. **Annual Accounts**

13.1.1. The Chief Financial Officer/Operational Director of Finance on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards (IFRS).

(b) prepare and submit annual financial reports to the Department of Health and Social Care and NHS England certified in accordance with current guidelines.
(c) submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

~~(a) keep accounts and in respect of each financial year must prepare annual financial accounts, in such form as the Independent Regulator may, with the approval of NHSE/I~~
~~(b) ensure that, in preparing annual accounts, the Trust complies with any directions given by the Independent Regulator with the approval of NHSE/I as to:~~
~~(i) the methods and principles according to which the accounts are to be prepared; and~~
~~(ii) the information to be given in the accounts;~~
~~(c) ensure that a copy of the annual accounts and any report of the External Auditor on them are laid before Parliament and that copies of these documents are sent to the Independent Regulator in accordance with the timescales prescribed.~~

13.2. **Auditing of Accounts**

The Trust's annual accounts, financial returns and annual report must be audited by the External Auditor appointed by the Audit Committee in accordance with appropriate auditing standards.

The Trust's Audited Annual Accounts (including the Auditor's report) must be presented to the Board for approval or the Audit Committee (when specifically delegated the power to do so, under the authority of the Board). The Trust's audited accounts must be made available to the public.

13.3. **Publication of Annual Report**

The Group Director of Communications and Stakeholder Engagement~~Director of Governance~~, will, on behalf of the Trust, prepare the annual report in accordance with the NHS General Accounting Manual (GAM), the provisions of the License Self-Assessment declaration (FT4/G6), and the requirements of the Code of Governance for NHS Trusts (2023).~~on behalf of the Trust, will prepare an annual report in accordance with the requirements of Department of Health's Annual Reporting Manual.~~ This annual report will be presented to the Board for approval. A copy will be forwarded to the Independent Regulator in line with the prescribed timescales.

13.4. **Quality Account**

The Director of Nursing on behalf of the Trust will prepare the Quality Report in the format prescribed by NHSEI. The Quality Report presents a balanced picture of the Trusts performance over the financial year and up to the June submission date. The Chief Executive and Chairman shall sign off the "Statement of Directors Responsibilities in respect of the "Quality Report" under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 as well as NHSE/I Quality Account requirements.

14. BANK AND GBS ACCOUNTS

14.1. **General**

14.1.1. The Chief Financial Officer/Operational Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the regulator. The Board shall approve the banking arrangements.

14.1.2. The Board shall approve the banking arrangements in line with the Treasury Management Policy.

14.1.3. The Audit Committee will review banking arrangements periodically.

14.2. **Bank and GBS Accounts**

14.2.1. The Chief Financial Officer/Operational Director of Finance is responsible for:

(a) bank accounts and Government Banking Services (GBS) accounts
(b) establishing separate bank accounts for the Trust's non-exchequer funds/charitable funds
(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) reporting to the Board all arrangements and instances where the bank accounts became or may have become overdrawn, and the arrangements made with the Trust's bankers ~~for accounts to be overdrawn~~.
(e) monitoring compliance with NHSEI or DHSC guidance on the level of cleared funds.
~~(e)~~(f) Ensuring covenants attached to bank borrowing are adhered to.

14.3. **Banking Procedures**

14.3.1. The Chief Financial Officer/Operational Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:
(a) the conditions under which each bank and GBS account is to be operated;
(b) those authorised to approve payments, bank transfers, sign cheques or other orders drawn on the Trust's accounts.

14.3.2. The Chief Financial Officer/Operational Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

14.3.3. No-one but the Chief Financial Officer/Operational Director of Finance shall open a bank account in the name of the Trust.

14.4. **Tendering and Review**

14.4.1. The Chief Financial Officer/Operational Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders or benchmarking for the Trust's commercial banking business.

14.4.2. Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

14.5. **Purchase Cards**

14.5.1. The Chief Financial Officer/Operational Director of Finance shall approve the allocation, limits and operation of credit/purchase cards on behalf of the Trust (in line with SFIs 20 and 23); implement arrangements to monitor whether the credit/purchase cards are being used appropriately; and take action where inappropriate use is identified.

14.5.2 Changes to the limits of purchase cards can be approved by the Chief Financial Officer ~~or~~ /Operational Director of Finance.

~~14.5.3 Permanent changes to purchase card limits will require an approved business case.~~

14.5.3 All changes to limits whether temporary or permanent must be reported to the Audit Committee.

14.5.4 The Chief Financial Officer/Operational Director of Finance will produce detailed procedures regarding their use.

15. SERVICE AGREEMENTS FOR PROVISION OF SERVICES

15.1. **Contracts with Commissioners**

15.1.1. The Board shall regularly review and shall at all times maintain and ensure the capacity of the Trust to provide the commissioner requested services referred to in the Provider License and other Terms of Authorisation and related schedules.

15.1.2. The Chief Executive, as Accounting Officer, supported by the Chief Financial Officer/Operational Director of Finance, is responsible for ensuring that contracts are in place with commissioners for the provision of services to patients in accordance with the Business Plan.

15.1.3. Contracts with commissioners shall comply with best costing practice and shall be so devised as to minimise contractual risk whilst maximising the Trust's opportunity to generate income. Contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation's liabilities under the terms of the contract, should be considered.

15.1.4. Contracts with commissioners will be signed by both parties in accordance with the ~~Scheme of Delegation~~Scheme of Reservation and Delegation.

15.1.5. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer/Operational Director of Finance regarding:

(a) costing and pricing of services (in accordance with the National Financial Framework) and the activity/volume of services planned;
(b) payment terms and conditions;
(c) billing systems and cash flow management to ensure all activity is captured and coded to ensure full recovery of ERF;
(d) any other matters of a financial nature;
(e) the contract negotiation process and timetable;
(f) the provision of contract data;
(g) contract monitoring arrangements;
(h) amendments to contracts; and
(i) any other matters of a legal or non-financial nature.

15.1.6. Prices should match national tariff under PbR, where appropriate, but the Trust can negotiate locally agreed prices where services are not covered by the national tariff.

15.1.7. The Chief Financial Officer/Operational Director of Finance shall produce regular reports (in the form of service line reports) detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income. These reports will be submitted to ~~the Performance and~~ , Finance~~Finance~~ and Productivity ~~and Investment~~ Committee and the Trust Board.

15.1.8. The Trust will maintain a public and up-to-date schedule of the authorised goods and services which are being currently provided, including non-mandatory health services, as set out in the Trust Licence.

15.2. **Other Contracts**

15.2.1. Where the Trust enters into a relationship with another organisation for the supply or receipt of services – clinical or non-clinical – the responsible officer should ensure that an appropriate contract is in place and signed by both parties.

15.2.2. No officer shall enter into any form of contract on behalf of the Trust unless they have specific authority to do so, in line with the ~~Scheme of Delegation~~Scheme of Reservation and Delegation and relevant Trust policies and procedures. This applies even if the contract has no obvious financial value attached to it, e.g. agreements to advertise on Trust premises or documentation. ~~Refer also to the Trust's "Advertising Policy" for such agreements~~.

15.2.3. Contracts should incorporate:

(a) a description of the service and indicative activity levels;
(b) the term of the agreement;
(c) the value of the agreement;

(d) lead officers;
(e) performance and dispute resolution procedures; and
(f) risk management and governance arrangements.

15.2.4. Contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise any potential loss of income and maximisation of income.

15.3. **Involving Partners and Jointly Managing Risk**

15.3.1. A good contract will result from a dialogue of clinicians, users, carers, public, health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

15.3.2. The Trust has a duty to work together collaboratively with all other local stakeholders. The interests of the Trust will not be pursued where this will adversely impact upon the interests of the local health and care system as a whole.

15.3.3. Services that are looking to enter a financial or non-financial contract/SLA/memorandum of understanding for a product and/or service, clinical or non-clinical, either as a supplier or purchaser, have a responsibility to contact both the internal contracting and procurement teams; which are part of the Finance directorate, prior to entering into any agreement. Together they advise on the contractual processes that need to be undertaken to avoid non-payment and/or legal consequences.

15.3.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contract and SLA's. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1. The Chief Financial Officer/Operational Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, early identification, appropriate invoicing, collection and coding of all monies due.

16.1.2. All such systems shall incorporate, where practicable, the principles of internal check and separation of duties.

16.1.3. The Chief Financial Officer/Operational Director of Finance is also responsible for the prompt banking of all monies received.

16.2. Fees and Charges

16.2.1. The Trust shall follow the Department of Health and Social Care's guidance and regulations in setting prices for NHS service agreements.

16.2.2. The Chief Financial Officer/Operational Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of

Health's Commercial Sponsorship – Ethical standards in the NHS (Nov 2000), 2017 NHS England Managing Conflicts of Interest in the NHS: Guidance for staff and organisations and the Trust policy on Conflicts of Interest shall be followed.

16.2.3. All employees must inform the Chief Financial Officer/Operational Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

16.2.4. Under no circumstances will the Trust accept cash payments in any currency in excess of £15,000 in respect of any single transaction or series of transactions which appear to be linked. Any attempts by an individual to effect payment above this amount should be notified immediately to the Chief Financial Officer/Operational Director of Finance.

16.3. Debt Recovery

16.3.1. The Chief Financial Officer/Operational Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

16.3.2. Outstanding debts will be reviewed periodically and follow up action taken, dependent upon the value of the debt and length of time outstanding.

16.3.3. Income and salary overpayments not received after all attempts at recovery have failed should be dealt with in accordance with losses procedures.

16.3.4. The Chief Financial Officer/Operational Director of Finance is responsible for ensuring systems are in place to prevent overpayments. Where overpayment occurs systems should be in place for their detection and recovery initiated. Overpayments should be detected (or preferably prevented) and recovery initiated.

16.4. Security of Cash, Cheques and other Negotiable Instruments

16.4.1. All officers have a responsibility to ensure that any Trust monies in their possession or under their responsibility are properly safeguarded and are held securely when not in use.

16.4.2. The Chief Financial Officer/Operational Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.3. Trust monies shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.4. All cheques, postal orders, payable orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer/Operational Director of Finance.

16.4.5. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.5. Free of Charge/Donated Goods/Services

16.5.1. Free of charge or donated goods or equipment from any supplier or would be supplier to the Trust must not be used to avoid the procurement regulations.

16.5.2. A budget manager or budget holder must approve in writing the acceptance of such goods or services prior to delivery. If the goods are to be donated or accepted on loan, whether for service provision or testing, before such approval may be given:

(a) an official order number must be allocated if the acquisition by this method is part of a procurement process by the Trust;
(b) the owner must provide a written indemnity to the Trust, in a form approved by the Trust Company Secretary, which will be signed, if necessary, on the Trusts behalf by the Chief Executive or an officer authorised by the Chief Executive;
(c) responsibility for maintenance and other revenue consequences must be agreed in writing and must be approved in accordance with these SFIs.

16.5.3. The acceptance of any such goods or services must be confirmed in writing to the donor/owner and, except in the case of charitable donations, such confirmation shall include a notice that the acceptance does not amount to an express or implied obligation on the Trust to continue to use the goods/services or to purchase any goods/services.

16.5.4. The donation of clinical equipment shall undergo the same rigour as applied to an NHS funded purchase.

16.5.5. Where there are revenue consequences arising out of the donation of any asset then the donation shall not be accepted or put into use until a budget has been agreed with the Chief Financial Officer/Operational Director of Finance in respect of the revenue consequences.

16.6. Payment in Kind to the Trust

16.6.1 A budget manager or holder may authorise the provision by the Trust of services to third parties in return for payments in kind provided:

(a) the value received is reasonably commensurate with the value given.
(b) the arrangement is confirmed in writing to the third party under the signature of a budget manager or budget holder and a copy retained.
(c) the confirmation includes a notice that the Trust reserves the right to joint ownership on terms to be agreed or fixed by arbitration of any intellectual property arising from the collaboration between the Trust and the third party.
(d) the confirmation includes a notice that the arrangement does not bind the Trust to continue any collaboration on the terms agreed or to purchase / use the benefits of any collaboration

~~16.~~17. TENDERING AND CONTRACTING

~~16.1.~~17.1. Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

In particular, directors and officers should be aware of the definition of "pecuniary interest" as set out in Standing Order 7.3. Directors and/or officers with a pecuniary interest in a contract or potential contract should declare any such interest to the Chief Executive and should not participate in any process (including any evaluation) associated with the award of the contract

The Bribery Act 2010 replaces the fragmented and complex offences at common law and in the Prevention of Corruption Acts 1889-1916. This broadly defines the new Act:

- Two general offences of bribery:
  - Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly; and
  - Requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper.

- A corporate offence of failure by a commercial organisation to prevent a bribe being given or offered by an employee or agent of the Trust, subject to a defence of 'adequate procedures' being in place at the Trust to prevent a bribe.

- Bribing a foreign official.

Staff must be aware of the provisions of the bribery risks associated with gifts and hospitality, conflicts of interest and abuse of authority within the procurement process.

Staff should be aware of the Trust's Anti-fraud, Bribery and Corruption policy and Conflicts of Interest policy.

Staff involved in tendering, procurement and contracting processes should make declarations regularly for each transaction of any interest that they may have, or family or friends may have in a supplier.

Declarations of Interests, and gifts and hospitality should also be sought regularly from staff engaged in procurement related activities.

~~16.2.~~17.2. Government Directives Governing Public Procurement

The United Kingdom joined the WTO Agreement on Government procurement on 1st January 2021. Under this agreement, the European Union and the United Kingdom have taken mutual commitments to give access to each other operators for goods and services and other public procurement opportunities.

Directives by the Government Procurement Agreement promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

~~16.3.~~17.3. E-Tendering

The Trust should have policies and procedures in place for the control of all tendering activity carried out using an e-tendering system, this will incorporate reverse auction processes.

~~16.4.~~17.4. Capital Investment in accordance with IFRS and Department of Health and Social Care Guidance

17.4.1 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care, IFRS and “Estate code” in respect of capital investment and estate and property transactions.

17.4.2 In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS" and guidance from NHSE/I.

~~16.5.~~17.5. Formal Competitive Tendering

~~16.5.1.~~17.5.1. General Applicability

The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the tendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC); Prior approval from NHSE is required for Management Consultancy before engaging.

(c) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

(d) For disposals.

~~16.5.2.~~17.5.2. Testing/Quotations/Tendering

(a) Informal price testing, i.e. written competitive quotes from one or more suppliers wherever possible. £0-£10,000
(b) Competitive quotations are required from three suppliers for contracts valued at between £10,000 and £50,000
(c) Competitive tenders should be obtained for all contracts where the estimated expenditure or income is likely to exceed £50,000+

All include VAT.

~~16.5.3.~~17.5.3. It is a breach of regulations to split contracts to avoid appropriate tendering / quotation thresholds. The value used should be the overall contract value for the life of the equipment or service not annual costs, and including VAT.

~~16.5.4.~~17.5.4. The Trust shall ensure that requirements are tendered openly in a clear and transparent manner or procured via approved framework agreements. Use of approved frameworks must be in line with the requirements of the framework. Any use of frameworks which is not through a mini competition exercise, for example a direct award, should be justified with a waiver.

~~16.5.5.~~17.5.5. **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with SFI No. 15.

~~16.5.6.~~17.5.6. **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 (life of contract) including VAT;
(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with (such as procure22);
(c) regarding disposals as set out in Standing Financial Instructions No.23;

In exceptional circumstances it may be impractical to follow the tendering process. If so, a request for waiver of Standing Financial Instructions (SFIs) (relating to quotations and tenders) must be completed.

The reason for waiving competitive tendering procedures shall be documented in a permanent record and approved, before any order may be placed or any financial commitment entered into, by the relevant Executive Director and Committee.

All waivers must be completed prospectively.

If any officer is uncertain about the Trust's tendering and quotation requirements or the waiver procedure they must contact the Trust's Procurement team for advice and guidance.

Failure to plan the work properly and as a result be time restricted is not a justification for waiver. Such instances will be recorded as non-compliant and reported to the Audit Committee.

All waivers will be reported to the Audit Committee for oversight and scrutiny purposes.

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;
(e) where the requirement is covered by an existing contract;
(f) where framework agreements are in place and have been approved by the procurement

department;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned;

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

All single source waivers MUST be authorised by the Deputy Director of Procurement or Director of Procurement (~~under~~ upto £250k) and Operational Director of Finance ~~/or~~ Chief Financial Officer (over £250k).

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

~~16.5.7.~~17.5.7. Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 17.1 and 17.5.~~3~~6 do not apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Business partners and suppliers should be made aware in writing of the Trust's Anti-Fraud, Bribery and Corruption policy.

All suppliers should be required to declare any personal or family relations within the NHS organisation at the pre-contract stage.

Suppliers will be asked to complete a non-collusion declaration and non-canvassing declaration as part of the tendering process. Nil return declarations need to be made, and will be routinely sought from suppliers throughout the tendering process, at both the commencement and conclusion of the process.

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded with the approval of the ISPD Procurement board.

Where only one tender is sought and/or received, the ~~Operational Director of Finance~~Chief Financial Officer/Operational Director of Finance ~~or Chief Financial Officer~~ and the Deputy Director of Procurement shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the trust.

~~16.5.8.~~17.5.8. List of Approved Firms

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote)

are among those on approved lists. Where in the opinion of the Chief Financial Officer/Operational Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 17.6.8 List of Approved Firms).

~~16.5.9.~~17.5.9. Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health and Social Care approval.

~~16.5.10.~~17.5.10. Items which subsequently breach thresholds after originalapproval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive/Audit Committee, and be recorded in an appropriate Trust record.

~~16.6.~~17.6. Contracting/Tendering Procedure

~~16.6.1.~~17.6.1. Invitation to tender

(i) All invitations to tender shall be exclusively submitted through the Trusts chosen e-tendering portal and will follow the protocols within the package. The e-tendering system must be compliant with HMG Security Policy to be used up to and including HM Government Information Security Impact Level Three (Restricted) supporting Risk Management Accreditation Document Set (RMADS).

(ii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works (except for maintenance work, when Estate code guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

~~(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.~~

~~(b) The Trust may require that tenders are submitted electronically and/or in hard copy. Where tenders are required in hard copy the invitation to tender shall state that no tender will be accepted unless:~~

~~(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager~~

~~(ii) that tender envelopes/packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.~~

~~(iii) Every invitation to tender must require each bidder to give an undertaking not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the Trust, its employees or officers concerning the contract opportunity tendered.~~

~~(i v) For electronic tenders, no tender will be considered for acceptance unless submitted~~

~~electronically through the appropriate process using the eTendering service as instructed in the tender.~~

~~Separate procedures shall be established to cover the electronic tendering system, which will enable tenders to be electronically handled from the UK Government e-notification Find A Tender Service (FTS) advertisement to award stage, with all mail and documentation sent and received via a fully auditable and verified eTendering portal.~~

~~(c) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.~~

~~(d) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical~~

~~Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.~~

~~16.6.2.~~17.6.2. Receipt and safe custody of tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

For electronic tenders, an electronic date/time stamp of all actions is automatically created through the eTendering service. This audit trail is available for review in real-time by all officers with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-determined time and date for opening has passed.

~~16.6.3.~~17.6.3. Opening tenders and Register of tenders

~~For Electronic Tenders:~~

~~- All tenders will be accepted by the unlocking of the E-Tendering tool.~~
~~- All changes will be fully auditable within the E-Tendering tool.~~

~~For paper based tenders:~~

~~As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.~~

~~(a) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation~~Scheme of Reservation and Delegation

~~(b) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.~~

~~(c) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Chief Financial Officer or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.~~

~~(d) All members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department. The Company Secretary will count as a Director for the purposes of opening tenders.~~

~~(e) Every tender received shall be marked with the date of opening and initialled by those~~

present at the opening.

(f) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations dispatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(a) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

(i) The e-tendering system must maintain a full audit trail registering expressions of interest prequalification invitations, clarification questions and responses, date of invitation to tender and closure and any late responses.

(ii) The e-tendering system will automatically reject incomplete tenders.

16.6.4.17.6.4. Admissibility

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.
(b) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer/Operational Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer for approval by the Chief Financial Officer/Operational Director of Finance.

16.6.5.17.6.5. Late tenders

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.
(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.
(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

16.6.6.17.6.6. Acceptance of formal tenders

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.
(b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons

to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;
(ii) understanding of client's needs;
(iii) feasibility and credibility of proposed approach;
(iv) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(c) The use of these procedures must demonstrate that the award of the contract was:
  (i) not in excess of the going market rate / price current at the time the contract was awarded
  (ii) that best value for money was achieved.
(d) All tenders should be treated as confidential and should be retained for inspection.

~~16.6.7.~~17.6.7. **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

~~16.6.8.~~17.6.8. **List of Approved Firms (see SFI No. 17.5.8 List of Approved Firms)**

(a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be considered. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147) or more recent guidance.

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) Financial Standing and Technical Competence of Contractors

The Chief Financial Officer/Operational Director of Finance may make or institute any

enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

~~16.7.~~17.7. Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Chief Financial Officer/Operational Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

~~16.8.~~17.8. Quotations: Competitive and non-competitive

~~16.8.1.~~17.8.1. General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed the amounts as laid down in the Trust's Scheme of Reservation and Delegation.

~~16.8.2.~~17.8.2. Competitive Quotations

(a) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust; or where it can be shown that less than three is a sufficient number of quotes to ensure fair and adequate competition as appropriate to ensure the Trust receives good value for money subject to market conditions.

(b) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(c) All quotations should be treated as confidential and should be retained for inspection in line with SFI Section 28, Retention of Records.

(d) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

~~16.8.3.~~17.8.3. Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (17.5.6 (a), (b) apply.

~~16.8.4.~~17.8.4. Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer/Operational Director of Finance.

~~16.9.~~17.9. Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with (e.g. an appropriate budget exists), formal authorisation and awarding of a contract is stated in the Appendix. **Note, that contracts over £10M require NHSE centralised approval, and contracts over £20M require NHSE and Cabinet Office approval.**

17.9.1 All contract awards above £50,000 to be reported to Trust Board for information

~~16.10.~~17.10. Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use the NHS Supply Chain ~~(formerly NHS Logistics)~~ for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain ~~(formerly NHS Logistics)~~ - where tenders or quotations are not required, because expenditure is below £10,000 the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer/Operational Director of Finance.

~~16.11.~~17.11. Private Finance for Capital Procurement

The Trust should normally market-test for PFI (Private Finance Initiative) funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health team for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust in the light of such professional advice as should be reasonably sought in particular with regard to vires.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

~~16.12.~~17.12. Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) Government Directives and other statutory provisions;

(c) Any relevant directions including the Capital Investment Manual, Estate code~~Health Building Note HBN 00-08 Part A and B~~ and guidance on the Procurement and Management of Consultants;

(d) Such guides like the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

~~(g)~~(h) all contracts are subject to scrutiny and penalty clauses are actioned as appropriate.

~~16.13.~~17.13. Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts via framework approved suppliers.

It is important to note the difference between interim and management consultancy. An interim or independent contractor refers to self-employed workers engaged by the Trust to undertake specific work for which they directly invoice the Trust. These are generally interim contractors who are covering vacant posts or interims appointed to undertake a specific piece of work i.e. project management.

Management Consultancy is a service provided by a company to provide expertise and advice to the Trust on a specific issue where the Trust does not have the skills, expertise or capacity to deliver the required piece of work or advice.

~~16.14.~~17.14. Procurement of Consultancy Services

The Regulators have issued specific guidance setting out expenditure delegation limits for individual organisations and requiring central Regulator approval for all consultancy engagements above a certain value. All Trust budget holders must follow the latest iteration of this guidance whenever procuring consultancy services and ensure that they are approved by the Chief Finance Officer/Operational Director of Finance.

For consultancy engagements the latest Regulator guidance and the rules in these SFI's apply.

~~16.15.~~17.15. Healthcare Services Agreements

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the Care Act 2014 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers / purchasers of healthcare in line with a commissioning plan approved by the Board.

~~16.16.~~17.16. Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;
(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
(c) items to be disposed of with an estimated sale value of less than £10,000 this figure to be reviewed on a periodic basis;
(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
(e) land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

All such instances will be fully documented.

~~16.17.~~17.17. In-house Services

~~16.17.1.~~17.17.1. The Chief Executive shall be responsible for ensuring that best value for money can

be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

~~16.17.2.~~17.17.2. In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be setup:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Financial Officer/Operational Director of Finance representative. For services having a likely annual expenditure exceeding £1,000,000, a non-executive member should be a member of the evaluation team.

~~16.17.3.~~17.17.3. All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

~~16.17.4.~~17.17.4. The evaluation team shall make recommendations to the Board.

~~16.17.5.~~17.17.5. The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

~~16.18.~~17.18. **Applicability of SFIs on Tendering and Contracting to funds held in trust**

~~16.18.1.~~17.18.1. These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

~~16.18.2.~~17.18.2. Contracts Involving Funds Held on Trust - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts/Charity Commission.

~~17.~~18. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

18.1. **Payment to Board Members (Chairman and Non-Executive Directors)**

18.1.1 The Trust will pay allowances to the Chairman and the Non- Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

~~17.1.~~18.2. **Board Remuneration and Terms of Service**

~~17.1.1.~~18.2.1. In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

~~17.1.2.~~18.2.2. The Committee will:

(a) Make decisions and inform the Board about appropriate remuneration and terms of service for the Chief Executive, other very senior managers including:
- all aspects of salary (including any performance-related elements / bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms;

(b) Agree and inform the Board on the remuneration and terms of service of officer

members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

~~17.1.3.~~18.2.3. The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

~~17.1.4.~~18.2.4. The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

~~17.1.5.~~18.2.5. The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health.

~~17.2.~~18.3. **Funded Establishment**

~~17.2.1.~~18.3.1. The workforce plans incorporated within the annual budget will form the funded establishment.

~~17.2.2.~~18.3.2. The funded establishment of any directorate or department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the Chief Executive or Chief Financial Officer/Operational Dirrector of Finance or their delegated officer.

~~17.2.3.~~18.3.3. Each Director must ensure that all of their budget holders operate within the agreed staffing establishment.

~~17.3.~~18.4. **Staff Appointments**

~~17.3.1.~~18.4.1. No officer or member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or nominated representative;

(b) within the limit of their approved budget and funded establishment.

~~(b)~~(c) subject to a regular vacancy control panel (VCP) check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits. Ensure that approval is at an Executive level.

~~17.3.2.~~18.4.2. The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

18.4.3. All staff engagements must comply with the latest regulations on staff appointments issued by the Independent Regulator and HM Revenue and Customs (HMRC).

18.4.4. Non-Clinical Agency can only be authorised at Director level and then will be forwarded to ICB for further authorisation.

18.4.5. Agency staff to be authorised by Executives or named senior managers.

18.4.6. Any monies due to employees as a result of all employments with the Trust howsoever arising

shall be paid through the Trust payroll

~~17.4.~~18.5. ~~Processing~~ Payroll Arrangements

~~17.4.1.~~18.5.1. The Chief Financial Officer/Operational Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

~~17.4.2.~~18.5.2. The Chief Financial Officer/Operational Director of Finance will issue instructions regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act and General Data Protection Regulations (GDPR);
(g) methods of payment available to various categories of employee and officers;
(h) procedures for payment by cheque, bank credit including BACS, or cash to employees and officers;
(I) procedures for the recall of cheques and bank credits including BACS;
(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash;
(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

~~17.4.3.~~18.5.3. Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Chief Financial Officer/Operational Director of Finance's instructions and in the form prescribed by the Chief Financial Officer/Operational Director of Finance;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer/Operational Director of Finance must be informed immediately to consider appropriate action to prevent or recover any overpayment.

~~17.4.4.~~18.5.4. Regardless of the arrangements for providing the payroll service, the Chief Financial Officer/Operational Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

Managers and employees are jointly responsible and accountable for ensuring that claims for pay and expenses are timely and correct.

-

~~17.4.5.~~18.5.5. All employees have a responsibility to check their own payslips each month and bring any under or overpayments to the attention of the Trust's Payroll and Pensions department as soon as discovered so that appropriate corrective action can be taken. The Trust has specific policies in relation to the recovery of salary overpayments and also the correcting of salary underpayments.

~~17.5.~~18.6. **Contracts of Employment**

~~17.5.1. It is the responsibility of the Director of People and Culture for:~~
18.6.1. The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and
(b) dealing with variations to, or termination of, contracts of employment.

~~17.6.~~18.7. **Agency, Self-employed or Third Party Workers including Contract for Services and IR35~~Use of self-employed management consultants and contractors (IR35)~~**

18.7.1. Where exceptional circumstances exist within a department and agency, self- employed workers or workers supplied via a third party are to be retained then:

(a) the contract may only be entered into by a budget holder having sufficient resources within the limit of their budget who is authorised for that purpose by the Chief Executive or his delegated officer; and

(b) the Chief Financial Officer/Operational Director of Finance shall be consulted if the contractor is not on the current list of authorised suppliers; and

(c) the ~~Director of~~ lead for Workforce shall be consulted with regard to the remuneration package; and

(d) contractual provisions shall be in place which allow the Trust to seek assurance regarding the income tax and national insurance contribution obligations of the engagee and the ability to terminate the contract if that assurance is not provided; and

(e) appropriate arrangements shall be in place to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenues & Customs in line with current legal and regulatory requirements.

~~17.6.1. The Director of People and Culture shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as Intermediaries Legislation, or "IR35".~~

~~17.6.2. All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.~~

~~18.~~19. NON-PAY EXPENDITURE

~~18.1.~~19.1. **Delegation of Authority**

~~18.1.1.~~19.1.1. The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers (including approval of credit notes).

~~18.1.2.~~19.1.2. The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;
(b) the maximum level of each requisition and the system for authorisation above that level.

~~18.1.3.~~19.1.3. The Chief Executive shall set out procedures on the seeking of professional

advice regarding the supply of goods and services.

~~18.2.~~19.2. Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

~~18.2.1.~~19.2.1. Official Ordering and Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer/Operational Director of Finance (and/or the Chief Executive) shall be consulted.

~~18.2.2.~~19.2.2. System of Payment and Payment Verification

The Chief Financial Officer/Operational Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

~~18.2.3.~~19.2.3. The Chief Financial Officer/Operational Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the ~~Scheme of Delegation~~Scheme of Reservation and Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of employees (including specimens of their signatures) authorised to certify invoices and facilitate release of payment for goods and services.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- in the case of expenses claims, authorisation confirms that the claims reflect travel and journeys which were necessary in discharging the employee's work-related duties, and that the claim has been submitted within 3 months of the expense being necessarily incurred;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct, with discounts having being taken as appropriate;

- VAT has been correctly accounted for with the recovery being identified where appropriate; and

- the account is in order for payment, containing a valid cost code.

(iii) A timetable and system for submission to Chief Financial Officer/Operational Director of Finance ~~and Performance~~ of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 19.2.4 (Prepayments) below.

19.2.4. Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the ~~financial~~ economic advantages outweigh the disadvantages.
(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
(c) The Chief Financial Officer/Operational Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account Government public procurement rules where the contract is above a stipulated financial threshold);
(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Exceptions to the requirements of (b) and (c) above are:

(i) Service and maintenance contracts which require payment when the contract commences;

(ii) Minor services such as training courses, conference bookings;

(iii) Prepayments of up to £500 where a value for money and financial risk assessment demonstrates clear advantage in early payment

19.2.5. Official orders

Official orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Chief Financial Officer/Operational Director of Finance;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Executive.

19.2.6. Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) all contracts (except as otherwise provided for in the ~~Scheme of Delegation~~Scheme of Reservation and Delegation) leases, tenancy agreements and other commitments

which may result in a liability are notified to the Chief Financial Officer/Operational Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with Government rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must have prior approval from NHSE and be in accordance with guidance issued by the Department of Health and Social Care and NHS Englandmust be in accordance with guidance issued by the Department of Health and Social Care and NHSE/I;

(d) Comply with Procurement Policy Notices issued by the Cabinet Office

(e) Offers of gifts and hospitality should be dealt with in line with the trust conflicts of interest policy.

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer/Operational Director of Finance on behalf of the Chief Executive;

(g) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or the purchasing card;

(h) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Financial Officer/Operational Director of Finance;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer/Operational Director of Finance;

(m) petty cash records and purchases made using the Trust's credit card are maintained in a form as determined by the Chief Financial Officer/Operational Director of Finance.

(n) invoice/Purchase Order approvals are actioned in a timely manner to ensure late payment interest is avoided and BPPC target is achieved.

~~(m)~~(o) Be raised for all goods/services in advance of receipt unless expressly excluded in SFIs

19.2.7. The Chief Executive and Chief Financial Officer/Operational Director of Finance~~, Contracts and Performance~~ shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with all applicable guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

~~18.3.~~19.3. Joint Finance Arrangements with Local Authorities and Voluntary Bodies

~~18.3.1.~~19.3.1. Payments to local authorities and voluntary organisations made under the powers of section 256 & 257 of the NHS Act 2006 **shall** comply with procedures laid down by the Chief Financial Officer/Operational Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

19.3.2 Section 75 partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated and functions can be reallocated between partners.

~~19.~~20. EXTERNAL BORROWING & INVESTMENTS

The Chief Financial Officer will be responsible for the management of the Trust's cash flow.

~~19.1.~~20.1. External Borrowing

~~19.1.1.~~20.1.1. The Trust must ensure compliance with the Prudential Borrowing Code set by the Independent Regulator.

19.1.2.20.1.2. The Chief Financial Officer/Operational Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay Public Dividend Capital (PDC) , both the originating capital debt and any proposed new borrowing within the limits set by the Department of Health and Social Care. The Chief Financial Officer/Operational Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt (PDC) and all loans, overdrafts and associated interest.

19.1.3.20.1.3. The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive, Deputy Chief Executive and the Chief Financial Officer/Operational Director of Finance.

19.1.4.20.1.4. The Chief Financial Officer/Operational Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

19.1.5.20.1.5. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care.

19.1.6.20.1.6. Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive, Chief Financial Officer/Operational Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

19.1.7.20.1.7. All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board as reported to the Department of Health and Social Care.

19.2.20.2. **Investments**

19.2.1.20.2.1. The Audit Committee will review and approve the Trust's Treasury Management Policy

19.2.2.20.2.2. Temporary cash surpluses must be held only in such public or private sector investments as notified authorised by the Department of Health and Social Care Secretary of State and authorised by the Board

19.2.3.20.2.3. The Chief Financial Officer/Operational Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

19.2.4.20.2.4. The Chief Financial Officer/Operational Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

20.21. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

20.1.21.1. Capital Investment

20.1.1.21.1.1. The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue

consequences, including capital charges.

~~20.1.2.~~21.1.2. For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the current Department of Health and Social Care guidance) is produced setting out:
(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
(ii) the involvement of appropriate Trust personnel and external agencies;
(iii) appropriate project management and control arrangements;
(iv) that the Chief Financial Officer/Operational Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to NHSE and/or the Department of Health and Social Care in line with the current guidelines.

~~(b) that the Chief Financial Officer has reviewed and confirmed the accuracy of costs and revenue consequences detailed in the business case.~~

Every business case requiring authorisation above the division/directorate's delegated authorities will need an executive sponsor.

~~20.1.3.~~21.1.3. For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Department of Health and Social Care~~Health Building Note HBN 00-08 Part A and B~~.

~~20.1.4.~~21.1.4. The Chief Financial Officer/Operational Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue & Customs~~Inland Revenue~~ guidance.

21.1.5. The Chief Financial Officer/Operational Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure., which as a minimum shall include reporting to the Board on:

(a) The individual scheme/projects;
(b) The source and level of funding; and
(c) The expenditure incurred against the annual profile.

~~20.1.5.~~21.1.6. The approval of a capital programme shall not constitute approval for expenditure on any scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

The Chief Executive shall issue to the manager responsible for any scheme:
(a) specific authority to commit expenditure;
(b) authority to proceed to tender ~~(see overlap with SFI No.17.6)~~;
(c) approval to accept a successful tender ~~(see overlap with SFI No. 17.6)~~.

The Chief Executive will issue a ~~scheme of delegation~~Scheme of Reservation and Delegation for capital investment management and the Trust's Standing Orders.

~~20.1.6.~~21.1.7. The Chief Financial Officer/Operational Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes as ~~determined~~ notified by the Department of Health and ~~'s Delegated Limits for Capital Investment (Gateway reference 15284) and other NHSEI guidance~~Social Care.

~~20.2.~~21.2. **Private Finance**

~~20.2.1.~~21.2.1. The Trust should normally test for PFI when considering capital procurement. When

the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Chief Financial Officer/Operational Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.
(c) The proposal must be specifically agreed by the Board.

20.3.21.3. **Asset Registers**

20.3.1.21.3.1. The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer/Operational Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted at least once a year.

21.3.2. Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified within the International Financial Reporting Standards, (IFRS) and Capital Accounting Manual as issued by the Department of Health and Social Care.

20.3.2.21.3.3. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
(c) lease agreements in respect of assets held under a finance lease and capitalised.

20.3.3.21.3.4. Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

20.3.4.21.3.5. The Chief Financial Officer/Operational Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

20.3.5.21.3.6. The value of each asset shall be indexed to current values in accordance with methods specified in IFRS or as specifically directed by the Department of Health and Social Care.

20.3.6.21.3.7. The value of each asset shall be depreciated using methods and rates as specified in IFRS or as specifically directed by the Department of Health and Social Care

20.3.7.21.3.8. The Chief Financial Officer/Operational Director of Finance shall calculate and pay capital charges as specified IFRS or as specifically directed by the Department of Health and Social Care.

20.3.8.21.3.9. All departments must ensure that where equipment is loaned out, it is reported to the Finance Department. A register of loan equipment will be maintained on behalf of the Chief Financial Officer/Operational Director of Finance.

21.3.10. The Chief Financial Officer/Operational Director of Finance ~~of the Trust~~ shall calculate and pay PDC dividend as specified by the Department of Health and Social Care

20.4.21.4. **Security of Assets**

~~20.4.1.~~21.4.1. The overall control of fixed assets is the responsibility of the Chief Executive.

~~20.4.2.~~21.4.2. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer/Operational Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) identification of all repairs and maintenance expenses;
(d) physical security of assets;
(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset;
(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

~~20.4.3.~~21.4.3. All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer/Operational Director of Finance.

~~20.4.4.~~21.4.4. Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

~~20.4.5.~~21.4.5. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

~~20.4.6.~~21.4.6. Where practical, assets should be marked as Trust property.

21.5. Contract Framework Agreements

21.5.1. Contract framework agreements (including P22 schemes) should always be considered for all construction projects and used where in line with best practice as set out by HM treasury and the Cabinet Office as a set out in Health Building Notes – Strategic framework for the efficient management of health care estates and facilities. The management of contracts awarded under the P22 Framework Agreement shall follow the current guidelines issued by the Department of Health and Social Care.

21.5.2. All Contractual Framework Agreements should be reviewed at regular intervals, usually annually, to ensure anticipated benefits are being realised and that cost improvements and value for money objectives are achieved.

21.5.3. The Contractual Framework Agreement shall be subject to formal tender procedures and shall comply with the prevailing directives governing public procurement (EU or otherwise).

21.5.4. The Chief Financial Officer/Operational Director of Finance shall issue procedure notes governing the control, management, reporting and audit arrangements of the Contract Framework Agreement.

21.5.5. The committee overseeing the capital programme shall receive regular reports on the performance of the Contract Framework Agreement and detailed project progress reports on all on going schemes.

21.5.6. Any capital monies spent should be in accordance with the requirements laid down in the Manual for Accounts as issues by the Department of Health and Social Care.

21.6. Leases

21.6.1. Where it is proposed that leasing shall be considered in preference to capital procurement then the following should apply:

(a) the selection of a contract/finance company shall be on the basis of competitive tendering and quotations sought via the procurement department;

(b) All proposals to enter into a leasing agreement shall be referred to the Chief Finance Officer/Operational Director of Finance before acceptance of any offer;

(c) The Chief Finance Officer/Operational Director of Finance shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the Chief Finance Officer/Operational Director of Finance prior to acceptance of any offer to the lease.

In the case of property leases the guidance in the Health Building Note – Strategic framework for the efficient management of healthcare estates and facilities shall be followed.

~~21.~~22. STORES AND RECEIPT OF GOODS

~~21.1.~~22.1. General position

~~21.1.1.~~22.1.1. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take (there shall be a physical check covering all items in store at least once a year);
(c) valued at the lower of cost and net realisable value.

~~21.2.~~22.2. Control of Stores, Stocktaking, Condemnations and Disposal

~~21.2.1.~~22.2.1. Subject to the responsibility of the Chief Financial Officer/Operational Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer/Operational Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any other stores such as theatres or fuel oil shall be the responsibility of a designated manager

~~21.2.2.~~22.2.2. The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

~~21.2.3.~~22.2.3. The Chief Financial Officer/Operational Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

~~21.2.4.~~22.2.4. Stocktaking arrangements shall be agreed with the Chief Financial Officer/Operational Director of Finance and there shall be a physical check covering all items in store at least once a year. External Audit and Internal Audit will be consulted on appropriate levels of stocktaking to ensure the trust has control but not onerous stock counting. High value items will be counted at least once per year. In exceptional circumstances alternative arrangements may be agreed with the Chief Financial Officer/Operational Director of Finance.

~~21.2.5.~~22.2.5. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer/Operational Director of Finance.

~~21.2.6.~~22.2.6. The designated Manager/Pharmaceutical Officer shall be responsible for a system

approved by the Chief Financial Officer/Operational Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer/Operational Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

~~21.3.~~22.3. **Goods supplied by NHS Supply Chain**

~~21.3.1.~~22.3.1. For goods supplied via the NHS Supply Chain ~~(formerly NHS Logistics)~~ central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer/Operational Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge. If there are any discrepancies these should be reported to the Chief Finance Officer/Operational Director of Finance or delegated officer to avoid overpayments where such discrepancies cannot be resolved via the procurement team.

~~22.~~23. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

~~22.1.~~23.1. **Disposals and Condemnations**

~~22.1.1.~~23.1.1. **Procedures**

The Chief Financial Officer/Operational Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

~~22.1.2.~~23.1.2. When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer/Operational Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

~~22.1.3.~~23.1.3. All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer/Operational Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer/Operational Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer/Operational Director of Finance.

~~22.1.4.~~23.1.4. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer/Operational Director of Finance who will take the appropriate action.

~~22.2.~~23.2. **Losses and Special Payments**

~~22.2.1.~~23.2.1. **Procedures**

The Chief Financial Officer/Operational Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

~~22.2.2.~~23.2.2. Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer/Operational Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately

inform the Chief Financial Officer/Operational Director of Finance and/or Chief Executive. Where a criminal offence (theft and assault) is suspected, the Chief Financial Officer/Operational Director of Finance must immediately inform the Security Management Director and the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies which may indicate fraud, corruption or bribery, the Chief Financial Officer/Operational Director of Finance must inform the relevant LCFS and the NHSCFA in accordance with the Government Functional Standard 013: Counter Fraud.

The Chief Financial Officer/Operational Director of Finance must notify the NHSCFA and the External Auditor of all frauds.

23.2.3 For significant losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer/Operational Director of Finance must immediately notify:

(a) the Board,
(b) the External Auditor.

23.2.4 Within limits delegated to it by the Department of Health and Social Care, the Audit Committee shall approve the writing-off of losses (including invoices and adjusting debtors in the balance sheet).

23.2.5 The Chief Financial Officer/Operational Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

23.2.6 For any loss, the Chief Financial Officer/Operational Director of Finance should consider whether any insurance claim can be made.

23.2.7 The Chief Financial Officer/Operational Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

23.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

~~23.2.8~~23.2.9 NHS England must be consulted before making any special payments that are novel, contentious or repercussive.

~~23.2.9~~23.2.10 All losses and special payments must be reported to the Audit Committee at ~~least on a quarterly basis~~regular intervals.

24 INFORMATION TECHNOLOGY AND DATA SECURITY

24.1 Responsibilities and Duties Chief Financial Officer/Operational Director of Finance

24.1.1 The ~~Director of IT~~Chief ~~Information~~ Finance Officer/Operational Director of Finance and SIRO is responsible for the accuracy and security of the computerised performance and financial data of the Trust they shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act ~~2018~~ 1998 and the G~~eneral~~ D~~ata~~ P~~rotection~~Regulation~~R~~ 2018.
(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director or Data Protection Officer

may consider necessary are being carried out.

24.1.2 The ~~Director of IT~~~~Chief Information Officer~~Chief Finance Officer/Operational Director of Finance and SIRO shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

24.2 Responsibilities and Duties of other Directors and Officers

24.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer/Operational Director of Finance and the SIRO:

(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

24.2.2 The Group Director of Assurance ~~Information Governance Lead and Data Protection Officer~~ shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

24.2.3 The Trust shall nominate an executive director or other senior member of the Board (or equivalent senior management group/committee) to be responsible to the Board for information risk management, called a senior information risk owner (SIRO). The role of the SIRO is defined within the information governance toolkit. The SIRO is the leading advocate for information risk to the Board, advising on how information security risks could impact upon the strategic goals of the Trust.

24.3 Contracts for Computer Services with other health bodies or outside agencies

The Chief Finance Officer/Operational Director of Finance ~~Director of IT~~~~Chief Information Officer~~ and SIRO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer/Operational Director of Finance ~~Director of IT~~~~Chief Information Officer~~ and SIRO shall periodically seek assurances that adequate controls are in operation.

24.4 Risk Assessment

The Chief ~~Information Officer~~ Executive and SIRO shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

24.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Chief Financial Officer/Operational Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) data produced for use with financial systems is adequate, accurate, complete

and timely, and that a management (audit) trail exists;

(c) Chief Financial Officer/Operational Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

25 PATIENTS' PROPERTY

25.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital, or dead on arrival.

25.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

25.3 The Chief Operating Officer in liaison with the Chief Financial Officer/Operational Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

25.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer/Operational Director of Finance.

25.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 https://www.legislation.gov.uk/ukpga/1965/32/contents the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

25.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

25.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

~~25.7~~25.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Social Care and Department of Social Security instructions and guidelines.

26. FUNDS HELD ON TRUST

26.1. Corporate Trustee

Standing Order No. 2.9 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, and the need for compliance with Charities Commission latest guidance and best practice.

The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non- charitable purposes.

The Chief Financial Officer/Operational Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

26.2. Accountability to Charity Commission and Secretary of State for Health and Social Care

Although the management processes may overlap with those of the Organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

The Schedule of Matters Reserved to the Board and the ~~Scheme of Delegation~~Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

26.3. Applicability of Standing Financial Instructions to funds held on Trust

In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on Trust.

The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

The Chief Financial Officer/Operational Director of Finance is to arrange for the administration of all existing trusts in conjunction with the Legal Adviser if appropriate. They are to ensure that a governing instrument exists for every trust and are to produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines are to identify the restricted nature of certain funds.

The Chief Financial Officer/Operational Director of Finance is to periodically review the funds in existence and make recommendations, where appropriate. The Chief Financial Officer/Operational Director of Finance may recommend an increase in the number of funds where this is consistent with this Body's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific stations or departments.

26.4. Sources of New Funds

Donations. In respect of donations, the Chief Financial Officer/Operational Director of Finance is to:

a. provide guidelines to officers of the Trust as to how to proceed when offered funds. These include:
   i. the identification of the donors intentions;
   ii. where possible, the avoidance of new trusts;
   iii. the avoidance of impossible, undesirable or administratively difficult objects;
   iv. sources of immediate further advice; ~~and~~
   v. treatment of offers for personal gifts; and
b. provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's trust funds and that the donor's intentions have been noted and accepted.

Legacies and Bequests. The Chief Financial Officer/Operational Director of Finance is to:

a. provide guidelines to officers of the Trust covering any approach regarding:
   i. the wording of wills; and
   ii. the receipt of funds/other assets from executors;
b. where necessary, obtain grant of probate, or make application for grant of letters of

administration, where the Trust is the beneficiary.;

c. be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty.; and

d. be directly responsible, in conjunction with the Legal Adviser, for the appropriate treatment of all legacies and bequests.

Fund-raising. The Chief Financial Officer/Operational Director of Finance is to:

a. after consultation with the Legal Adviser, deal with all arrangements for fund- raising by and/or on behalf of the Trust and ensure compliance with all statutes and regulations;

b. be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge. The Chief Financial Officer/Operational Director of Finance is the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

c. be responsible, along with the Legal Adviser, for alerting the Board to any irregularities regarding the use of the Trust's name or its registration numbers; and

d. be responsible, after due consultation with the Legal Adviser, for the appropriate treatment of all funds received from this source.

Trading Income. The Chief Financial Officer/Operational Director of Finance is to:

a. be primarily responsible, along with the Legal Adviser and other designated officers, for any trading undertaken by the Trust as corporate trustee; and

b. be primarily responsible, along with the Legal Adviser, for the appropriate treatment of all funds received from this source.

Investment Income. The Chief Financial Officer/Operational Director of Finance is responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

26.5. Investment Management

The Chief Financial Officer/Operational Director of Finance is to be responsible for all aspects of the management of the investment of funds held on trust. The issues on which advice is to be provided to the Board include:

a. in conjunction with the Legal Adviser, the formulation of investment policy within the powers of the Trust under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

b. the appointment of advisers, brokers, and, where appropriate, fund managers:
   i. the Chief Financial Officer/Operational Director of Finance is to agree, in conjunction with the Legal Adviser, the terms of such appointments; and for which
   ii. written agreements are to be signed by the Chief Executive;

c. pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

d. the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

e. that the use of Trust assets are to be appropriately authorised in writing and charges raised within policy guidelines;

f. the review of the performance of brokers and fund managers; and

g. the reporting of investment performance.

26.6. Disposition Management

The exercise of the Trust's dispositive discretion is to be managed by the Chief Financial Officer/Operational Director of Finance in conjunction with the Board. In so doing the Chief Financial Officer/Operational Director of Finance is to be aware of the following:

a. the objects of various funds and the designated objectives;
b. the availability of liquid funds within each trust;
c. the powers of delegation available to commit resources;
d. the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer is discharged by trust funds at the earliest possible time;
e. that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and
f. the definitions of 'charitable purposes" as agreed by the DHSC with the Charity Commission.

26.7. Banking Services

The Chief Financial Officer/Operational Director of Finance is to advise the Board and, with its approval, is to ensure that appropriate banking services are available to the trust as corporate trustee. These bank accounts are to permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

26.8. Asset Management

Assets in the ownership of or used by the Trust as corporate trustee, are to be maintained along with the general estate and inventory of assets of the Trust. The Chief Financial Officer/Operational Director of Finance is to ensure:

a. in conjunction with the Legal Adviser, that appropriate records of all assets owned by the Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;
b. that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
c. that donated assets received on trust rather than into the ownership of the Secretary of State are accounted for appropriately; and
d. that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Secretary of State.

26.9. Reporting

The Chief Financial Officer/Operational Director of Finance is to ensure that regular reports are made to the Board with regard to, *inter alia*, the receipt of funds, investments, and the disposition of resources.

The Chief Financial Officer/Operational Director of Finance is to prepare annual accounts in the required manner, which is to be submitted to the Board within agreed timescales.

The Chief Financial Officer/Operational Director of Finance, in conjunction with the Legal Adviser, is to prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the DHSC and to the Charity Commission for adoption by the Board.

26.10. Accounting and Audit

The Chief Financial Officer/Operational Director of Finance is to maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

The Chief Financial Officer/Operational Director of Finance is to ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. The Chief Financial Officer/Operational Director of Finance will liaise with external audit and provide them with all necessary information.

The Board is to be advised by the Chief Financial Officer/Operational Director of Finance on

the outcome of the annual audit. The Chief Executive is to submit the Management Letter to the Board.

26.11. Administration Costs

The Chief Financial Officer/Operational Director of Finance is to identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, is to charge such costs to the appropriate trust accounts.

26.12. Taxation and Excise Duty

The Chief Financial Officer/Operational Director of Finance is to ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

27. ACCEPTANCE OF GIFTS BY STAFF

27.1. The Group Company Secretary shall ensure that all staff are made aware of the trust's Conflicts of Interest Policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance issued by NHSE "Managing Conflicts of Interest in the NHS" and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

27.2 This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;
b) Conduct by an individual in a position to influence purchases;
c) Employment and business which may conflict with the interests of the Trust;
d) Relationships which may conflict with the interests of the Trust;
e) Hospitality and gifts and other benefits in kind such as sponsorship.

27.3 Declarations relating to the above must be made to the Group Company Secretary via Civica ~~my declarations~~ for inclusion in the Register of Interests.

27.4 Staff must be made aware of and follow the law as set out in the Bribery Act 2010 at all times. Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

28. RETENTION OF RECORDS

28.1. The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with NHS England and Department of Health and Social Care ~~(DHSC)~~ guidelines ~~i.e. Records Management Code of Practice for Health and Social Care 2021~~.

28.2. The records held in archives shall be capable of retrieval by authorised persons.

28.3. Records held in accordance with latest Department of Health and Social Care ~~DHSC~~ guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or Chief Financial Officer/Operational Director of Finance. Proper details shall be maintained of records and information so destroyed ~~at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed~~.

29. RISK MANAGEMENT AND INSURANCE

29.1. Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;
b) engendering among all levels of staff a positive attitude towards the control of risk;
c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
f) a clear indication of which risks shall be insured;
g) arrangements to review the Risk Management programme.
~~g)~~h) appropriate levels of external accreditation.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

29.2. Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution (NHSR) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the ~~risk pooling schemes~~NHSR for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually

29.3. Insurance Arrangements with Commercial Insurers

There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **~~three~~ four exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

1) insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use;

2) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

3) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool.

   Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

4) Where it is necessary to ensure that the Trust is able to continue providing a service where adequate levels of insurance are not available under any of the schemes administered by the NHSR, the Trust arranges a policy in the name of "the employees of the Trust" or "members, for the time being, of a specific team". In such cases, the premium must be:
   i. Paid by the use of charitable funds, providing the Trust establishes through the Charities Commission, or other relevant regulatory bod, whether this is an appropriate use of funds, or

ii. Paid by members of the team and then reimbursed by the Trust, or

iii. Paid by the Trust, provided this is with the recognition, and approval, of the Chief Finance Officer and/or internal audit.

In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should first consult the NHSR and then the Department of Health and Social Care.

~~(a) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;~~

~~**(b)** Where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurancearrangements are entered into; and~~

~~(c) Where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should consult the Department of Health and Social Care.~~

29.4. Arrangements to be followed by the Board in agreeing Insurance Cover

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Financial Officer/Operational Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer/Operational Director of Finance shall ensure that documented procedures cover these arrangements.

(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer/Operational Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Financial Officer/Operational Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses, which will not be reimbursed.

(c) All the NHSR risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer/Operational Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

30. INTERNATIONAL FINANCIAL REPORTING STANDARDS (IFRS)

30.1 The Trust is required to report all its financial transactions in compliance with IFRS subject to amendments issued by the Department of Health and Social Care through the NHS Manual of Accounts. It is important that the reporting requirements of IFRS are anticipated and provided for when making decisions which have an impact on the Trust's financial position. This is particularly the case in respect of capital investment, leasing, use of external private finance and contractual relationships with other parties. The Chief Financial Officer/Operational Director of Finance and his team should be consulted for advice in such instances.

Appendix 1

AUTHORISATION LEVELS

CONTRACTING - Income

15 AGREEMENTS FOR PROVISION OF SERVICES

Approval to sign contracts other than for the provision of healthcare by the Trust:-

Contract Approval Level	Limit
~~Deputy Director of Procurement or Director of Procurement~~	~~To £50,000~~
Chief Executive/Chief Financial Officer~~/~~Operational Director of Finance	To £~~250,000~~1,000,000
Trust Board	Over £~~250,000~~1,000,000

Approval to sign contracts (including contract variations) where the trust is the provider of healthcare services to NHS and other Commissioners:-

Contract Approval Level	Limit
~~Divisional Directors~~	~~To £50,000~~
Chief Executive/Chief Financial Officer//Operational Director of Finance~~-~~	Up to 10% of Trust turnover
Trust Board	Above 10% of Trust turnover

TENDERING, ORDERING, CONTRACTING – Expenditure

12.3 Budgetary Control and Financial Reporting
12.3.6/12.3.7 Business Case Monitoring
21.1 Capital Investment
21.1.2 Business Case Approval Limits

Business Case Approval	Limits	Additional information
Divisional Board	Up to~~Above~~ £25,000	For Divisional oversight (within budget)
Trust Management Committee *	Up to~~Above~~ £250,000	Over £25k or any new funds~~CSS, Estates and Corporate~~
Finance and Productivity Committee	Above £250,000	Before going to Trust Board
Trust Board	Above £250,000	
NHSE centralised approval required	Over £10M	
NHSE and Cabinet Office approval required	Over £20M	

***Before being presented to Trust Management Committee, all cases need to be reviewed by Investment Group**

Capital*	
Group Director of Estates~~Head of Estates Development~~	up to £500,000
Chief Financial Officer/Operational Director of Finance	up to £750,000
Chief Executive **and** Chief Financial Officer/Operational Director of Finance	over £750,000
Capital schemes requiring Business Cases to be approved by ~~-~~value Trust Board	£1,000,000 capital and/ or £1,000,000 revenue cost and above

*Within Capital Programme limits

17.6 Contracting/Tendering Procedure
17.5.2 Testing/Quotations/Tendering
17.8 Quotations: Competitive and non-competitive

All financial limits quoted are the total for the life of the contract

Threshold £ excluding VAT	**Minimum* no. of quotations/ tenders**	**Activity**
Up to £10,000	Informal Price Testing: One or more quotations	• If no contract exists, one or more quotations should be sought using suppliers already on Integra system where possible. Raise a requisition within Integra.
£10,001 to £50,000	Competitive Quotations: Three written quotations	• If no contact exists, work alongside buyers in Procurement Department to produce an Invitation to Quote (which will be issued via e-tendering system). • Where estimated spend exceeds £25,000 and quotations are not sought under a Framework Agreement or Dynamic Purchasing System then the opportunity must also be advertised on Contracts Finder, unless the contract is to be awarded on a single tender basis. • All quotations received should be evaluated for best VFM • Raise a requisition within Integra
£50,001 up to UK Gov Public Contracts Regulations threshold ~~(currently £122,976) (or other applicable threshold, e.g. £4,733,252 for works)~~	Competitive Tenders: Three or more formal tenders	• Conduct a formal tender with the involvement of Procurement •
UK Gov threshold and above	Competitive Tenders: Five or more formal tenders	• Conduct a formal tender with the involvement of Procurement

***** unless agreed with the Deputy Director of Procurement or Director of Procurement

17.9 Authorisation of Tenders and Competitive Quotations

All financial limits quoted are the total for the life of the contract

Authorisation of Expenditure (including Contract Extensions)	**Limits**
Designated budget holders (or nominated officer)	Up to £10,000
Divisional Directors or Equivalent (or nominated officer)	Up to £25,000
Chief Executive and Chief Financial Officer (or nominated Director)	Up to £250,000
Trust Board	Over £250,000
NHSE centralised approval required	Over £10M
NHSE and Cabinet Office approval required	Over £20M

Authority to accept other than lowest quote	**Limits**
Deputy Director of Procurement or Director of Procurement	Up to £50,000

Chief Executive/Deputy Chief Executive/Chief Financial Officer/Operational Director of Finance	Up to £1,000,000
Trust Board	Above £1,000,000

17.5.6 Exceptions and instances where formal tendering need not be applied

Single Source Waivers – Authority to waive competitive process	Value
Deputy Director of Procurement or Director of Procurement	Up to £5025,000
Chief Executive / Deputy Chief Executive / Operational Director of Finance/ Chief Financial Officer/	Over £5025,000

Note – The above limits apply equally to asset disposals.

19. NON-PAY EXPENDITURE

19.1 Delegation of Authority

Approval limits for requisitions

Authorisation of Expenditure*	Limits
Budget Manager e.g. Ward Manager	Up to £10,000
Senior Budget Manager – eg Care Group	Up to £15,000
Divisional leadership; • Clinical Director • Divisional Director of Operations • Divisional Director of Nursing	Up to £50,000
Deputy Director	Up to £50,000
Executive Director	Up to £75100,000
Chief Executive **and** Chief Financial Officer/Operational Director of Finance	Over £10075,000

*** these limits are to be used with agreed delegated budgets and not in addition of those budgets.**

23 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

23.2 Losses and Special Payments

Approval limit	Limits
Chief Financial Officer/Operational Director of Finance or nominated deputy	Up to £5,000
Audit Committee	Above £5,000

Note – all losses, compensation and special payments to be reported to the Audit Committee

26. FUNDS HELD ON TRUST

The following authorisation limits apply to charitable funds expenditure:

Authorisation of Expenditure	Limits
Restricted to the relevant Fund manager for the designated fund balance, with the approval of the Divisional Director	Up to £5,000
Chief Executive, Chief Financial Officer/Operational Director of Finance and the Charitable Funds Committee **	Up to £100,000
Corporate Trustee	Over £100,000

** Urgent decisions in relation to expenditure outside of the Charitable Funds Committee meetings must have the approval of the Chair of the Charitable Funds Committee, the Chief Financial Officer and the Chief Executive. The urgent decision must be reported to the next meeting of the Charitable Funds Committee meeting for formal ratification.

EXCEPTIONAL AUTHORISATION ARRANGEMENTS

In the absence of the Chief Executive and Chief Financial Officer/Operational Director of Finance (For areas where Delegated Deputies are specifically not identified above.)

- Deputy Chief Executive
- Non Executive Director, only in the absence of the Deputy Chief Executive

PAY

All Starter, and Termination Forms:-
Budget Holders

Change Forms:-
Budget Holders plus counter signed by Divisional Director (or equivalent)

All turnaround documents, timesheets and expenses forms:-
Prime payroll documentation authorised officers plus Budget Holders/Managers
The Budget Manager is able to devolve responsibility for the sign off to a Delegated Manager.

Expenses of Non-Executive Directors/Chair and Chief Executive:-
Expenses of Non Executive Directors/Chair – Chief Executive
Expenses for Chief Executive - Chair and Chief Financial Officer

Appendix 3 - SECTION D - SCHEME OF RESERVATION AND DELEGATION

A DECISIONS RESERVED TO THE BOARD

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2.1. **5.** Approve a ~~scheme of delegation~~Scheme of Reservation and Delegation of powers from the Board to committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. Approve arrangements for dealing with complaints. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 9. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 10. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 11. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property. 14. Authorise use of the seal. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chairman of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO2.2) 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees. of the Chief Executive for staff not covered by the Remuneration Committee.
NA	THE BOARD	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State for Health and Social Care 3. Approve the Trust's policies and procedures for the management of risk and Health and Safety; Risk Management; Fit and Proper Person Requirements; and Conflicts of Interest. 4. Approve all business cases requiring investment in excess of £250,000 5. Approve budgets. 6. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 7. Approve PFI proposals. 8. Approve the opening of bank accounts. 9. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £250,000 over a 3 year period or the period of the contract if longer. 10. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer (for losses and special payments) previously approved by the Board. 11. Approve individual compensation payments. 12. Approve proposals for action on litigation against or on behalf of the Trust. 13. Review use of NHS Resolution risk pooling schemes.
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
	THE BOARD	**Audit** 1. Approve the appointment (and where necessary dismissal) of External Auditors and advise the Audit Commission on the appointment. Approval of external auditors' arrangements for the separate audit of funds held on trust, and the submission of reports to the Audit Committee meetings who will take appropriate action. 2. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
NA	THE BOARD	**Annual Reports, Accounts and Quality Account** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust. 3. Receipt and approval of the Trust's Quality Account
NA	THE BOARD	**Health and Safety** 1. Approval of the Trusts Health and Safety Policy 2. Receipt of the Annual Health and Safety Report
NA	THE BOARD	**Monitoring** 1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. All monitoring returns required by the Department of Health and Social Care and the Charity Commission shall be reported, at least in summary, to the Board. 4. Receive reports from ~~DoF~~CFO on financial performance against budget and Annual Plan. 5. Receive reports from CE on actual and forecast income from SLA.

B DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO 4.9 SFI 11.1	AUDIT COMMITTEE	**The Committee will**: 1. Establish and maintain effective systems of internal control to inform the annual governance statement, with company regulatory requirements, policies and procedures oversee a program and process of internal audit and external audit 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. Oversee other aspects of financial reporting including value for money, budgetary control and adherence with the standing instruction (SFI) 4. Oversee adequate arrangements for counter fraud work and reporting 5. Oversee all aspects of security including the physical security buildings and property 6. Oversea the provision of the losses and compensations 7. Review proposes changes to standing orders, the scheme of reservations and standing financial instructions and have oversite of waivers 8. Have oversite of the green plan and sustainability impact 9. Work with, inform and be informed by the work of the other committees of the board regarding the priorities for the internal audit program
SO 4.11 SFI 18.1	REMUNERATION COMMITTEE	**The Committee will**: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including: 2. All aspects of salary (including any performance-related elements/bonuses); 3. Provisions for other benefits, including pensions and cars; 4. Arrangements for termination of employment and other contractual terms; 5. Make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff;
SO 5.22 SO 5.3.	Any Committee established by the Board	1. The Committee(s) will advise the Board according to the specific Terms of Reference agreed by the Board of Walsall Healthcare NHS Trust and in accordance with NHS Policy and Legislation.

C SCHEME OF RESERVATION AND DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
8	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
8, 10 and 20	CHIEF EXECUTIVE~~CEO~~ AND CHIEF FINANCIAL OFFICER	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
11	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
3, 13 and 14	CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
14	CHAIRMAN	Implement requirements of corporate governance.
15	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO).
17	~~DoF~~ CFO	Operational responsibility for effective and sound financial management and information.
17	CHIEF EXECUTIVE	Primary duty to see that ~~DoF~~CFO discharges this function.
18	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
8, 10 and 20	CE~~O~~ and ~~DoF~~CFO	Chief Executive, supported by Chief Financial Officer, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.

REF	DELEGATED TO	DUTIES DELEGATED
21	CHIEF EXECUTIVE	If CEO considers the Board or Chairman is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the SHA and Department of Health.
23	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CEO's responsibility for value for money, the CEO should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CEO should inform the Strategic Health Authority and the DH. In such cases, and in those described in paragraph 24, the CEO should as a member of the Board vote against the course of action rather than merely abstain fromvoting.

D SCHEME OF RESERVATION AND DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
BOARD	Approve procedure for declaration of conflicts of interest including hospitality and sponsorship.
BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe to Code of Governance (including Fit and Proper Persons Test)~~Code of Conduct and the fit and proper persons~~ regulations.
BOARD	Board members share corporate responsibility for all decisions of the Board.
CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives, (delegated to remuneration committee.) 4 to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5 to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6 to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
BOARD	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Board Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
CHAIRMAN	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Board Nominations and remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.
CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.
CHIEF EXECUTIVE	The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
NON EXECUTIVE DIRECTORS	Voting Non-Executive Directors are appointed by NHSI/E to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
NON EXECUTIVE DIRECTORS	Associate Non-Executive Directors are appointed by the trust following recruitment through NHSI/E to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
CHAIR AND DIRECTORS	Declaration of conflict of interests.
BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers'money.

E SCHEME OF RESERVATION AND DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Section A & 3.10	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chairman
3.1	CHAIRMAN	Call meetings.
3.9	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.10	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIRMAN	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13.4	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.4 & 4.5	BOARD	Formal delegation of powers to ~~sub~~ board committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Reservation and Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	BOARD	Declare relevant and material interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with national guidance contained in Managing Conflicts of Interest in the NHS: Guidance for staff and organisations" issued Feb 17 by NHS England);
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CEO to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE /EXECUTIVE DIRECTOR	Approve and sign all documents, which will be necessary in legal proceedings.

F SCHEME OF RESERVATION AND DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	CHIEF FINANCIAL OFFICER	Approval of all financial procedures.
10.1.4	CHIEF FINANCIAL OFFICER	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.
10.2.3	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.3	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions
10.2.5	CHIEF FINANCIAL OFFICER	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented. c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) the design, implementation and supervision of systems of internal financial control f) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.7	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.3	AUDIT COMMITTEE	Provide an independent and objective view of internal control
11.1.4	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
11.2.1	CHIEF FINANCIAL OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	CHIEF FINANCIAL OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with guidance from Department of Health and Social Care and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective, efficient External Audit.
11.5	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Monitor and ensure compliance with NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Requirements of the Government Functional Standards 013: Counter Fraud.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with security management arrangements
12.1.3 & 12.1.4	CHIEF FINANCIAL OFFICER	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
12.1.6	CHIEF FINANCIAL OFFICER	Ensure adequate training is delivered on an ongoing basis to budget holders.
12.2.1	CHIEF EXECUTIVE	Delegate budget to budget holders
12.2.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
12.3.1	CHIEF FINANCIAL OFFICER	Devise and maintain systems of budgetary control.
12.3.3	BUDGET HOLDERS	Ensure that: a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CEO other than those provided for within available resources and manpower establishment.
12.3.4	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Plan.
12.5.1	CHIEF EXECUTIVE	Submit monitoring returns
13.1	CHIEF FINANCIAL OFFICER	Preparation of annual accounts and reports.
13.3	GROUP DIRECTOR OF COMMUNICATIONS AND STAKEHOLDER ENGAGEMENT	Preparation of Annual Report

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.4	DIECTOR OF NURSING	Preparation of Quality Account
14.1	CHIEF FINANCIAL OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
14.5	CHIEF FINANCIAL OFFICER	Approve the allocation, limits and operation of credit/purchase cards
15.1.2	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services.
15.1.7	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA.
16	CHIEF FINANCIAL OFFICER	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform CFO of money due from transactions which they initiate/deal with.
17	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.6	CHIEF EXECUTIVE	Waive formal tendering procedures.
17.5.6	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Audit Committee.
17.5.8	CHIEF FINANCIAL OFFICER	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations dispatched.
17.6.4	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote, which gives the best value for money.

17.7.4	CHIEF EXECUTIVE **OR** CHIEF FINANCIAL OFFICER	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	Demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	Nominate an officer who shall oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	Nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.14	CHIEF EXECUTIVE	Nominate officers to commission service agreements with providers / purchasers of healthcare in line with a commissioning plan approved by the Board
17.16	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
17.16.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	BOARD	Establish a Board Remuneration Committee.
18.1.2	RENUMERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CEO, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
18.1.3	RENUMERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
18.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
18.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
18.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
18.4.1 18.4.2 18.4.4	CHIEF FINANCIAL OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
18.4.3	NOMINATED MANAGERS	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time
18.5	CHIEF PEOPLE OFFICER	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
18.6	CHIEF PEOPLE OFFICER	The Chief People ~~and Culture~~ Officer shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors.
19.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
19.1.1	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
19.2.1	REQUISITIONER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
19.2.2	CHIEF FINANCIAL OFFICER	Shall be responsible for the prompt payment of accounts and claims.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
19.2.3	CHIEF FINANCIAL OFFICER	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Reservation and Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Chief Financial Officer. Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
19.2.4	EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
19.2.4	CHIEF FINANCIAL OFFICER	Approve proposed prepayment arrangements.
19.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered).
19.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
19.2.6	MANAGERS AND OFFICES	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer.
19.2.7	CHIEF EXECUTIVE CHIEF FINANCIAL OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the applicable guidance. The technical audit of these contracts shall be the responsibility of the relevant Director
19.3	CHIEF FINANCIAL OFFICER	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 256 & 257 of the NHS Act.
20.1.2	CHIEF FINANCIAL OFFICER	The CFO will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
20.1.3	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CEO, Deputy CEO and CFO.)
20.1.4	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.1.6	CHIEF EXECUTIVE OR CHIEF FINANCIAL OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval.
20.2.3	CHIEF FINANCIAL OFFICER	Will advise the Board on investments and report, periodically, on performance of same.
20.2.4	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions on the operation of investments held.
21.1.1	CHIEF EXECUTIVE	(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; (b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; (c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.
21.1.2	CHIEF EXECUTIVE	that a business case is produced setting out: (i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; (ii) the involvement of appropriate Trust personnel and external agencies; (iii) appropriate project management and control arrangements;
21.1.2	CHIEF FINANCIAL OFFICER	Review and confirm the accuracy of costs and revenue consequences detailed in the business case.
21.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
21.1.4	CHIEF FINANCIAL OFFICER	Assess the requirement for the operation of the construction industry taxation deduction scheme.
21.1.5	CHIEF FINANCIAL OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
21.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a Scheme of Reservation and Delegation for capital investment management.
21.1.7	CHIEF FINANCIAL OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
21.2.1	CHIEF FINANCIAL OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
21.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
21.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from CFO).
21.3.5	CHIEF FINANCIAL OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
21.3.8	CHIEF FINANCIAL OFFICER	Calculate and agree capital charges in accordance with IFRS or as specifically directed by the Department of Health and Social Care requirements.
21.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
21.4.2	CHIEF FINANCIAL OFFICER	Approval of fixed asset control procedures.
21.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.
22.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to CFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
22.2	CHIEF FINANCIAL OFFICER	Responsible for systems of control over stores and receipt of goods.
22.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
22.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
22.2.2	NOMINATED OFFICERS	Security arrangements and custody of keys
22.2.3	CHIEF FINANCIAL OFFICER	Set out procedures and systems to regulate the stores.
22.2.4	CHIEF FINANCIAL OFFICER	Agree stocktaking arrangements.
22.2.5	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
22.2.6	CHIEF FINANCIAL OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
22.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to CFO evidence of significant overstocking.
22.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain.
23.1.1	CHIEF FINANCIAL OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
23.2.1	CHIEF FINANCIAL OFFICER	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
23.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CEO and CFO.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
23.2.2	CHIEF FINANCIAL OFFICER	Where a criminal offence (theft and assault) is suspected, immediately inform the Security Management Director and the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies which may indicate fraud, corruption or bribery, inform the relevant LCFS and the NHSCFA in accordance with the Government Functional Standard 013: Counter Fraud.
23.2.2	CHIEF FINANCIAL OFFICER	Notify the NHSCFA and the External Auditor of all frauds
23.2.3	CHIEF FINANCIAL OFFICER	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
23.2.4	AUDIT COMMITTEE	Approve write off of losses (within limits delegated by DHSC).
23.2.6	CHIEF FINANCIAL OFFICER	Consider whether any insurance claim can be made.
23.2.7	CHIEF FINANCIAL OFFICER	Maintain losses and special payments register.
24.1.1	CHIEF FINANCIAL OFFICER	Responsible for accuracy and security of computerised financial data.
24.1.2	CHIEF FINANCIAL OFFICER	Satisfy them self that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
24.2.2	GROUP DIRECTOR OF ASSURANCE	Shall publish and maintain a Freedom of Information Scheme.
24.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to Chief Information Officer
24.3	CHIEF INFORMATION OFFICER AND SIRO	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
24.4	CHIEF INFORMATION OFFICER AND SIRO	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place. This will be under the IT team.
24.5	CHIEF FINANCIAL OFFICER	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) CFO and staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
25.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.3	CHIEF OPERATING OFFICER AND CHIEF FINANCIAL OFFICER	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission
25.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
26.1	CHIEF FINANCIAL OFFICER	Shall ensure that each trust fund, which the Trust is responsible for managing is managed appropriately.
27	COMPANY SECRETARY	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
28	CHIEF EXECUTIVE	Retention of document procedures in accordance with NHS England and Department of Health and Social Care guidelines
29.1	CHIEF EXECUTIVE	Ensure a risk management programme exists.
29.1	BOARD	Approve and monitor risk management programme.
29.2	BOARD	The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.
29.4	BOARD	(a) Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements. (b) Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses, which will not be reimbursed. (c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible').
29.4	CHIEF FINANCIAL OFFICER	Ensure documented procedures cover the management of claims and payments below the deductible in each case
30.1	CHIEF FINANCIAL OFFICER	Ensure the Trust reports all its financial transactions in compliance with IFRS

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in public on 14th February 2024		
Title of Report:	Chief Nursing Officer Report	Enc No: 8.7
Author:	Caroline Whyte – Deputy Chief Nursing Officer caroline.whyte3@nhs.net	
Presenter/Exec Lead:	Lisa Carroll – Chief Nursing Officer lisa.carroll5@nhs.net	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: TMC is asked to discuss the contents prior to reporting to Board.			

Implications of the Paper:			
Risk Register	Yes ☒ No ☐ Risk Title: 2587 - Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks – score 9. 2601 - Sepsis/deteriorating patient identification, assessment, and treatment of the sepsis 6. 3043 - Suboptimal paediatric nursing ratios – score 16 3061 - CYP and adults with learning disabilities are not receiving care in line with local and national best practice standards – score 12		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	Workforce: agency costs for paediatric nurses, pending business case allocation of funds.		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Registration and licensing Well led.
	NHSE	Yes☒No☐	Details: Related standards
	Health & Safety	Yes☒No☐	Details: Health & Safety Act
	Legal	Yes☒No☐	Details: Duty of Candour, Claims and Litigation
	NHS Constitution	Yes☒No☐	Details: Constitutional Standards
	Other	Yes☒No☐	Details: Professional registration issues
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
Equality and Diversity Impact	None identified within the report		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: TMC 21/09/2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • Safeguarding adult and children's training is achieving the Trust target for levels 1 and 2 training. • Falls per 1000 bed days was 3.09 in November and 3.30 in December 2023. • Agency cessation plans continue to see a minimal usage of agency nursing staff, with a robust risk assessment process in place for the agreement of agency usage. • The timeliness of observations for November and December 2023 was 88.63% and 87.01% including the Emergency Department (ED), the compliance excluding ED was 91.79% and 91.28%. • Data from November and December 2023 demonstrates a consistent level of pressure ulcer incidents. • Clinical accreditation reviews of ward areas continue with Goscote Hospice achieving the first sapphire rating for the trust. • An update paper is available in the reading room which articulates progress for the National Patient Safety Alert regarding avoidable serious injury and deaths associated with medical beds, trolleys, bed rails, bed grab handles, and lateral turning devices.
Advise • The nursing and midwifery vacancy rate is just under 6% in December 2023, a slight increase from just over 4% in October 2023. • Within the Emergency Department 81.96% of patients received antibiotics within the first hour in November 2023 and 79.86% in December 2023. • For adult inpatients, 73.63% of patients received antibiotics within the first hour in December 2023, an increase from 67.11% in November 2023. • Several actions are underway in response to the increase in community prevalence of measles.
Alert • A total of 5 C. *diff* toxin cases were reported in November 2023 and 7 in December 2023.

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

Chief Nursing Officer Report to Trust Board

EXECUTIVE SUMMARY

This report summarises the key highlights of the Chief Nursing Officers' portfolio. This includes quality, patient experience, workforce, infection prevention & control, safeguarding and education. More detailed information in available within the reading room where applicable.

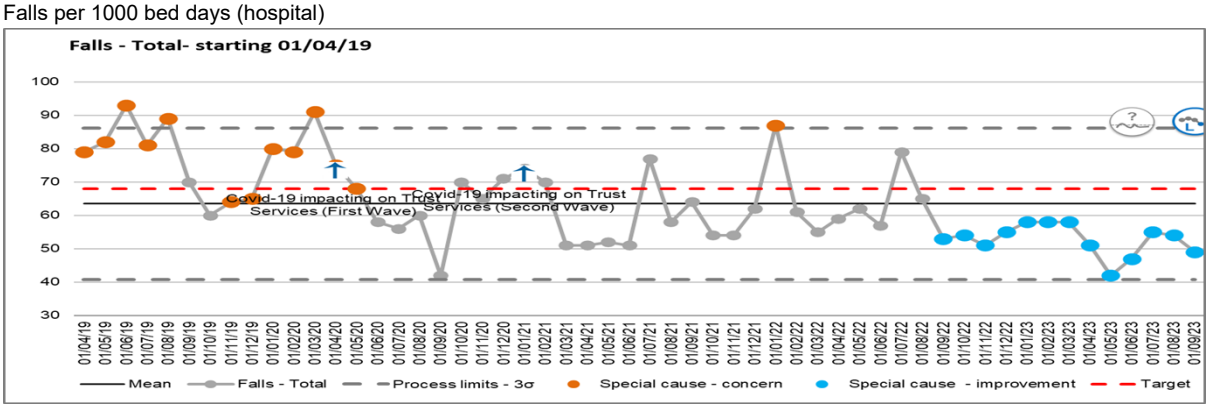
BACKGROUND INFORMATION

1.0 Quality

1.1 Falls

- The number of Trust falls recorded for November and December 2023 was 54 and 60 respectively, a decrease from 62 in October 2023.
- The Royal College of Physicians' mean average performance of 6.1 falls per 1000 occupied bed days has been achieved continuously.
    - Falls per 1000 bed days was 3.09 in November and 3.30 in December 2023. (3.46 in October 2023).
- The Falls Steering Group continues to implement an enhanced risk assessment for patients at high risk of falls.

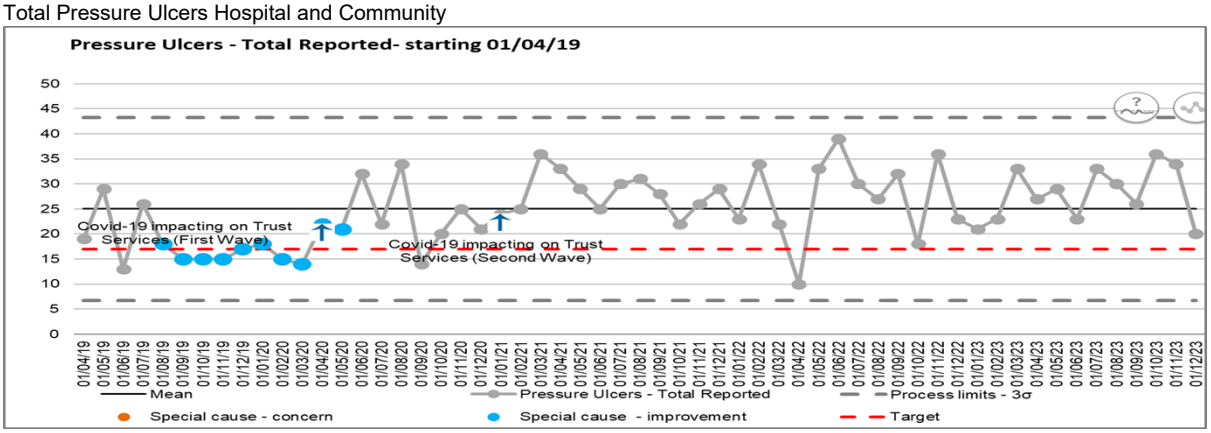
Falls per 1000 bed days (hospital)



1.2 Tissue Viability

- Data from November and December 2023 demonstrates a decrease in pressure ulcer incidents, with reductions in both hospital and community acquired pressure ulcers.

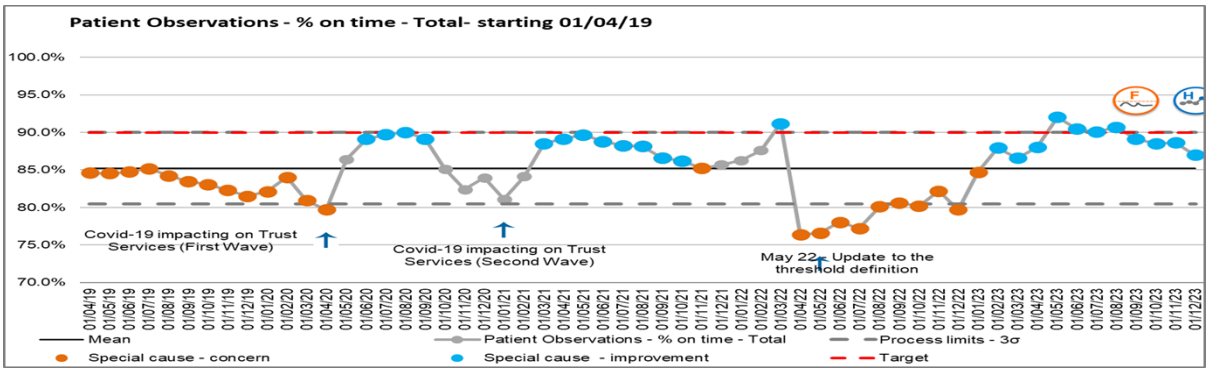
Total Pressure Ulcers Hospital and Community



1.3 Observations on Time

- The timeliness of observations for November and December 2023 was 88.63% and 87.01% (October 88.52%), including ED and the compliance was 91.79% and 91.28% for November / December 2023 (October 92.24%), excluding ED.
- 17 out of 28 clinical areas achieved the 90% target in December 2023, a reduction from 25 in October 2023 and 21 in November 2023. There has been a reduction in scores within MLTC which has seen changes of leadership within the division.

Patient Observations on Time



1.4 Clinical Accreditation Scheme

- The Clinical Accreditation Scheme was launched at the beginning of April 2023. A Clinical Accreditation Board and Shared Professional Decision-Making council for Clinical Accreditation have been established.
- 18 wards have been reviewed since April 2023. 12 wards have been accredited, 4 ward areas have been awarded Emerald, 7 areas awarded Ruby and 9 areas 'Working Towards Accreditation' to date. 9 wards have received their second accreditation visit. 4 ward accreditation visits await ratification of outcomes at Clinical Accreditation Board.
- Goscote Hospice is the first Trust area to be awarded a sapphire accreditation.

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

1.5 Deteriorating Patients

- The critical care outreach team continue to identify all patients placed onto Scale 2 for appropriateness of use.
- Interviews are due to take place for a sepsis and outreach team Matron in February 2024.
- As of December 2023, 51.7% of clinical staff had completed the NEWS2, Royal College of Physicians e-Learning package (an increase from 45.48% in November 2023). Scale 2 training has now been linked to the NEWS2 e-Learning package on My Academy

1.6 Nursing Quality Audits

Performance remains relatively consistent and monthly divisional confirm, challenge and support meetings, where audit results are discussed, and action plans produced to improve results and celebrate successes are established across the Trust. The table below details the audit results from January 2023 to date.

Trust overall – Audit Compliance

	CARE OF THE DYING	CATHETER AUDIT	CONTINENCE	DETERIORATING PATIENT & SEPSIS	DOCUMENTATION	ENVIRONMENT	FALLS & DECONDITIONING	IPC	MEDICINES MANAGEMENT	NUTRITION & HYDRATION	ORAL CARE	PAIN MANAGEMENT	PATIENT EXPERIENCE	TISSUE VIABILITY
JANUARY	95.7%	67.5%	83.2%	77.8%	91.7%	93.7%	78.8%	95.0%	91.7%	91.2%	89.4%	95.7%	88.0%	79.5%
FEBRUARY	95.9%	82.3%	93.4%	97.5%	92.3%	92.5%	87.6%	95.3%	92.0%	89.2%	96.1%	98.1%	95.8%	96.0%
MARCH	93.1%	87.0%	82.4%	98.9%	86.4%	92.9%	85.7%	94.2%	92.8%	92.0%	88.8%	97.2%	95.8%	90.6%
APRIL	99.6%	91.5%	80.1%	99.0%	88.0%	93.2%	89.4%	95.7%	92.8%	90.5%	91.8%	94.5%	95.6%	88.1%
MAY	90.4%	81.5%	77.7%	97.0%	87.3%	91.8%	90.6%	95.2%	93.1%	89.8%	87.8%	96.4%	96.7%	91.2%
JUNE	96.9%	85.7%	90.7%	95.8%	92.3%	92.6%	90.7%	95.8%	94.3%	84.3%	95.4%	95.4%	96.8%	89.9%
JULY	97.7%	84.6%	89.6%	98.8%	87.8%	94.0%	89.2%	96.5%	95.1%	88.8%	94.0%	95.0%	97.8%	94.6%
AUGUST	95.1%	82.6%	92.4%	99.2%	91.7%	95.7%	88.1%	94.9%	95.6%	90.8%	90.6%	93.4%	95.7%	96.2%
SEPTEMBER	96.2%	88.7%	84.9%	97.6%	92.3%	95.6%	91.3%	96.9%	95.0%	91.8%	91.2%	91.7%	96.0%	98.0%
OCTOBER	89.1%	90.8%	76.9%	98.7%	93.4%	95.1%	90.3%	97.4%	95.9%	86.1%	91.6%	83.8%	96.6%	91.7%
NOVEMBER	94.9%	88.9%	84.6%	90.0%	94.7%	94.7%	92.4%	97.3%	95.5%	93.5%	95.2%	91.3%	94.4%	95.3%
DECEMBER	93.2%	92.7%	67.4%	88.9%	93.5%	94.9%	85.2%	90.5%	96.2%	89.7%	85.7%	90.8%	97.8%	94.1%

1.7 Medicines Management

- A total of 124 medication incidents were reported in November 2023 a decrease of 6 incidents from previous month (October 2023). Most incidents were reported as near misses to no harm (n=92), 30 incidents were low harm and 2 incidents caused moderate harm (2), there were no severe harm incidents.
- There has been a reduction in errors for omissions, prescriptions errors and dispensing errors in November 2023.
- A total of 97 weekly audits have been conducted by the nursing and midwifery teams across the divisions. The average weekly score for compliance of medication standards of ward storage is 96%.
- CD audits completed by pharmacy: 9 audits took place in November 2023; average compliance was 81% which is a slight decrease from 84% in October 2023.
- Themes for improvement continue to be documentation within the CD register, signing receipt of receiving controlled drugs, twice daily stock check, running balance within CD register and patients own drugs being recorded within CD Patients Own Drug register.

1.8 Infection Control - *Clostridiodes difficile (C. diff) and measles*

- A total of 5 C. *diff* toxin cases were reported in November 2023 and 7 in December 2023. Of the November 2023 cases, cases in 4 were deemed avoidable and 1 unavoidable. In December 2023, 3 were avoidable and 4 were unavoidable.

C. Diff cases

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Max Cases per Month	2	2	2	2	2	2	2	2	3	3	2	2
Actual cases per month	4	9	6	12	9	12	7	5	7			
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	26
Acute Cumulative actual	4	13	19	31	40	52	59	64	71			

- Community prevalence of measles in England has increased, as it has globally, with large outbreaks currently underway in multiple countries
- The occupational health team are identifying staff who are not vaccinated against measles and are offering the MMR vaccine.
- The IPC team are currently scoping a process for contact tracing and administration of immunoglobulin for clinically high-risk patients / visitors in the trust who may come into contact with a measles case.

1.9 Patient Experience

Quarterly report is available in the reading room.

1.10 Adult and Children's Safeguarding and Associated Training

Current Training Compliance – adult and children's levels 1 and 2 remain above Trust target.
Adult Safeguarding Level 3 = 83.24% (80.50% November 2023).
Child Safeguarding Level 3 = 79.24% (76.97% November 2023).

Further review has taken place to work through stafing competencies, ensuring staff roles align with the intercollegiate guidance. A paper outlining this is due to safgeuarding committee in February 2024.

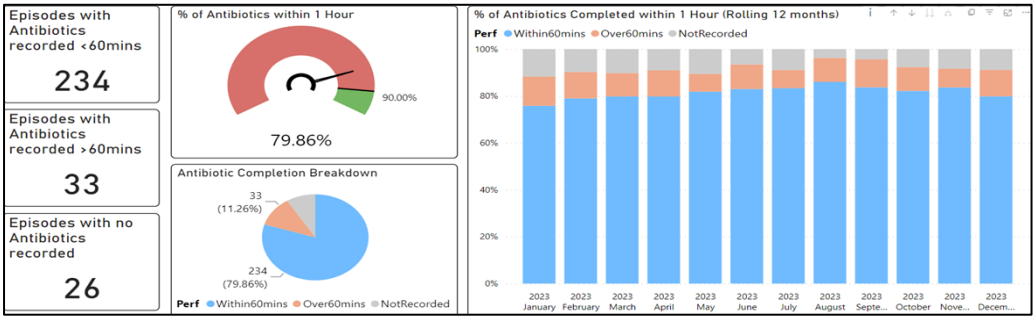
1.11 Mental Capacity Assessment (MCA)

- The data has been collected in Tendable Audit (Respect) since June 2023 and results for November 2023 and December 2023 are 86.21% and 86.25% respectively (84.94% in October 2023).
- An MCA action plan is monitored via the Trustwide Safeguarding Group.

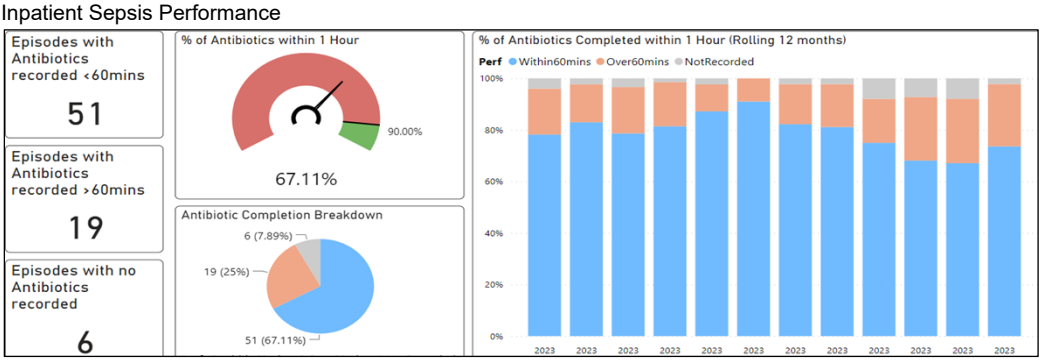
1.12 Sepsis

- Within the Emergency Department (ED), 81.96% of patients received antibiotics within the first hour in November 2023 and 79.86% in December 2023 (83.07% in October 2023).
- For adult inpatients, 73.63% of patients received antibiotics within the first hour in December 2023, an increase from 67.11% in November. Previous decrease in performance has been discussed at deteriorating patient group where sepsis performance and actions to improve are overseen.

ED Sepsis Performance



Inpatient Sepsis Performance

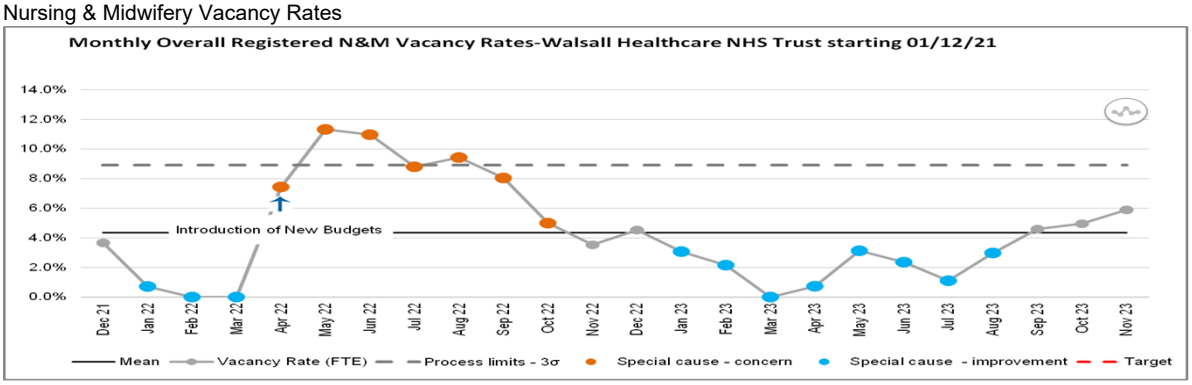


2.0 Workforce

2.1 Nursing and Midwifery Vacancies

- In December 2023, the total number of Registered Nurse/Midwife vacancies increased to just under 6%. An increase was seen within MLTC as a result of Ward 17 vacancies being advertised.

Nursing & Midwifery Vacancy Rates

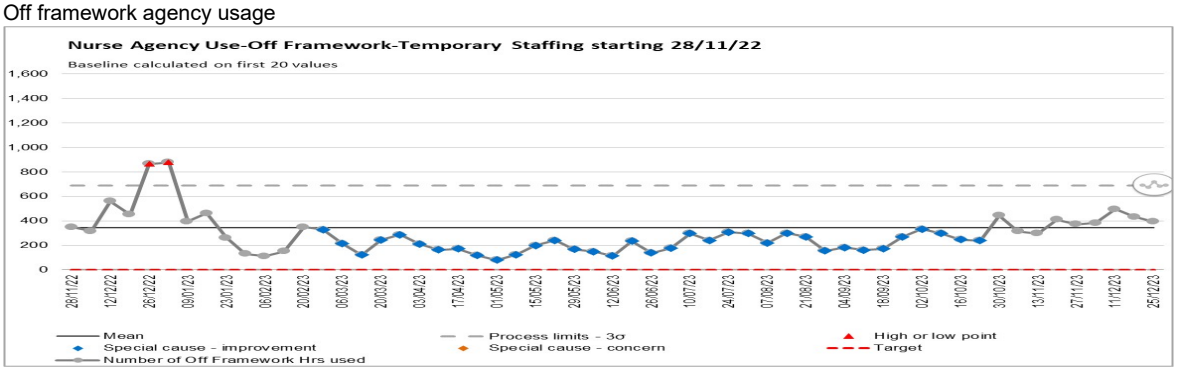


2.2 Agency Cessation

Agency use was ceased on the 1st April 2023 in all but a few areas and exceptional circumstances.

- There are limited exceptions to allow for specialist areas (ED and Paediatrics) where there are vacancies, Wards 5/6 (Winter Ward), 9 and 14 where substantive staffing are being recruited after being funded and Mental Health RMN or CSW cover.
- Agency Authorisation now requires risk assessments to have been completed and reviewed by senior divisional leadership before being presented to Chief Nursing Officer or on call Directors for authorisation.

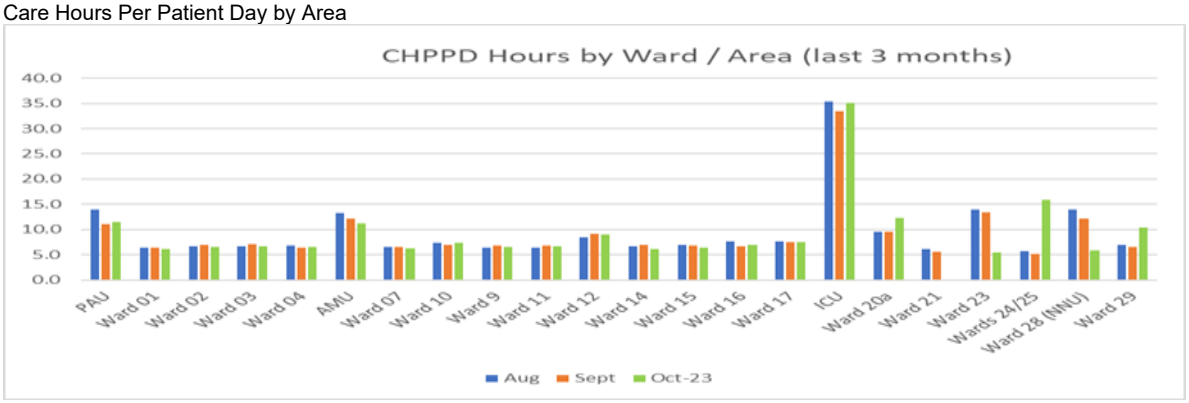
Off framework agency usage



2.3 Care Hours per Patient Day

- The CHPPD trust average for December 2023 was 9.4 (November 2023 was 9.1). The national overall CHPPD average for May 2023 (latest data) was 9.77.

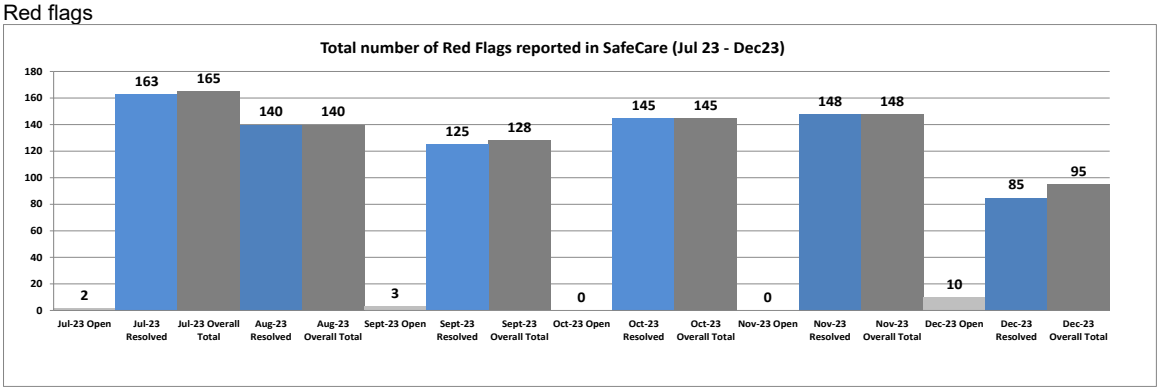
Care Hours Per Patient Day by Area



2.4 Red Flags

- There were no open Red Flags reported in November, and in December 2023 10 red flags remained opened.
- 148 red flags were opened and resolved in November 2023, and 95 red flags were reported in December 2023 and 85 were resolved. Red flags that remained open in December 2023 were in relation to increased patient acuity and patients requiring one to one care.

Red flags



2.5 Annual Workforce Safeguards Review

The annual workforce safeguards review for nursing and AHPs was undertaken in December 2023.

Of the 14 recommendations within the NHSI workforce safeguard document, the Trust is fully compliant with 10 recommendations and partially compliant but on track with 4.

The report and action plan can be found in the reading room.

3.0 Education

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

- Standards for Student Supervision and Assessment S(SSA) training compliance in November 2023 is at 67% and has increased to 78.3% in December 2023 which is a significant increase in compliance and reflects recent focus on this element of training. Communication via the matrons has been provided to ensure that staff complete this training.
- 83% of Clinical Support Workers (CSW) have completed their care certificate and increase from 63% in November 2023.
- A new band 5 nursing development programme is due to commence at the end of January 2023 in collaboration with RWT.

RECOMMENDATIONS

To note the contents of the report.

Reading Room Information/Enclosures:

NatPSA/2023/010/MHRA - National Patient Safety Alert update paper (Agenda Item 8.7.1)
Patient experience report & patient voice update (Agenda Item 8.7.2)
Annual Workforce Safeguards report and action plan (Agenda Item 8.7.3)

NHS
Walsall Healthcare
NHS Trust

Paper for Public Trust Board 14 February 2024		
Title of Report:	Briefing on NatPSA Bed Rails Alert Compliance at Walsall Healthcare NHS Trust (NatPSA/2023/010/MHRA)	Enc No: 8.7.1
Author:	Christian Ward – Deputy Chief Nursing Officer christian.ward@nhs.net	
Presenter/Exec Lead:	Lisa Carroll – Chief Nursing Officer lisa.carroll5@nhs.net	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The committee is asked to note the contents of the report and be sighted on actions completed and remaining actions to achieve compliance with the MHRA alert.			

Implications of the Paper:			
Risk Register	Yes ☐ No ☒ Risk Title: [Risk Pending		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	To be defined		
Report Data Caveats	The data in this report is partial and awaits the final audit result.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Registration and licensing Well led.
	NHSE	Yes☒No☐	Details: Related standards
	Health & Safety	Yes☒No☐	Details: Health & Safety Act
	Legal	Yes☒No☐	Details: Duty of Candour, Claims and Litigation
	NHS Constitution	Yes☒No☐	Details: Constitutional Standards
	Other	Yes☒No☐	Details: Professional registration issues
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based on individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Equality and Diversity Impact	None identified within the report		
Report Journey/Destination or matters that may have been referred to other	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date:
	Board of Directors	Yes☐No☒	Date:

Board Committees	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • Walsall Healthcare NHS Trust has updated policies and risk assessments in accordance with NatPSA/2023/010/MHRA, ensuring compliance with national patient safety standards. • Awareness of policy changes and training adaptations is being integrated into the Trust's existing Manual Handling Training curriculum, focusing on bed assessments and bed rail training. • The Trust has completed an inventory of paediatric bed stock, identifying a need for compliant beds as per BS EN 50637:2017 standards. • WCCSS Division is developing a risk that highlights risk, controls, mitigations, gaps and actions.
Advise • The current adult bed stock, primarily older models, is expected to show significant non-compliance with the standard EN BS 60601-2052:2010+A1:2015, necessitating future procurement considerations. • Paediatric bed stock requires immediate attention, as all beds reviewed do not meet BS EN 50637:2017 standards, posing a risk to patients fitting the defined at-risk group. • The Trust is advised to be prepared to procure paediatric beds with integrated bed rails compliant with BS EN 50636:2017 to meet the diverse needs of Ward 21, Paediatric Day Case and PAU patients.
Alert • Failure to comply with the NatPSA requirements by March 1, 2024, may lead to regulatory action by the Care Quality Commission. • A significant gap in paediatric bed stock compliant with BS EN 50637:2017 is noted, with a current count of 9 compliant cots and no compliant beds. • The Trust is alerted to the need for bespoke bed provisions for adults with atypical anatomy, suggesting a cost-effective approach of specialist bed hire, as per current practices for bariatric patients.

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

The NatPSA/2023/010/MHRA is a National Patient Safety Alert regarding avoidable serious injury and deaths associated with medical beds, trolleys, bed rails, bed grab handles, and lateral turning devices. It emphasises the danger of death and serious injuries due to entrapment or

falls. It outlines that chest or neck entrapment in bed rails is a recognised 'Never Event' in the NHS and highlights several factors contributing to these incidents, including inadequate risk assessment, maintenance issues, and the use of adult-designed beds for children and patients less than 40kg, less than 146cm in height or BMI less than 17.

Key actions required include updating policies and procedures, developing staff training plans, reviewing medical device management systems, implementing maintenance schedules, and prioritising risk assessments for children and adults with atypical anatomy. The document also specifies compliance with international standards for medical beds to reduce entrapment risks and stresses the importance of regular updates of risk assessments in light of changes in equipment or patient conditions.

The alert sets a deadline of March 1, 2024, for completing these actions and notes that failure to comply may result in regulatory action by the Care Quality Commission. The NatPSA also included statistics on the number of deaths (18) and serious injuries (54) reported between 2018 and 2022 related to these devices, primarily due to entrapment or falls.

Policy and Risk Assessments: Walsall Healthcare NHS Trust has successfully updated policies and risk assessments in line with the National Patient Safety Alert (NatPSA) on bed rails, medical beds, and related devices. This ensures compliance with the required actions highlighted in the NatPSA document.

Awareness and Training: We plan to integrate these policy changes into existing training methodologies. Adjustments will be made in the Trust's Manual Handling Training curriculum, explicitly focusing on bed assessments and bed rail training.

Audit of Adult Bed Stock: An audit is being conducted by EBME to assess the current bed stock at WHT. Preliminary expectations from common bed stock indicate a significant non-compliance with the standard EN BS 60601-2052:2010+A1:2015, primarily due to the age of the bed stock. Whilst EN BS 60601-2052:2010+A1:2015 is noted in the NatPSA, this is not a required action from the document but has been noted by Trust Procurement Specialists for any future procurement.

Compliance with EN BS 50637:2017: The NatPSA requires as an action the use of beds compliant with BS EN 50637:2017 for children and adults with atypical anatomy unless there is a reason for using a non-compliant bed.

This standard is a primary focus for required action in relation to the patient definition highlighted in the NatPSA. To reduce risk to the following patients defined as: less than 146cm in height, less than 40kgs in weight, or a BMI less than 17.

Audit of Paediatric Bed Stock: An inventory has been completed for paediatric areas; initial findings show that the current paediatric bed stock at WHT does not meet the BS EN 50637:2017 standard.

Regarding the current bed stock in paediatric services, we have nine compliant and eight non-compliant cots. The Trust has never purchased paediatric beds, and thus, all its beds are non-compliant.

The WCCSS are preparing a risk on the risk register to highlight risk severity, including mitigations/controls in place. In the medium term, there will be a requirement to procure paediatric beds with integrated bed rails that meet BS EN 50636:2017 and retain adult beds. This will allow Ward 21/Paediatric Day Case/PAU and Paed ED to meet patient group bed needs based on an assessment of weight and size.

For information, on average, children exceed 40kgs and 147cm at 12-13 years of age in the UK.

Potential solutions for Adults with altered anatomy: Adults with altered anatomy will be best served by bespoke provision of a suitable bed meeting their requirements via specialist bed hire as we would do currently for a bariatric patient. This would be cost-effective and remove the need to purchase and securely store appropriate bed frames on-site.

Conclusion: Walsall Healthcare NHS Trust, in conjunction with RWT, has made significant progress in policy update and training integration; challenges remain in equipment compliance, particularly concerning the paediatric bed stock. Ongoing efforts are required to address these gaps to maintain patient safety and regulatory compliance.

NHS
Walsall Healthcare
NHS Trust

Paper for submission to the Trust Board Meeting – to be held in public on Thursday 14th February 2024		
Title of Report:	Patient Voice Report September – December 2023	Enc No: To be completed by Board Administrator
Author:	Garry Perry, Associate Director – Patient Voice	
Presenter/Exec Lead:	Lisa Carroll, Chief Nurse	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☐No☒	Yes☒No☐
Recommendations: Note the contents of the report and improvement work linked to patient feedback			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Delays in responding to formal complaints. On Risk Register: Yes☒No☐ Risk Score (if applicable): 12		
Changes to BAF Risk(s) & TRR Risk(s) agreed	Risk Description None Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	Revenue: none Capital: none Workforce: none Funding Source: n/a		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led Regulation 16: Receiving and acting on complaints
	NHSE	Yes☒No☐	Details: NHS England » NHS England and NHS Improvement guidance: Using the Friends and Family Test to improve patient experience
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details: The National Health Service (Complaints) Regulations 2004 (legislation.gov.uk)
	NHS Constitution	Yes☒No☐	Details: Patient rights and NHS promises
	Other	Yes☒No☐	Details: NHS Complaints Standards: https://www.ombudsman.org.uk/organisations-we-investigate/nhs-complaint-standards/nhs-complaint-standards-summary-expectations

CQC Domains	**Safe:** you are protected from abuse and avoidable harm **Effective:** your care, treatment and support achieve good outcomes, helps you to maintain quality of life and is based ono the best available evidence **Caring:** staff involve and treat you with compassion, kindness, dignity, and respect **Responsive:** services are organised so that they meet your needs		
Equality and Diversity Impact	The work of the Patient Relations and Experience team seeks to advance equality of opportunity and inclusion. Recent assessment for our servce against the EDS2 domains demonstrated achieving activity Domain 1a: Patient (service users) have **required level of access** to the service and 1b: Individual patients (service users) health needs are met with **activity exceeds requirements** for 1c: When patients (service users) use the service they are free from harm and 1d: Patients (service users) report positive experiences of the service.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • Complaint timeframes have remained above target for the past 9 months with an 80% average for the months Jun-Aug 2023 (agreed timeframes in line with new standards) • Note the improvement in Friends and Family recommendation scores particularly in Maternity.
Advise • All activity contributes to an improved Patient Experience and progress against the Patient Experience Enabling Strategy
Alert • NIL

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement. • Prioritise the treatment of cancer patients. • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Improve overall staff engagement
Improve the Healthcare of our Communities	• Develop a health inequality strategy. • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative. • Implement technological solutions that improve patient experience. • Progress joint working across Wolverhampton and Walsall

Walsall Healthcare NHS Trust

Patient Voice Report, September – December 2023

Report to Trust Board

EXECUTIVE SUMMARY

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 September - December 2023. 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.

BACKGROUND INFORMATION

A report on patient and carer experiences is presented to the Quality Patient Experience and Safety Sub-Committee on a quarterly basis (inc. September for this report due to cyclical changes mid-year) 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 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.

RECOMMENDATIONS

Any Cross-References to Reading Room Information/Enclosures:

- Detailed Patient Voice Update inc. National Surveys, Volunteering, Family & Carer Service and Spiritual, Pastoral and Religious Care updates

1.0 Details

1.1 Feedback data

20514 feedback contacts were received between 1st September 2023 and 31st December 2023. This includes all Patient Relations related contacts (1313), along with Friends and Family Test and Mystery Patient responses.

Complaints (including MP letters)	145
Concerns this included queries / comments & suggestions etc	906
Compliments	262
Friends and Family Test	18856
Mystery Patient (QR code)	345

Table 1. Patient Feedback by contact type

1.2 Complaints and Concerns

During September - December 2023, Surgery received the most contacts Trustwide with 509 contacts received. MLTC received 406, Community received 176, and WCCSS received 1158. The remaining 64 contacts were logged as Corporate or “other” in the event of a referred-on case.

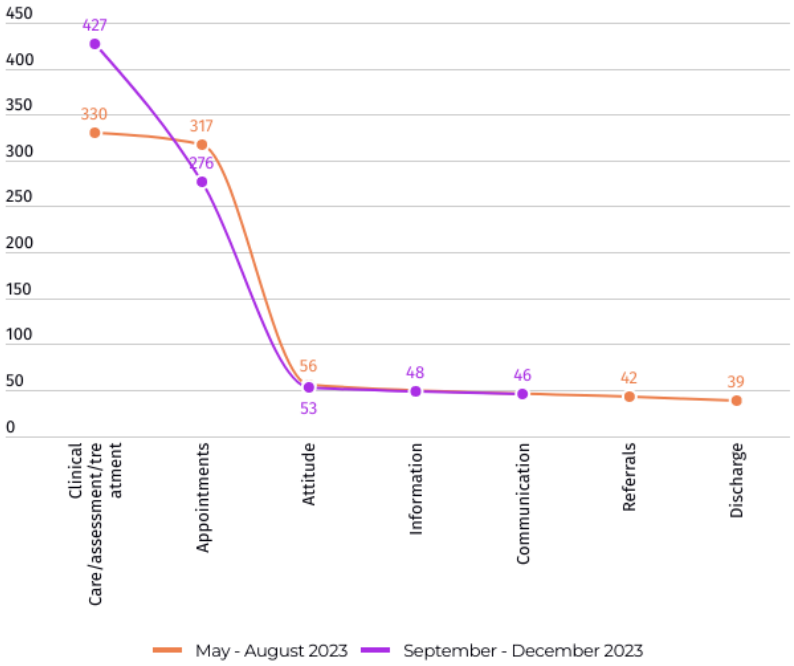


Table 2. Complaints and Concerns by trend type

- Trust wide, the highest trend in contacts for this period was in relation to Clinical Care / Assessment / Treatment with 427 contacts received, which equates to 40.6% of the total contacts received (excluding compliments). 206 contacts were in relation to Treatment Advice / Issues with an additional 93 contacts in relation to Treatment/Procedure Delays.

- The Emergency Department received the highest number of related contacts with 42, followed by the Urology Team with 35.

- With regards to Treatment/Procedure delays, whilst contacts were spread across the Trust, both in inpatient and outpatient areas, Urology and Trauma & Orthopaedics received the highest number of contacts with 19 and 15 contacts respectively. Urology received a number of contacts in relation to delayed cancer treatment, whilst within Trauma & Orthopaedics, there were a number of contacts related to delayed knee surgery.

- The second highest trend is contacts relating to Appointments with 276 contacts received, which equates to 26.2% of the contacts received (excluding compliments). 103 contacts related to Appointment Queries / Advice and 79 related to cancelled appointments. The ENT service received the highest number of contacts with 43 contacts received. The ENT Service received the second highest contacts with 39 contacts received.

53 (5%) of contacts received related to staff attitude. 35 of these contacts were in relation to staff being perceived as “rude” and 8 related to staff showing a lack of empathy. The number of contacts have reduced throughout the reporting period however, with September 2023 receiving the highest number of contacts (20), this reduced each month up to December 2023 (9).

1.3 Complaint response timeframes

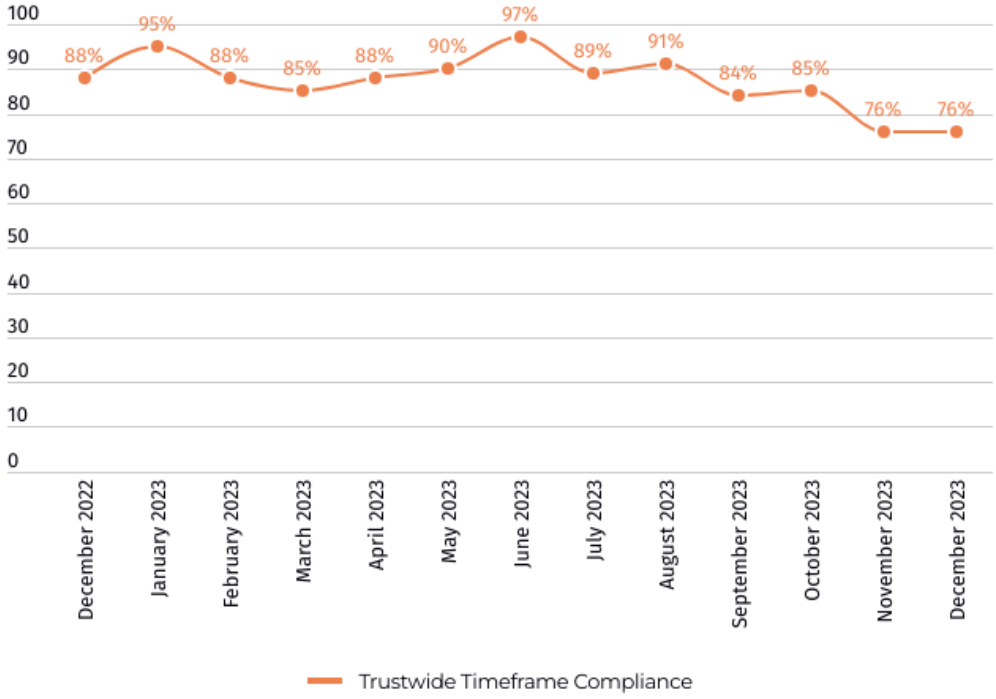


Table 3: Complaint response timeframes

- Trustwide, our average agreed response timeframe compliance in September – December 2023 was 81%. During this period, WCCSS achieved 100% compliance. MLTC and Community both achieved an average timeframe compliance of 98% and Surgery achieved an average compliance of 38%.

- Our timeframe compliance has decreased in comparison to the previous report period, with the aim contributory factor being Surgery achieving 0% timeframe compliance in both September and December 2023. Delayed responses from the Urology department were a predominant factor. The Patient Relations Team are meeting with the Urology Team on a weekly basis in and providing additional support to resolve their outstanding concerns.

2.0 Friends and Family Test

2.1 Recommendation

Table 4 illustrates the FFT recommendation scores for all 8 touchpoints.
Q3 has seen a significant improvement for Maternity Services, with Birth, Postnatal Ward, and Postnatal Community each achieving the current target (90%) and on track to achieve the 95% strategy target. Inpatients, Outpatients and Community have maintained a consistent score over Q3, with ED fluctuating over the period.

FFT Recommendation (%)	Q1 Average	Q2 Average	Oct-23	Nov-23	Dec-23	Q3 Average
Inpatients	**89**	**88**	88	89	90	**89**
Outpatients	**93**	**92**	92	91	91	91
ED	**84**	**80**	75	80	82	**79**
Community	**99**	**99**	99	99	100	**99**

Antenatal	**90**	**87**	88	82	90	**87**
Birth	**72**	**88**	87	93	96	**92**
Postnatal Ward	**82**	**82**	89	93	95	**92**
Postnatal Community	**93**	**90**	98	97	100	**98**

Table 4. FFT recommendation score
Colour coding key on right.

Equal or above 90% target	Above future 92% target (Q4)	Below current 90% target

2.2 Trust Review

FFT Recommendation (%)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Trust	88	88	87	87	88	90	90	91	93

Table 5 – FFT Trust averages

Table 5 Illustrates the average FFT recommendation score for the Trust. On average, since April 23, the Trust has shown an overall improvement in the first 3 quarters of the financial year, with Q3 showing a significant improvement when compared to Q1.

Table 6 illustrates the FFT response rates for all 8 touchpoints. With the exception of Antenatal, Maternity services have seen a significant increase in the number of responses in Q3 when compared to Q1 and Q2, with this increase appearing to contribute to the improved recommendation score. All other touchpoints have maintained a response rate with minor fluctuation over the period.

FFT Response Rate (%)	**Q1 Average**	**Q2 Average**	Oct-23	Nov-23	Dec-23	**Q3 Average**
Inpatients	**35.3**	**27.4**	26.1	29.3	22.6	**26.0**
Outpatients	**18**	**16.4**	17.3	15.1	16	**16.1**
ED	**17.3**	**15.2**	15.4	13.7	15.4	**14.8**
Community	**174 (n)**	**324 (n)**	363 (n)	339 (n)	253 (n)	**318 (n)**
Antenatal	**12.3**	**9.0**	7.9	7.3	6.9	**7.4**
Birth	**23.4**	**20.0**	10.8	52.9	41.2	**35.0**
Postnatal Ward	**38.1**	**42.9**	65.9	34.4	54.3	**51.5**
Postnatal Community	**17.9**	**20.6**	22.3	27.3	20	**23.2**

Table 6. FFT Response Rate

(n) Community report total responses **not** response rate due to data validation of community eligible population.

2.3 Friends and Family Test Themed Analysis

Chart 7 shows the themed analysis across Q1, 2 and 3 for free text FFT comments. Negative comments about staff attitude has increased through Q1, 2 and 3 with positive comments also increasing. This change suggests an improvement when compared to the pervious report highlighting staff attitude as an increasing negative theme across the Trust. Negative comments have increase in relation to waiting times. In line with the previous report, Community has been added to the themed Analysis Dashboard, with work currently underway to include Outpatient in February 2024.

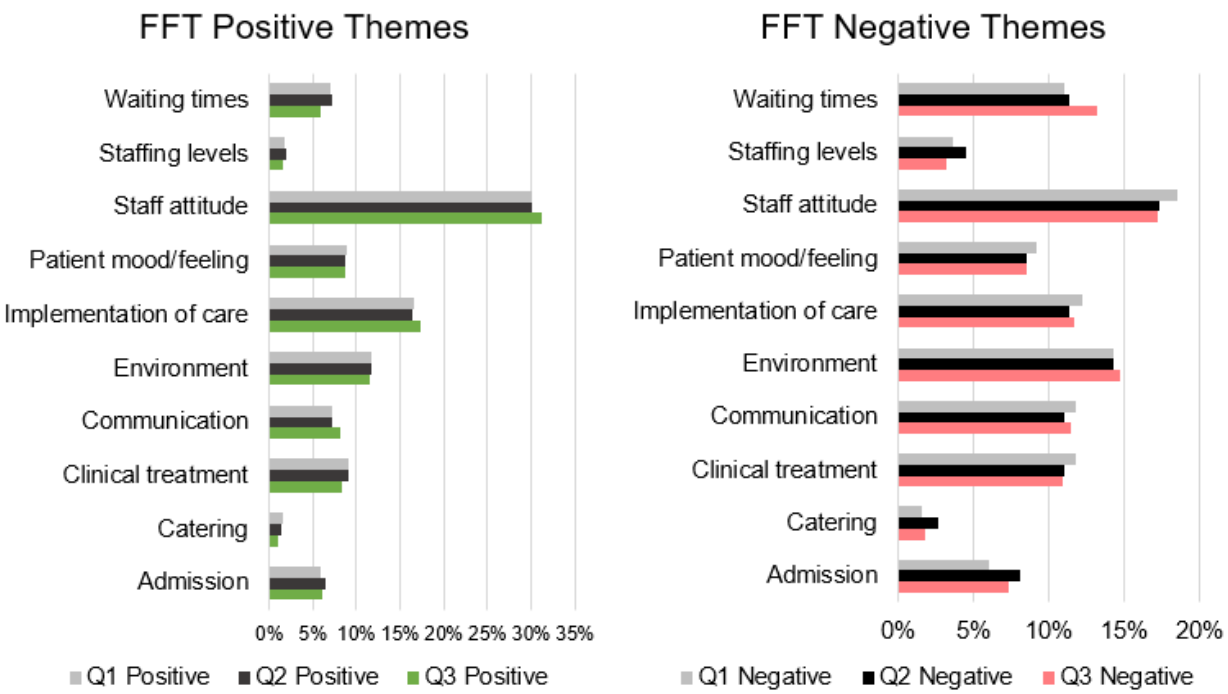


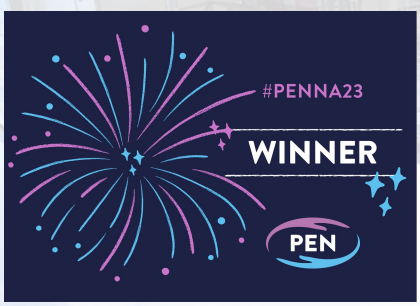
Chart 7. Themed Analysis (Inpatient ED and Community

Walsall Healthcare NHS
NHS Trust

Patient Voice Update

September 2023 - December 2023

Patient Relations & Experience



1.Feedback

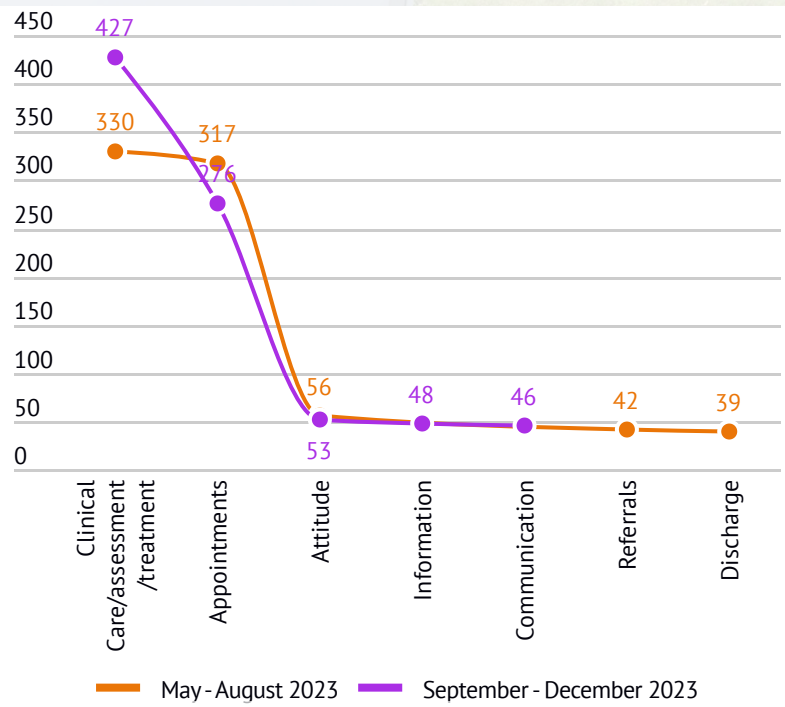
1.1 Feedback data

20,514 feedback contacts were gathered between 1st Septmber 2023 and 31st December 2023. This includes all Patient Relations related contacts (1313), along with Friends and Family Test (18856) and Mystery Patient responses (345).

Complaints (including MP letters)	145
Concerns this included queries / comments & suggestions etc	906
Compliments	262
Friends and Family Test	18856
Mystery Patient (QR code)	345

1.2 Complaints and concerns

During September - December 2023, Surgery received the most contacts Trustwide with 509 contacts received. MLTC received 406, Community received 176, and WCCSS received 1158. The remaining 64 contacts were logged as Corporate or "other" in the event of a referred-on case.



Trust wide, the highest trend in contacts for this period was in relation to Clinical Care / Assessment / Treatment with 427 contacts received, which equates to 40.6% of the total contacts received (excluding compliments).

206 contacts were in relation to Treatment Advice / Issues with an additional 93 contacts in relation to Treatment/Procedure Delays.

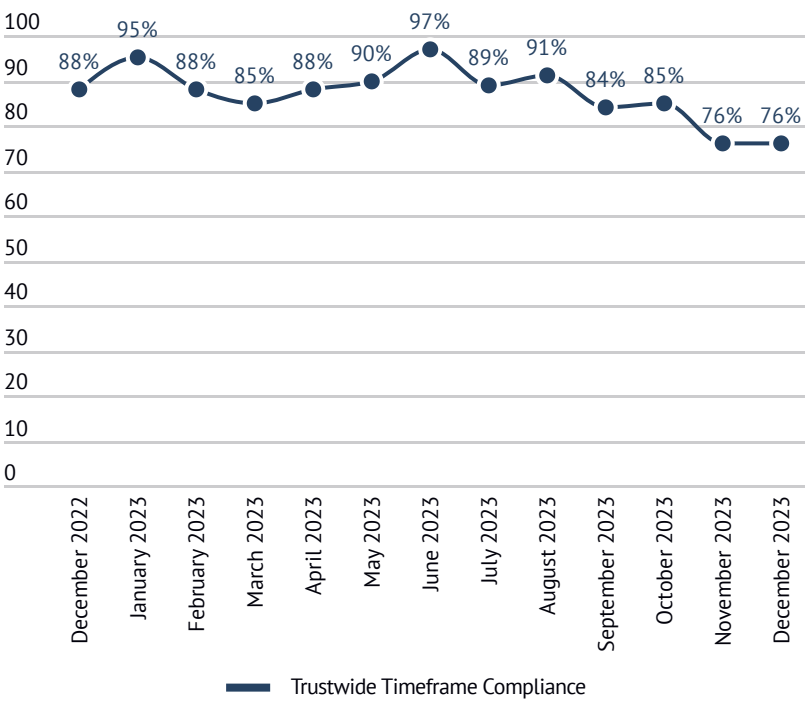
The Emergency Department received the highest number of related contacts with 42, followed by the Urology Team with 35.

- With regards to Treatment/Procedure delays, whilst contacts were spread across the Trust, both in inpatient and outpatient areas, Urology and Trauma & Orthopaedics received the highest number of contacts with 19 and 15 contacts respectively. Urology received a number of contacts in relation to delayed cancer treatment, whilst within Trauma & Orthopaedics, there were a number of contacts related to delayed knee surgery.

- The second highest trend is contacts relating to Appointments with 276 contacts received, which equates to 26.2% of the contacts received (excluding compliments). 103 contacts related to Appointment Queries / Advice and 79 related to cancelled appointments. The ENT service received the highest number of contacts with 43 contacts received. The ENT Service received the second highest contacts with 39 contacts received.

53 (5%) of contacts received related to staff attitude. 35 of these contacts were in relation to staff being perceived as "rude" and 8 related to staff showing a lack of empathy. The number of contacts have reduced throughout the reporting period however, with September 2023 receiving the highest number of contacts (20), this reduced each month up to December 2023 (9).

1.3 Complaint Response Timeframes



- Trustwide, our average agreed response timeframe compliance in September – December 2023 was 81%. During this period, WCCSS achieved 100% compliance. MLTC and Community both achieved an average timeframe compliance of 98% and Surgery achieved an average compliance of 38%.

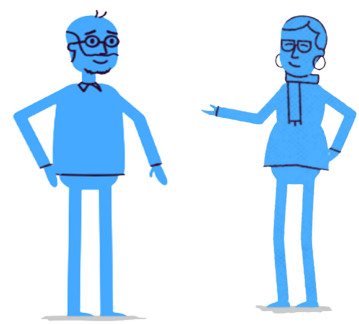
Patient Relations

Parliamentary and Health Service Ombudsman

Our agreed timeframe compliance has decreased in comparison to the previous report period, with the aim contributory factor being Surgery achieving 0% timeframe compliance in both September and December 2023. Delayed responses from the Urology department were a predominant factor. The Patient Relations Team are meeting with the Urology Team on a weekly basis in and providing additional support to resolve their outstanding concerns.

1.4 Parliamentary & Health Service Ombudsman (PHSO)

There were 6 cases confirmed by the PHSO during September - December 2023. 1 case was partly upheld and 1 case was not upheld by the PHSO during this period.



The partly upheld case was in relation to a complaint raised regarding the care of the complainant's father on Ward 15.

The complainant stated that after the ward team stopped the patient's prophylaxis medication enoxaparin, the team did not restart it when her father's planned operation did not go ahead.

The complainant reported that when the patient had a cardiac arrest, the team also gave him an injection which caused a catastrophic bleed to his brain. The complainant stated that as a result of what happened her father died.

The PHSO's review outlined that there is no evidence to show that the risks of bleeding outweighed the need for prophylactic anticoagulant at this point in the patient's care and treatment. They also noted there was no note in the patient's health records of a reassessment, as required by the guidance. For this reason, the PHSO determined there were failings in the failure to reassess the patient and restart the enoxaparin. The PHSO did conclude however, that there is no evidence the patient's cardiac arrest was caused by not restarting the enoxaparin and the balance of probabilities, could not say the outcome would have been any different in this case. The PHSO made recommendation around the administration of enoxaparin, which have been shared with the divisional team for their attention/action.

In relation to the injection, the PHSO advised the actions taken by the doctors and the treatment they gave was in line with guidance, taking into account the information they had at the time, the need to act quickly, and the symptoms the patient was displaying. It was noted that bleeding on the brain was a recognised side effect of the drug given.

Patient Relations

1.5 Learning from complaints

Case 41601

This complaint relates to the level of care a patient received in the Emergency Department. The initial concern was the patient was discharged without their discharge paperwork. The patient was also still in pain. it was later identified that the patient had a fractured neck of femur on discharge which has not been identified.

During the investigation, the case was discussed with the ED clinician who saw the patient who has been advised to carry out a reflective learning log. A clinical incident was also raised, which re-emphasised that the imaging department will red dot X-rays to highlight any potential fractures, before they are reported. Advice has also been re-enforced to the ED clinicians to follow the national recommendations, which state if there is a clinical suspicion of a fracture in the elderly, even in the presence of a normal X-ray and the patient remains immobile, a CT scan should be considered as a further investigation modality.

The Patient Relations Team continue to actively encourage staff to complete Reflective Shoes Action plans as part of their investigations to aid in our journey of moving from “we will” to “we have”.

Patient Experience

2.0 Friends & Family Test

2.1 Recommendation

The below table illustrates the FFT recommendation scores for all 8 touchpoints. Q3 has seen a significant improvement for Maternity Services, with Birth, Postnatal Ward, and Postnatal Community each achieving the current target (90%) and on track to achieve the 95% strategy target.
Inpatients, Outpatients and Community have maintained a consistent score over Q3, with ED fluctuating over the period.

FFT Recommendation (%)	Q1 Average	Q2 Average	Oct-23	Nov-23	Dec-23	Q3 Average
Inpatients	89	88	88	89	90	89
Outpatients	93	92	92	91	91	91
ED	84	80	75	80	82	79
Community	99	99	99	99	100	99
Antenatal	90	87	88	82	90	87
Birth	72	88	87	93	96	92
Postnatal Ward	82	82	89	93	95	92
Postnatal Community	93	90	98	97	100	98

FFT Recommendation score

Equal or above 90% target	Above future 92% target (Q4)	Below current 90% target

2.2 Trust review

FFT Recommendation (%)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Trust	88	88	87	87	88	90	90	91	93

FFT Trust Averages

The above table Illustrates the average FFT recommendation score for the Trust. On average, since April 23, the Trust has shown an overall improvement in the first 3 quarters of the financial year, with Q3 showing a significant improvement when compared to Q1.

The below table illustrates the FFT response rates for all 8 touchpoints. With the exception of Antenatal, Maternity services have seen a significant increase in the number of responses in Q3 when compared to Q1 and Q2, with this increase appearing to contribute to the improved recommendation score. All other touchpoints have maintained a response rate with minor fluctuation over the period.

Patient Experience

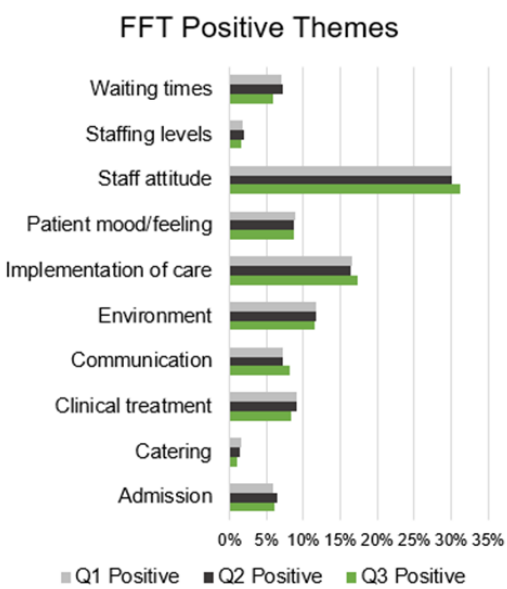
FFT Response Rate (%)	Q1 Average	Q2 Average	Oct-23	Nov-23	Dec-23	Q3 Average
Inpatients	**35.3**	**27.4**	26.1	29.3	22.6	**26.0**
Outpatients	**18**	**16.4**	17.3	15.1	16	**16.1**
ED	**17.3**	**15.2**	15.4	13.7	15.4	**14.8**
Community	**174 (n)**	**324 (n)**	363 (n)	339 (n)	253 (n)	**318 (n)**
Antenatal	**12.3**	**9.0**	7.9	7.3	6.9	**7.4**
Birth	**23.4**	**20.0**	10.8	52.9	41.2	**35.0**
Postnatal Ward	**38.1**	**42.9**	65.9	34.4	54.3	**51.5**
Postnatal Community	**17.9**	**20.6**	22.3	27.3	20	**23.2**

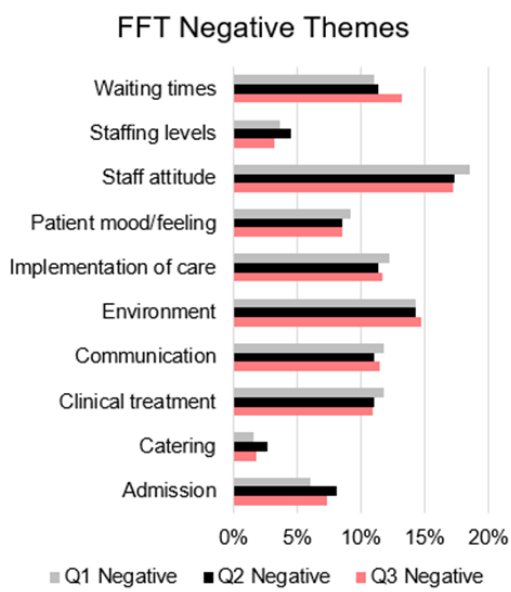
(n) Community report total responses not response rate due to data validation of community eligible population.

2.3 Friends & Family Themes Analysis

The below chart shows the themed analysis across Q1, 2 and 3 for free text FFT comments. Negative comments about staff attitude has increased through Q1, 2 and 3 with positive comments also increasing.

This change suggests an improvement when compared to the pervious report highlighting staff attitude as an increasing negative theme across the Trust. Negative comments have increase in relation to waiting times. In line with the previous report, Community has been added to the themed Analysis Dashboard, with work currently underway to include Outpatient in February 2024.





Patient Experience

3.0 Mystery Patient / Feedback Friends

In Q3 Mystery Patients was changed to reflect a change in focus as outlined in the national survey results. New questions we introduced to provide an updated assurance against the new areas. Table 8 illustrates the scored Trust level Mystery Patient questions and the Trust performance against the targets. Controlling Pain remains below target despite improving in November.

Question 5 is the only question that remained from the existing questions. Q3 has shown significant improvement for Question 5,Respect and Dignity, with 3 consecutive months scoring above target.

The below table (Mystery patient responses by area) illustrates the number of Mystery Patient responses received. There has been a 52% reduction in response across Q3

Items for escalation

Focus required in Outpatients due to a significant reduction in responses throughout Q3

Trust	Target	Oct-23	Nov-23	Dec-23
1. Do you think the hospital staff did everything they could to help control your pain?	8.3	7.0	8.6	7.4
2. Did you feel able to talk to members of hospital staff about your worries and fears?	6.8	7.5	8.5	8.5
3. Thinking about any medicine you were to take at home, were you given any of the following?	3.3	4.3	4.6	4.4
4. Did healthcare professionals speak to each other about you as if you weren't there?	8.2	8.0	8.7	8.8
5. Overall, did you feel you were treated with respect and dignity?				

Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
8.5	7.7	8.3	7.6	7.8	7.7	8.1	8.7	8.6	8.7

Mystery Patient Scored Questions – Scored in line with CQC national survey scoring matrix.

Responses	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3
Inpatients	**98**	**148**	55	59	25	**139**
Outpatients	**23**	**41**	29	9	3	**41**
ED	**60**	**42**	14	7	9	**30**
Maternity	**10**	**6**	2	2	7	**11**
Community	**4**	**21**	7	5	7	**19**
Trust wide	**1**	**0**	0	0	0	**0**
Total	**196**	**258**	**107**	**82**	**51**	**240**

Mystery Patient Responses by Area

Voluntary Services Update

Type Volunteer activity has increased 3% in Q3 when compared to Q2. This increase is alongside a reduced activity in December due to the Christmas and New Year period. Active volunteers have reduced in Q3 when compared to pervious quarters, however, indicates an increased commitment by our volunteers as seen by the increased hours.

Area	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3
Hospital	2793	3037	1132	1073	799	3004
Community	901	1015	395	341	297	1033
Self Care Management	546	428	167	223	48	438
Chaplaincy	352	258	163	156	92	411
Trust Total	4592	4738	1857	1793	1222	4886
New Volunteers in period	36	30	15	4	2	21
Active Volunteers in period	130	134	122	117	106	115
Total cost (B2 equivalent)	£52,578	£54,250	£21,263	£20,530	£13,992	£55,945
Volunteer Hours						
1st	136	197	106	54	58	218
2nd	136	147	51	49	50	150
3rd	109	146	43	43	31	117

Family and Carers

Encounters	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3
Total Encounters	89	153	40	33	6	79
Identifies as an unpaid carer	48	76	22	15	4	41

Support Categories	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3
Pastoral	80	140	38	31	6	75
Signposting Internal	9	12	8	2	0	10
Signposting External	28	21	7	4	1	12
Care Update	3	11	2	2	1	5
Support Caring - In Hospital	14	35	43	30	4	77
Support Caring - Discharge/at home	26	14	16	18	0	34
Patient Relations	4	14	8	7	0	15

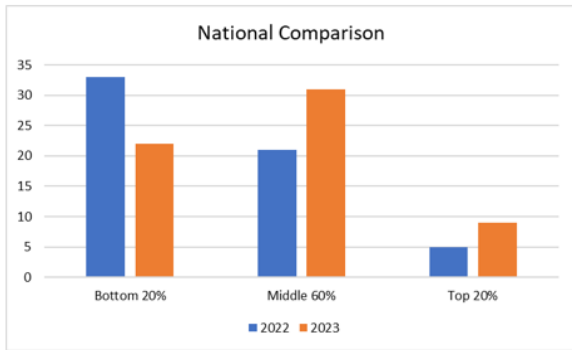
Who has received support?	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3
Unpaid Carer	48	76	23	15	2	40
Family Member	20	24	12	11	2	25
Patient	21	51	5	7	2	14

National Surveys

Maternity Survey 2023

The survey results were published in December - preliminary results were analysed and shared with the Maternity Division ahead of this in September and an action planning workshop.

Sample	300
Responses	111
Response rate	38%
Change	+5%



We have taken the opportunity to review the last three surveys over the period of time which has shown there are some areas to celebrate.

29

Questions have shown improvement over 3 consecutive years.

11

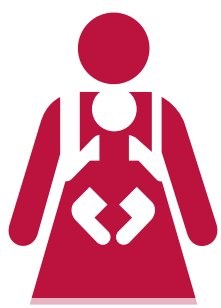
Questions improved in 2023 by 10% or more

8

Questions dropped in 2022, and improved to the same or better score than 2021

There are six areas of focus arising from the action planning workshops themed around:

1. Pain Management
2. Choice - offered a choice about where to have your baby
3. Support from those who matter
4. Getting help when you need it
5. Discharge
6. Feeding



Urgent & Emergency Care Survey 2023

Published results were released in July. 224 patients took part in the survey from 1250 with a response rate of 18% against 23% for all Trusts. The Trust scored the best nationally for arrival at A&E and patients being given enough privacy when discussing conditions with the receptionist. We also scored amongst the top 5 nationally for waiting.

Given the survey was conducted in the old Emergency Department, overall, this was a positive set of results for the Trust.

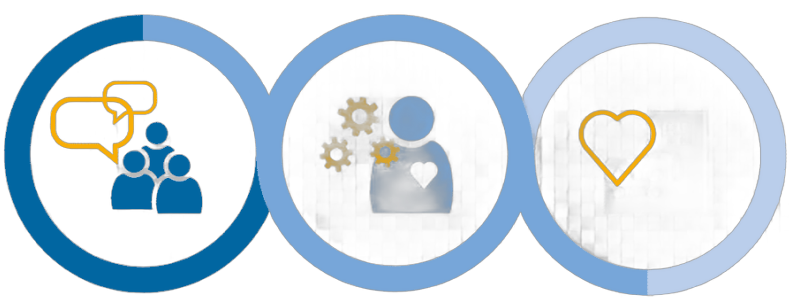
Urgent and Emergency Care Survey results have been presented to staff and sessions supported by the patient experience team have been held to help clinical staff understand what the data is telling them and what can be done differently or how they can behave differently.

The ED team have resurrected two patient focus groups regarding:

- Frequent patient user group
- ED Mental Health steering group

Both meetings work with the internal and external stakeholders to ensure individual patient reviews are completed ensuing the correct care plan and healthcare professionals are involved, supporting a safer and improved patient experience.

A medicines reconciliation task and finish group has been brough together for the organisation. There is clinical representative (medical and nursing) for MLTC involved as part of the core membership. Actions particularly looking at working with the patient relations team to communicate patients bringing their current medications into hospital with them at initial presentation, this will support the reconciliation process and reduce any medication omissions where drugs may not initially be available.



Cancer Patient Experience Survey 2022

Published in July there was a response rate of 46% against a national rate of 53% reported via tumour group Breast care had the higher proportion of responses.

There were 37 questions above the expected range. 10 questions were below the expected range.

Local actions underway, including a focus on patient experience improvement linked to CPES in the Colorectal Improvement Group.

	No. Responses	Proportion
Breast	77	38%
Colorectal / LGT	33	16%
Gynaecological	14	7%
Haematological	12	6%
Lung	19	9%
Prostate	19	9%
Sarcoma	0	0%
Urological	18	9%
Other	12	6%
Total	204	100%

Adult In-patient Survey Survey 2023

The National Adult Inpatient Survey was published in August. 333 Walsall Healthcare NHS Trust patients responded to the survey with a response rate for Walsall of 27.59% (National average was 40.2%). The Trusts results were worse than most trusts for 12 questions, somewhat worse for 5 questions and about the same as others for 28 questions. As the headline survey was shared with us ahead of publication, action planning workshops were held during July with over 50 staff of all disciplines taking part. 6 focus areas have been actioned which responds to the questions where we fared the worst in terms of the survey response. These are:

1. Delayed arrival – time on the waiting list before admission and time waiting for a bed after arriving at the hospital.
2. Nutrition and hydration – access to food outside of mealtimes and help from staff to eat meals.
3. Treatment and Care – patients able to talk to hospital staff about their worries and fears and staff doing all they can to control pain.
4. Leaving hospital – consideration of family and home situation when planning to leave hospital and enough notice about when patients are going to leave.
5. Medication – take home medicines, the purpose/side effects/ how to take and written information to take away.
6. Continued support – Getting support from health and social are services following leaving hospital and condition management.

The action plan has been shared with the Patient Feedback and Oversight Group and regular updates and assurance will be provided through this group in addition to Patient Experience Group.

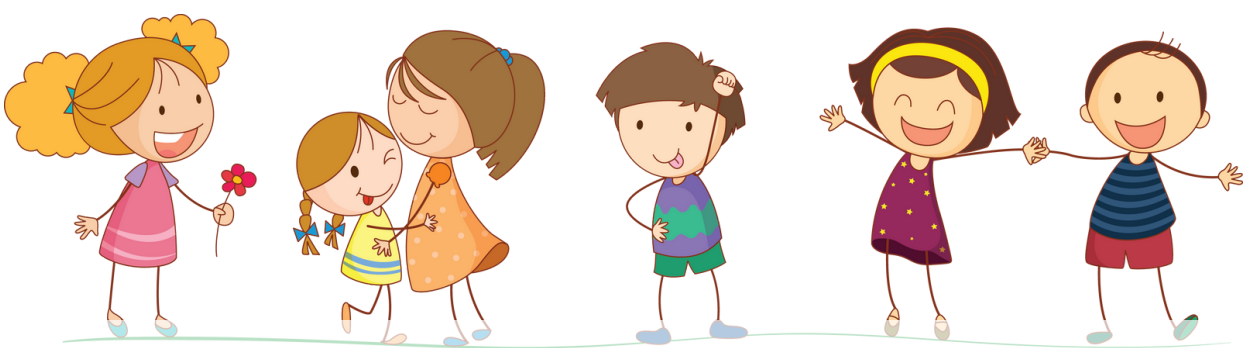
The actions align with the improvement priorities outlined in our Patient Experience Enabling Strategy and workstreams are underway supporting a response to the focus areas described. The Trust mystery patient scheme questions have also been changed to monitor how we are doing.

Children and Young People Survey 2024

The 2024 survey will use a mixed mode method for the first time, featuring options for both online and paper questionnaire completiono. This follows a mixed mode pilot survey completed in 2020 and further refinement work undertaken in 2022 on how mobile telephone numbers should be used for the survey.

It is likely that 16-18 year old's will be included in the survey for the inpateint aspects of treatment and this will be confirmed in April. The sampling period for the survey will April-May 2024, with the potential of adding in March. Results will not be expected until towards the end of the year.

We will be undertaking a local snapshot survey in February so we can align any immediate actions we may need to undertake ahead of the national survey being undertaken.



Spiritual, Pastoral & Religious Care

Team Recruitment and Development

Six (6) team bank chaplains (4 Christian and 2 Muslim) have been recruited in September and have been deployed since December. Five further interviews wre held in December and provisionally appointed two (Muslim) candidates as bank chaplains. We will be readvertising to recruit Sikh and Hindu bank chaplains. This development will enable us to provide better out-of-hours support across all the major faith communities in our locality.

At WHT we had 8 new volunteers complete the Volunteer Chaplains training course, and certificates of recognition have been sent to them. We are still waiting to recruit to the vacant Team Leader post.

Pastoral Encounters - Engaging

Analysis of the data captured by our SPARC tool; indicates we have had at least.

Month	RWT	WHT
October	554	981
November	425	920
December	471	526
Total	1450	2427

3877 separate pastoral encounters between our staff and volunteer team.

WHT

All inpatient areas in Walsall Manor and the Goscote Palliative Care Centre continue to receive regular visits. We also visited Holly Bank and continue to incorporate the Trust community services within our plan for regular visiting, as our team develops.

The breakdown of support received:

We maintain pastoral interactions at a level of approximately 810 pastoral encounters a month. In the last quarter, 86% had a Pastoral element, 45% a Spiritual element and Religious (faith-specific) care was present in 34% of our encounters. We visited on average 54 out of our 107 listed hospital areas, which means we visited and provided support to 50% of the Trust work areas this quarter.

Out of hours support

The need for religious, spiritual, and pastoral out-of-hours support continues. In the last quarter, we had over 160 requests across the faith and belief groups in our local communities. These were supported by our faith-specific chaplains. Many of these have to do with end-of-life care and support was given to the patient and their loved ones.

We continue to provide appropriate support and care for those with and without religious affiliation or belief and will utilise community links to enhance our provision. Noticeboards have been developed at WHT and we intend to share the template cross-site.

Training and Staff support - Empowering

We have continued to receive requests to support staff teams who have experienced traumas. In the past quarter, we have had 6 requests from six different areas – some to do with the deaths of team members and one following the sudden death of a patient.

WHT

The chaplaincy team continues to participate in the training of international nurses. We also provided resources regarding the Spiritual and Religious care of patients which were shared at Maternity Bereavement Study Day in December.

Over the past 6 months:

- Team members have taken more ownership and leadership for the delivery of training or leading faith and cultural events.
- Requests for support for staff following incidents have increased.

End-of-Life (EOL) / Bereavement care – Inspiring:

In the quarter from October to December at WHT, we conducted 10 hospital-arranged baby funerals and 4 adult funerals. We continue to offer support to families who attend the mortuary for viewings but have had no take-up on this offering to date. The bereavement office remains a vital cog in our provision, in this quarter they have dealt with 374 deaths between Manor, the Palliative Care Centre and the Community. The collaborative work continues with the Swan Champions (RWT) and the palliative care teams across both Trusts.

Celebrations and Special Events

In the last quarter, there have been several significant public/patient events – notably Diwali and Bandi Chhor.

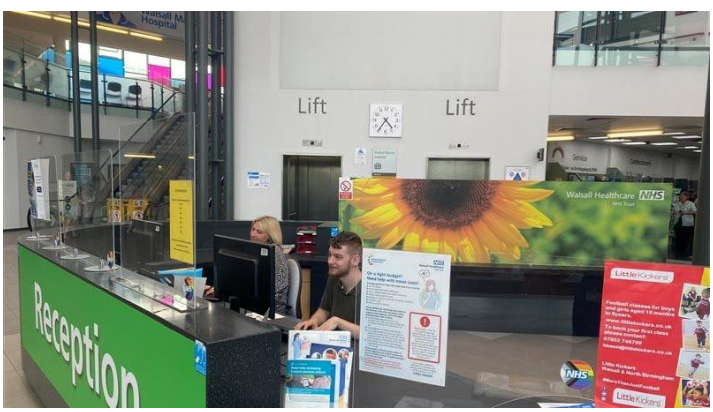
Chaplaincy led and worked with several other teams to deliver the Annual Babies Memorial Service in October (WHT) and November (RWT) with a combined attendance of well over 300 people representing at least 100 families.

At the start of Christmas 2023, Chaplaincy supported the Christmas Light Switch-on cross-site, giving both a word of encouragement and blessing. The newly developed WHT hospital choir, led by Rev Eddie Boampong, were also on hand to bring upliftment and Christmas cheer at the event in the Manor Atrium on 1 December.

At all RWT & WHT Trust sites, carol singing took place on the wards and sweet treats were offered to staff. Chaplaincy was present on Christmas Day delivering a Mass at RWT and at WHT resources were made available for staff to have personal prayer in St Luke's Chapel and Prayer Room.

The Welcome Hub & Walsall Connected

The main atrium welcome hub staff continue to offer a professionally courteous front of house service supported by Trust volunteers as the initial 'meet and greet' for Trust visitors and patients. The team also manage the 'access line' for patient location plus general queries as well as assisting in the collection of family and friend's feedback. In more recent weeks th eteam have also taken on responsibility for some of the patient facing responsibilities of General Office including taxi bookings and patient travel expenses.



September – December 2023	
Patient Location Query	1,661
General Query	182
Appointment Query	44
Wheelchair Query	547
TOTAL	**2,434**

Walsall Connected - Manor Hospital

Walsall Connected

5	361	284	331	45
Residents seen at Manor Hospital Walsall Connected last week	Total residents seen at Manor Hospital Walsall Connected	Customers feel confident to complete process independently	Customer supported fully at location on day	Residents registered disabled supported

How was customer supported	Users
Complete online process for customer	10
Contacted service with customer present	9
Customer self-serve	32
Customer upskilled via computer	10
Customer upskilled via iPad	28
Customer upskilled via own mobile device	11
Digital support with customer self-serving	28
Information given	173
Referral made to service	13
Telephone number for service provided	47
Grand Total	**361**

Green boxes highlights increased figures from previous week

Customer persona	Users
Have Access / Lack awareness	123
Have access but need help/support	117
Limited/data Access	54
No Access	67

Age Bracket	Users
25-64	214
65+	117
16-24	5
Working Age	4

Walsall Council

Data used up to 07.01.24

Walsall Connected

Andy Street, Mayor of the West Midlands and WMCA Chair, recently visited Walsall Manor Hospital to meet with partners and organisations that have been delivering the Connected Services Programme which has seen the 1,500 plus devices distributed around the borough since April this year.

Professor David Loughton CBE, group chief executive of Walsall Healthcare and The Royal Wolverhampton NHS Trusts, said: “It was a pleasure to welcome the Mayor of the West Midlands to see first-hand the difference that Walsall Connected is making to many people’s lives in our local communities. *“As an organisation that is committed to playing its part in widening digital access to the people it serves, we are encouraged by the feedback that we have received so far about the success of siting such a facility in our hospital. I’d also like to thank the volunteers who support Walsall Connected and our Trust values.*

Walsall Healthcare NHS Trust

Public Trust Board – 14 February 2024		
Title of Report:	Developing Workforce Safeguards Review- Nursing	Enc No: 8.7.3
Author:	Gaynor Farmer – Corporate Senior Nurse for Workforce gaynor.farmer@nhs.net	
Presenter/Exec Lead:	Lisa Carroll – Chief Nursing Officer – lisa.carroll5@nhs.net	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☒No☐	Yes☐No☐	Yes☐No☐
Recommendations: The committee is asked to note the contents of the report			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ • BAF: We will deliver the best quality of care evidenced by patient experience feedback and good clinical outcomes.		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None Risk Description Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable):		
Resource Implications:	None		
Report Data Caveats	This is an annual assurance report		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe domain
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date:
	NMAAF	Yes☒No☐	Date: 6th January 2024
	Trust Management Committee	Yes☒No☐	Date: January 2024
	People Committee	Yes☒No☒	Date: January 2024

Summary of Key Issues using Assure, Advise and Alert

Assure

- Of the 14 recommendations within the NHSI workforce safeguard document, the Trust is fully compliant with 10 recommendations and partially compliant but on track with 4.
- The review has indicated the following areas where actions are required:

  - The Annual Governance Statement to be reviewed.
  - Annual statement to include the AHP workforce outside of the community division.
  - Ensure an annual workforce plan is completed and discussed at public board.
  - Process for new roles and the re-establishment of New Roles Group to be considered. Nursing will liaise with HR Workforce.

- All nursing workforce within the acute Trust are on an electronic rostering system.
- The Trust has the necessary, in date, licences and tools for the SNCT data collections.

Advise

- There is no single guidance or standard validated methodology to inform staffing levels required for services provided by AHPs, each of the professional groups provide their own guidance. Varied tools are utilised for relevant areas.

Alert

- Nothing to alert

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels.

Walsall Healthcare NHS Trust

Developing Workforce Safeguards Review-Nursing

Review undertaken December 2023

Brief/Executive Report Details	
Brief/Executive Summary Title:	Developing Workforce Safeguards Review-Nursing

1.0 Background

NHS Improvement published 'Workforce safeguards' document in October 2018 it is used to assess Trusts compliance with the triangulated approach to staffing planning for all clinical staff in accordance with the National Quality Board guidance (NQB). This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skill are in the right place and time.

Trusts compliance with these safeguards will be assessed through the Single Oversight Framework and specific inclusions within the annual governance statements.

There remains no single guidance or standard approach to inform staffing levels required for services provided by AHPs. Each AHP group has profession specific information and guidance available to support staffing levels of a particular type of service/speciality. AHP staffing levels are generally determined via a range of methods which include the use of demand and capacity data, data collected on patient and non- patient related activity, patient outcomes, patient complexity, patient acuity and patient need. In addition, guidance that is nationally available for specific clinical services and/or conditions is also used e.g. stroke services, critical care, and cancer services. The extent to which allied health services employ and deploy allied health support workers varies according to the profession and clinical speciality. These roles can effectively support the registered AHP workforce to deliver patient care.

Although the 'Workforce Safeguards' document guidance applies to all clinical staff; this paper will **only** outline Nursing/Midwifery and AHP's current compliance with the 14 safeguard recommendations and identify any areas for improvement.

2.0 Findings of the latest self-assessment for Nursing

- The Trust has re self-assessed against the recommendations and is fully compliant with 10 of the recommendations- Indicators 1, 2, 5, 6, 8, 9, 10, 11, 13 and 14.
- There is partial compliance with recommendations 3, 4, 7 ,12.
- The review has indicated the following areas where actions are required:

  - The Annual Governance Statement to be reviewed and any additional actions to be placed into this document.
  - Annual statement to include the AHP workforce outside of the community division.
  - Ensure an annual workforce plan is completed and discussed at public board.
  - Process for new roles and the re-establishment of New Roles Group to be considered. Nursing will liaise with HR Workforce.

The detailed action plan is in Appendix 1

Recommendation 1 **-** *Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.*

–Compliant and ongoing

The Staffing Report that is shared with People Committee includes CHPPD for the month and the most recent Model Hospital CHPPD.

Figure 1: Principles of safe staffing

Figure 1 – Data source NHSI, 2018

Establishment reviews follow a robust methodology which includes a triangulated approach using the recommended NHSi tool (Safer Nursing Care Tool with Hurst Model recommended staffing ratio's). The Establishment Reviews are taking place with a methodology that includes the appraisal of any national benchmarking / guidance for specific areas such as ITU/Paediatrics/Midwifery. The Trust has renewed the licences for SNCT and will be using this from January 2024 onwards.

Recommendation 2 **-** *Ensuring the three components (see Figure 1 above) are used in safe staffing processes: – 1 evidence-based tools – 2 professional judgement – 3 outcomes.*

-Compliant

The Trust board will be receiving biannual nursing skill mix reports for all in patient nursing workforce. Currently data is collected in January and June of each year.

Table 1

Area	***Methodology***
Wards – adults, paediatrics, AMU and SAU	*Safer Nursing Care Tool (SNCT)*
Emergency Department	*ED specific Safer Nursing Care Tool (EDSNCT)*

Outpatient and Day Care Departments	*Professional Judgement as no current validated tool available*
Neonatal Unit	*BAPM guidelines*
Intensive, Coronary & High Dependency Care Units (including outreach teams)	*BACCN/RCN critical care forum/ICS guidelines*
Theatres	*Association for Perioperative Practitioners (AfPP)*
Maternity services	*Birthrate+*
Community Services	*Community Nursing Safer Staffing Tool (CNSST)*
Endoscopy	*JAG guidance/Professional Judgement methodology*
AHP teams	*Professional Judgement methodology*

NHSI recommend providing evidence of all available clinical capacity across the 7-day working week and recommend using e-job plans for all clinical staff not working a 24/7 shift system.

E-roster

- *All nursing and midwifery inpatient wards, emergency department, endoscopy, ICU, majority of outpatients departments and day care areas are on e-roster.*
- *Work to add student nurses to the health roster system has commenced.*
- *Clinical Fellowship Nurses (CFN's) are added onto the health roster system upon appointment.*
- *Licences have been procured for further roll out to other Trust staff and a Business Case is being developed to support the staff required within the Eroster Team to facilitate this.*

NHSI recommends in addition to these cycles workforce data and financial information are reconciled regularly to reflect changes. This process is currently undertaken at local level and variance is not reported externally.

***Recommendation 3** – Assessment will be based on review of the annual governance statement in which trusts will be required to confirm their staffing governance processes are safe and sustainable.*

and

	Recommendation 4 *– The review of the annual governance statement will be through the usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and financial performance measure.* ***– On Track and ongoing*** *Annual governance statement to be reviewed by Chief Nursing Officer and Chief Medical Officer -due January 2024.* ***Recommendation 5*** *– NHSE/I will seek assurance through the SOF monitoring performance.* ***– Compliant and ongoing*** *Monthly Reports for Nursing Activity and Staffing are part of the normal reporting business. (Monthly Staffing Report/ CNO Report)* ***Recommendation 6*** ***-*** *As part of the safer staffing review, the Director of Nursing and Medical Director, must confirm in a statement to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable.* ***– Compliant and ongoing-due January 24*** *Nursing/midwifery and AHP staffing is reported to the Trust Board.* ***Recommendation 7*** ***-*** *Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The board should discuss the workforce plan in a public meeting.* ***– On track*** *Updates to be requested form the workforce team for next annual plan.* ***Recommendation 8*** ***-*** *They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.* ***– Compliant and ongoing*** *Monthly Quality Report is shared, and a Ward Quality Dashboard is in use. Trust uses Tendable to record Audit data at ward level.* ***Recommendation 9*** ***-*** *An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.* ***- Compliant***

	Currently reported in the bi-annual Nursing and Midwifery skill mix/staffing report to the Trust Board. ***Recommendation 10*** *- There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.* ***– Compliant*** *Confirmed no local manipulation and Imperial Tools licences are in date and new tools are in use.* ***Recommendation 11*** *- As stated in CQC's Well led Framework guidance (2018) 6 and NQB guidance, any service changes, including skill mix changes must have a full quality impact assessment (QIA) review.* ***– Compliant and ongoing*** *process for sharing dynamic QIA and Risk Assessments is in place and shared with Chief Nursing Officer if staffing requirements are requested for amendment (short term)* ***Recommendation 12-*** *Any redesign or introduction of new roles (including but not limited to Physician Associate, Nursing Associate and Advanced Clinical Practitioners) would be service change and must have a full QIA.* ***-On track*** *process to be designed and consider recommencing new roles group which was previously managed by the HR Workforce Team.* ***Recommendation 13*** *- Given day-to-day operational challenges, we expect Trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance, and staff experience must be clearly described in these risk assessments.* ***– Compliant and ongoing*** *There are mechanisms in place for dynamic planning and review of staffing. Twice daily safe staffing meetings are in place which include a review of staffing in community-based setting. Escalation processes are in place and in times of extremis we have a mechanism for deploying the 'staffing hub' which is a central control room for staffing management. The site is risk assessed during the twice daily meetings and decisions taken to redeploy, work differently and escalate staffing demand where this may impact quality. There is consideration to Red Flags/Acuity/Enhanced levels of care during these meetings and not a singular focus on staffing numbers.* ***Recommendation 14*** *- Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality.*

	– Compliant and ongoing *Business continuity plans are enacted where required. Example-Covid19 response. Updates to the actions taken and escalations of concern are included in the Nurse Oversight Report. Information is shared across sub committees in both the Quality, People and Financial work streams.* ***References*** • *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing. 2018 NHSI* • *How to quality impact assess provider cost improvement plans. National Quality Board 2012* • *Well-led framework guidance. Care Quality Commission 2018* • *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe, sustainable and productive staffing. National Quality Board July 201*
Appendix 1	Detailed action plan Workforce Safeguards assurance

END OF REPORT

Reviewed 14.12.2023

Recommendation	Trust Position (Aug 2020)	Identified Action	Owner	Progress Update	Target Completion Date	RAG status
1. Trust must formally ensure NQB (2016) is embedded in their safe staffing governance	Trust has safe staffing governance and reporting in place to comply with safer staffing guidance	>twice yearly data capture from Safer Nursing Care Tool is to be reported to Board	Corporate Senior Nurse-Workforce	14.12.23- The Trust completes the SNCT for in patient wards twice yearly. Reviews of other areas such as theatres,OPDs are now planned annually	completed and ongoing	Compliant and ongoing
	Trust has been working using some data from the Model hospital to allow comparison with peers- this is still in infancy	>no action -practice embedded	Corporate Senior Nurse-Workforce	14.12.23- CHPPD is reported in the People Committee Staffing Report and most recent Model Hospital result included.	completed and ongoing	Compliant and ongoing
	Report in-patient planned and actual staffing levels on a monthly basis	>no action -practice embedded- reported monthly to PODC as part of the Staffing Paper	Corporate Senior Nurse-Workforce	14.12.23- The process is embedded and continues	completed and ongoing	Compliant and ongoing
	Monthly report on in patient staffing levels integrated with Monthly Staffing Report	>no action -practice embedded- reported monthly to PODC as part of the Staffing Paper	Corporate Senior Nurse-Workforce	14.12.23- The process is embedded and continues	completed and ongoing	Compliant and ongoing
2. Trust must ensure that the 3 components (see below) are used in their safe staffing processes: A) evidence based tools B) professional judgement C) outcomes	Establishment reviews follow a robust methodology which includes a triangulated approach using the recommended NHSi tool (Safer Nursing Care Tool with Hurst Model recommended staffing ratio's)	>ensure that all of the Workforce Safeguards inclusions are placed into the methodology for the Establishment reviews	Corporate Senior Nurse-Workforce	14.12.23- The current Establishment Reviews are taking place with a methodology using the SNCT with Hurst Model recommendations included. The reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing. The data capture has included the recommendations from the Developing Workforce Safeguards document.	completed and ongoing	Compliant and ongoing
	Best practice benchmarks are used and considered for Establishment reviews that have a 'specialism'- i.e. Paediatrics, Midwifery, Intensive Care.		Corporate Senior Nurse-Workforce	14.12.23- The current Establishment Reviews are taking place with a methodology that includes the appraisal of any national benchmarking / guidance for specific areas such as ITU/Paediatrics/Midwifery.	completed and ongoing	Compliant and ongoing

	Professional Judgement is used as part of the review considering the Quality indicators for an area and any factors that fall out of 'norm' for an area.		Corporate Senior Nurse-Workforce	14.12.23- During the Establishment Reviews there is a review of the Quality Indicators for that area and asking the Divisional Team to flag any indicators out of norm. Additional professional judgement factors are then considered as part of the review.	completed and ongoing	Compliant and ongoing
	Establishment reviews are undertaken in the presence of the Divisional Finance staff and also the Deputy Director of Nursing.		Corporate Senior Nurse-Workforce	14.12.23- The Establishment Reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing.	completed and ongoing	Compliant and ongoing
	Outcomes will be evaluated and a joint working group will meet and discuss the evidence gathered and recommendations to add another opportunity for professional judgement and sign off before being presented to Board		Corporate Senior Nurse-Workforce	14.12.23- The Establishment Reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing.	completed and ongoing	Compliant and ongoing
3. NHSE/I will base assessment on the Annual Governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable	Annual governance Statement	> annual governance statement to be reviewed annually.	Corporate Senior Nurse-Workforce	14.12.23- The Annual Governance Statement to be reviewed and any additional actions to be placed into this document. Sought from Trust Secretary	Jan-24	On track and ongoing
4. NHSE/I will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complete quality outcomes, operational and finance performance measures	Annual governance Statement	> annual governance statement to be reviewed and an evaluation completed re Nurse, midwifery and AHP Staffing Processes.	NHSE/I	14.12.23-Annual statement to include the AHP workforce outside of the community division	Ongoing	Ongoing activity by NHSE/I
5. NHSE/I will seek assurance through the SOF monitoring performance	Monthly Reports for Nursing Activity and Staffing are part of the normal reporting business. (Monthly Staffing Report/ CNO Report)	>monthy staffing report to People Committee in place. Chief Nurse also completes oversight report. Current report covers AHP workforce within the community division and needs to expand in 2023 to include the wider AHP workforce. Review of AHP workforce will be Q4 of 23/24 and presented with June 24 data.	Corporate Senior Nurse-Workforce/ CNO	14.12.23- The process is embedded for nursing and midwifery reporting and the AHP workforce that is wihtin the commmunity division. Report to include wider AHP following June 24 collection	Ongoing	Compliant and ongoing

	Monthly Reports for Nurse Rostering and Red Flag activity to the sub committee Nursing, Midwifery and AHP Advisory Forum. (Eroster Report/ Red Flag Report)	>no action -practice embedded- monthy Red Flag and Eroster Report is submitted to NMAAF.Report to include wider AHP workforce once Allocate further roll out completed during 23/24	Corporate Senior Nurse-Workforce/ CNO	14.12.23- The process is embedded for nursing and midwifery reporting and the AHP workforce that is within the commmunity division. Report to include wider AHP workforce once Allocate further roll out completed during 23/24	Ongoing	Compliant and ongoing
6. As part of the safer staffing review, the Director of Nursing and Medical Director, must confirm in a statement to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	>Nursing- this statement will form part of the establishment Review outcomes paper	>ensure statement is made for Nursing in Establishment review paper	CNO	14.12.23-statement of support was included in latest establishment review	Ongoing	Compliant and ongoing
7. Trust must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The Board should discuss the workforce plan in a public meeting	>ensure an annual workforce plan is completed	> ensure that the annual workforce plan is updated/ signed off and discussed at a Public Board	Corporate Senior Nurse for Workforce	2024s update to be requested form the workforce team	Mar-24	On track
8. Board must ensure that their organisation has an agreed quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital Dashboard. Trust should report on this to their Board every month.	Monthly Quality Report is shared and a Ward Quality Dashboard is in use. Trust has started to use the Tendable application for recording quality audits/outcomes	>no action	Corporate Quality Team	>12.01.2022- Tendable use for audit is in place and embedded. Quality Dashboard is embedded. Establishment reviews cross reference quality data during their process.	Ongoing	Compliant and ongoing
	NHSi Staffing fill rates is reported monthly as part of the Oversight report and includes CHPPD and most recent model hospital results for comparison	>no action-include model hospital benchmarking in PODC report for Staffing	Corporate Senior Nurse-Workforce	14.12.23- The current Staffing Report that is shared with People Committee includes CHPPD data and the most recent Model Hospital data	Ongoing	Compliant and ongoing
9. An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS improvement resources. This must also be linked to professional judgment and outcomes	There is a twice yearly review of Establishments using SNCT data/Professional Judgement and Quality Outcomes	>no action-There is a twice yearly review of Establishments using SNCT data/Professional Judgement and Quality Outcomes	Corporate Senior Nurse-Workforce	14.12.23-SNCT data collection takes place January and June every year.	Ongoing	Compliant and ongoing

10. There must be no local manipulation of the identified nursing resource from the evidence based figures embedded in the evidence based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	The tool used is the NHSi recommended Safer Nursing Care Tool (Imperial Tool) which includes the Hurst Model for establishment recommendations. Data is not manipulated. The tool gives the flexibility to apply recommended ratio's of staffing for specialised areas.	>no action-no local manipulation. Only amendments are to recommended ratio which is permitted depending on national guidance for a specialism.	Corporate Senior Nurse-Workforce	14.12.23- confirmed no local manipulation and Imperial Tools with licences are in use	Ongoing	Compliant and ongoing
11. As stated in CQC's Well led Framework guidance (2018) 6 and NQB guidance, any service changes, including skill mix changes must have a full quality impact assessment (QIA) review	QIA process is available and in use for large scale change but Corporate Nursing do not currently have sight of Divisional QIA and local risk assessments	>no action- process for sharing QIA and Divisional risk assessments re staffing are in place for daily operational changes. These are shared with CNO when requesting temporary amendment to staffing.	Corporate Senior Nurse-Workforce	14.12.23- daily operational QIA and Risk Assessments in place. Service change QIA and RA are part of Business Cases shared with Execs.	Ongoing	Compliant and ongoing
12. Any redesign or introduction of new roles (including but not limited to Physician Associate, Nursing Associate and Advanced Clinical practitioners) would be a service change and must have a full QIA	QIA process is available and in use for large scale change but Corporate Nursing do not currently have sight of new role QIA's automatically	> process for sharing QIA and New Roles risk assessments re staffing to be developed for transparency and reference. Corporate Senior Nurse for Workforce will liaise with HR Workforce Lead re New Roles Group	Corporate Senior Nurse-Workforce	14.12.23- process to be designed and consider recommencing new roles group	Apr-24	On track
13. Given day to day operational challenges, we expect Trusts to carry out business as usual dynamic staff risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments	There are mechanisms in place for dynamic planning and review of staffing. Twice daily approval meetings happen across the hospital which include a review of staffing in our Community based setting. Escalation processes are in place and in times of extremis we have a mechanism for deploying the 'staffing hub' which is a central control room for staffing management. The site is risk assessed during the twice daily meetings and decisions taken to redeploy, work differently, escalate staffing demand where is impacting quality. There is consideration to Red Flags/Acuity/Enhanced levels of care during these meetings and not a singular focus on staffing numbers.	>no action -practice embedded	Corporate Senior Nurse-Workforce	14.12.23- process embedded	Ongoing	Compliant and ongoing

14. should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue,(and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example wards , beds and teams, realignment, or a return to the original skill mix	Business continuity plans are enacted where required. Example- Covid19 response. Updates to the actions taken and escalations of concern are included in the Nurse Oversight Report. Information is shared across sub committees in both the Quality, People and Financial work streams.	>no action -practice embedded	Corporate Senior Nurse-Workforce	14.12.23 process embedded	Ongoing	Compliant and ongoing

Walsall Healthcare NHS Trust

Report for Public Trust Board – to be held in Public 14 February 2024		
Title of Report:	Maternity Services Report	Enc No: 8.8
Author:	Jo Wright Director of Midwifery, Gynaecology and Sexual Health josellewright@nhs.net	
Presenter/Exec Lead:	Jo Wright Director of Midwifery Gynaecology and sexual Health Lisa Carroll Chief Nursing Officer	

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

Recommendations:

The Board is asked to note the contents of the report and in particular the items referred to the Board for CNST Year 5 evidence, oversight and discussion.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description and Risk Number 2245 Maternity Service Staffing Risk Score 16, 2257 Can not implement full CoC model with current staffing 15		
Changes to BAF Risk(s) & TRR Risk(s) agreed	NONE Risk Description Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	Revenue: Capital: Workforce: Ockenden Phase 2 & 3 Business case Funding Source:		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details:
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	Authors: Please note that In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	YesxNo☐	Date:26.01.2024
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- The Trust was able to maintain 1:1 care in labour and the coordinator has been supernumerary at all times.
- Maternity Vacancy is lower than the regional and national average.
- Delivery Suite Coordinator has been supernumerary throughout December 2023
- Maternity Outreach Service supporting local communities.
- Maternity Safety Champion Walks are embedded.

Advise

- There have been 3 cases of perinatal mortality in January.
- No cases eligible for MNSI and there were no PSIRIF cases.
- Perinatal Equality Surveillance Dataset is reviewed.
- Maternity Support Worker Vacancy is currently

.

Alert

- Working with the LMNS and Public Health England to reduce smoking cessation.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Brief/Executive Report Details

Maternity Services Report This report will provide a concise update regarding the on-going position on the elements cited.

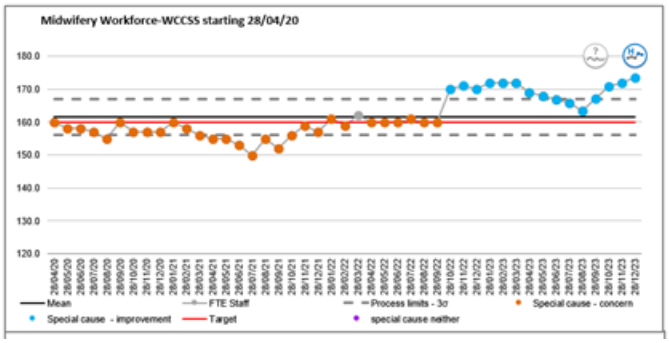
1.0 Growing and Retaining our Workforce: Maternity Workforce update

1.1 The service currently has 7 WTE midwifery vacancy which are now out to recruitment.

Maternity Services fill rates	RM Day	RM Night	RM Day	MSW Night
Ward 24/25	100%	100%	60%	53%
Ward 27	99%	95%	95%	91%

There is a 4.68 WTE band 2 and 3 vacancy, short listing has been completed for 3 WTE band 3 roles within this, the service will also be recruiting to a 3 WTE apprenticeship roles. The acuity for January was 71% which has been lower than previous months this has been due to winter sickness and the small vacancy we currently have. The birth to midwife ratio 1:28 against a target of 1:28. No adverse incidents have been identified via Safeguard incident reporting system linked to shortfalls in midwifery or MSW staffing.

	Leave	Sickness	Working day	Study day	Parenting	Other	Total
Registered Midwives %	32%	19.18%	5.1%	8.78%	14.11%	1.75%	13.48%
Unregistered staff %	26.35%	23.73%	0%	5.51%	0%	1.74%	9.5.4%



National and regional midwifery vacancy figures

National	7.5%
Regional	7.4%
Trust	6.0%

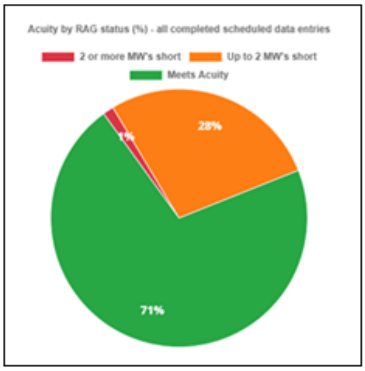
Midwifery recruitment and retention has continued to be successful and currently WHT vacancy rates are amongst some of the lowest in the country.

Staffing factor	Number	%
Unexpected MW absence/sickness	37	41%
Unable to fill vacant shifts	37	41%
MW redeployed to other area	11	12%
Support staff less than rostered numbers	6	6%
Total	91	100%

Clinical actions	Number	%
Delay in commencing IOL as per Trust guidelines	3	7%
Delay in continuing IOL as per Trust guidelines	41	93%
	44	100%

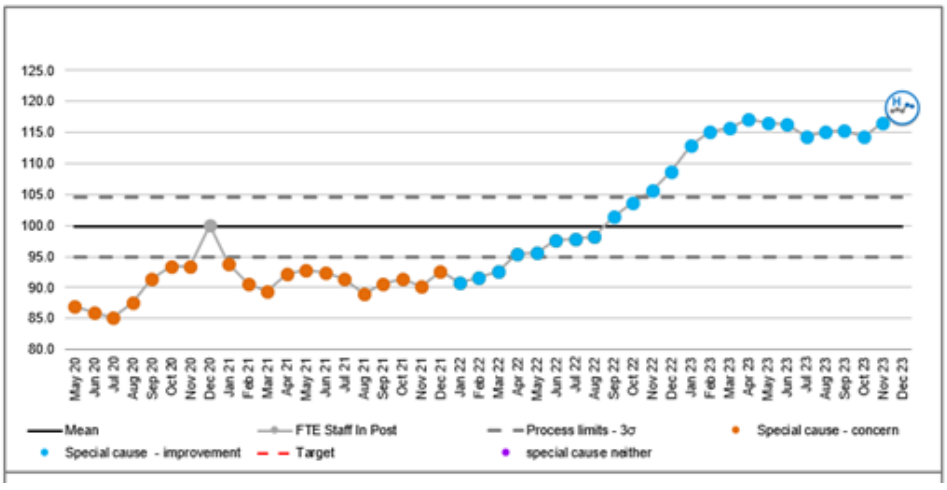
Management action	Number	%age
Redeploy staff internally	15	37%
Staff unable to take allocated breaks	9	22%
Escalate to manager on call	9	22%
Staff stayed beyond rostered hours	4	10%
Specialist Midwife working clinically	3	7%
Manager/Matron working clinically	1	3%
	41	100%

Red flags	Number	%
Delayed or cancelled time critical activity	24	96 %
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)		
Total	23	100%

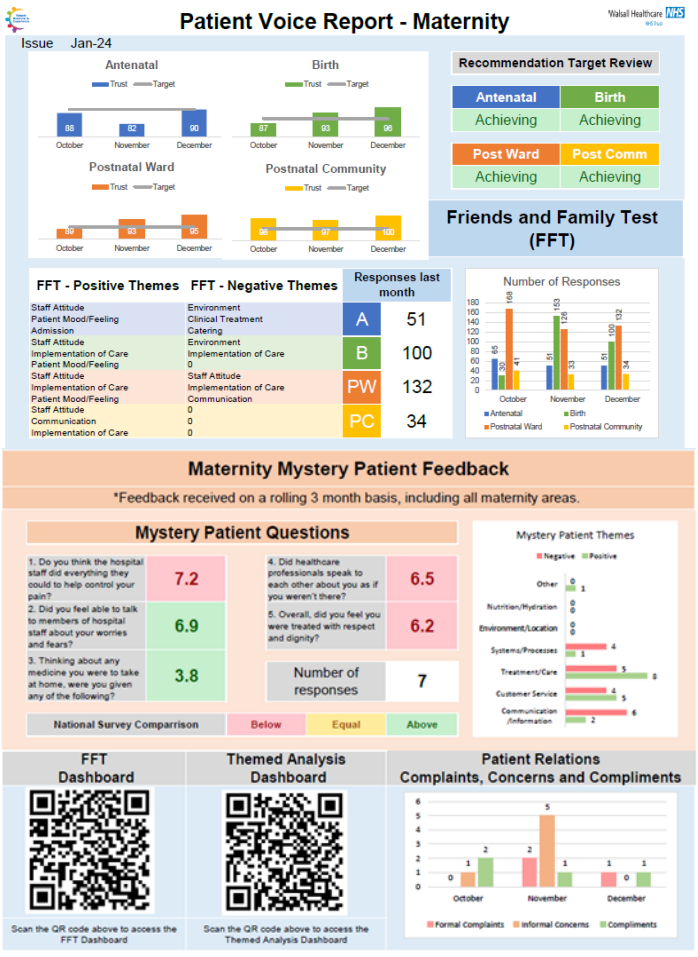


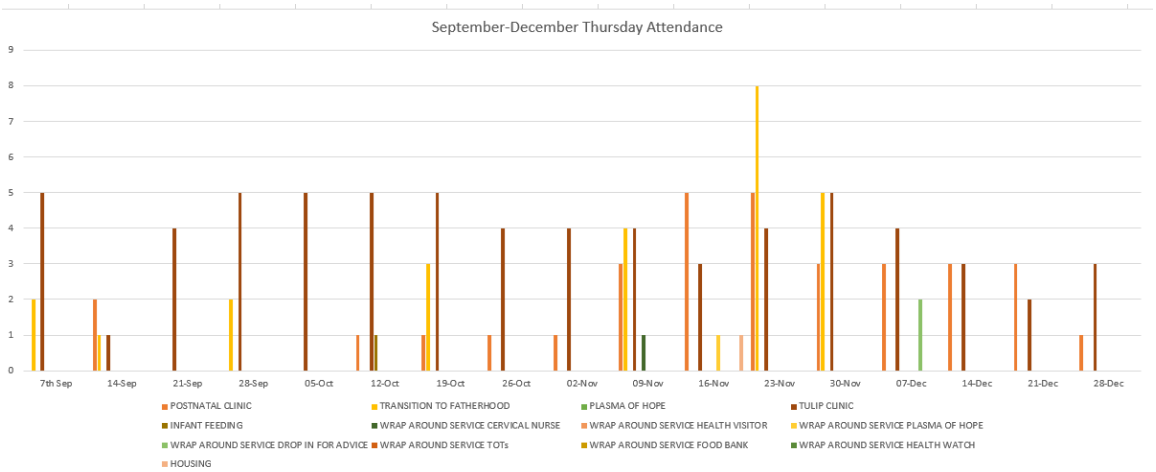
On occasions when the wards and delivery suite were at levels of high acuity the correct escalation procedures were activated, staff were redeployed, and the on-call maternity manager called. There were 23 occasions where red flags were triggered. The shift coordinator was supernumerary at all times and 1:1 care in labour was maintained 100% of the time.

Medical Workforce

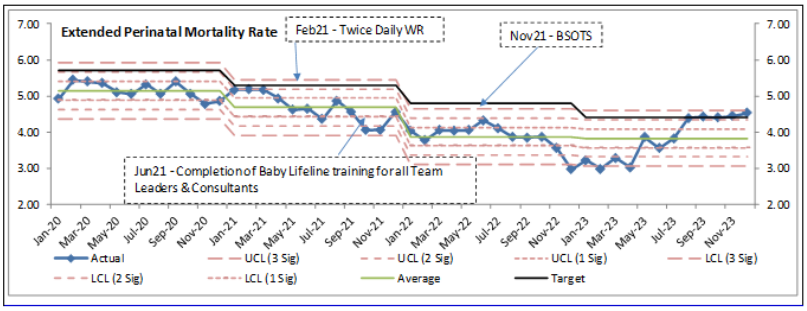


Obstetric rota's are covered with the required staffing levels. The delivery suite has the RCOG required consultant cover as per guidance. Any rota gaps are covered with internal temporary staffing, with locums, Consultant colleagues acting down.

	Neonatal Nursing Workforce In Q3 2023/2024 the Neonatal Unit has surpassed national average in relation to BAPM compliance with 82% of shifts staffed to BAPM recommendations ensuring safe delivery of Neonatal care. An area that is being targeted is QIS (Qualified in Speciality) nursing which is a national pressure in all Level 2 and 3 Neonatal units. Currently there is an ongoing rolling education programme at Keele University which supports Band 5 NNU nurses with an expected trajectory to meet compliance by April 2025. With a current sickness and maternity leave absence of 18%, the service is impacted by rota gaps that are mitigated using internal bank staff and via agency use. This is monitored via daily Senior Nurse reviews, 7 days a week across the Paediatric and Neonatal Care Group. Despite rota pressures, safe staffing has been maintained and there has been no harm incidents as a result of poor staffing reported within Neonates. At present Neonatal Nursing has 1.61 WTE vacancies, with 2 band 6 QIS/NICU trained roles out to advert closing date 18/1/2024. More recently, Neonates have successfully received recurrent national funding from the West Midlands Perinatal Operational Delivery Network to allow recruitment into x2 specialists roles; a governance manager and a Practice Education Facilitator.
2.0	**Listening to, and working with, women and families with compassion**
2.1	The patient experience with maternity continues to be a priority with the majority of wards meeting the response rate. All areas are meeting the 95% feedback Trust compliance target. 

2.3	The maternity outreach service continues to be a success with 287 service users being seen in Q3 2023/24, 86% of which were from a black or ethnic minority group. Services offered included clinical care, transition to parenting, social support, multi-agency and multiprofessional support and housing services. There were also 66% of women seen from WS1 and WS2 areas of Walsall, which are the most deprived areas of the region. This service has evaluated well with service users and staff alike. 
2.4	**Maternity specific data** NICE guidance currently specify that women should be booked by 10/40 weeks. Currently booking at 10/40 is 54% against the national average of 65%, this is an improvement on 42% in April 2023. To gain assurance that WHT is meeting compliance the fields on BadgerNet where the data is extracted were reviewed. This revealed that bookings up to 10+6/40 were being included which was incorrect booking should be included at only 10/40 and under. BadgerNet have been contacted and they have agreed to reduce the input field to exactly 10/40.
2.5	**Smoking in pregnancy** Women are carbon monoxide (CO) tested during pregnancy and those who smoke are tested at each appointment and if they have a CO reading > 4ppm are referred to the HIPs smoking cessation team. CO monitoring is currently being completed for 97% of women at booking and 91% of women at 36/40. When analysing progress with smoking cessation, WHT has reduced rates of smoking post delivery from 25% to 11% since January 2022. To support this work further WHT has met with the regional perinatal team, the LMNS and West Midlands Public Health teams to gain further support as post delivery rates have seen no further decrease.
3.0	**Standards and structures that underpin safer, more personalised, and more equitable care.**
3.1	Births within the service remain consistent, at around 300 births per month. The service is meeting with RWT to repatriate 30 births per month to Walsall Health Care NHS Trust. Of the 288 births in December (January not available at time of writing report) 32% were to women of Asian or Black heritage and 62% were in the 1st and 2nd Decile of the IMD, meaning the WHT support some of the most deprived women in the country. 
3.2	**Perinatal Mortality**

MBRRACE Report 2023 has revealed that perinatal mortality has increased from 4.4:1000 to 5.19: 1000 nationally. At WHT between April -September 2023 the stillbirth rate has increased from 2.72: 1000 in April to 3.87:1000 in December 2024. The Perinatal Mortality Rate has increased from 3.03: 1000 to 4.4:1000.



There have been three cases of perinatal mortality in January 2024 two of which have been reviewed and found to be unavoidable. A third case has been identified which may have potential care issues and is currently undergoing a multidisciplinary team concise investigation under governance process. There is ongoing work around cost of living and the impact this is having on women and their families. The Maternal Medicine service is working well and there is a monthly MDT. This is attended by Obstetric physician; anaesthetist and we have specialist inputs from different specialities. There is the capability and capacity to manage specific maternal medicine cases at WHT. As part of the LMNS and latest Ockenden recommendation, any expert opinions needed are referred to the local Maternal Medicine network and we have an extensive MDT with inputs from the Birmingham Women's Hospital and Queen Elizabeth Hospital. The Standard Operating procedure for maternal medicine has been updated and we have invited the regional maternal medicine team to visit our services.

3.3 **Maternity and Newborn Safety Investigations (MNSI formally HSSIB).**

From 1 October 2023, the Maternity and Newborn Safety Investigations (MNSI) programme is being hosted by the Care Quality Commission (CQC). There have been no cases sent to MNSI for December. However the organisation has received 5 completed reports for cases that occurred between December 2022 to July 2023. The reports and recommendations are currently being reviewed.

3.4 **Saving Babies Lives Care Bundle ver 3**

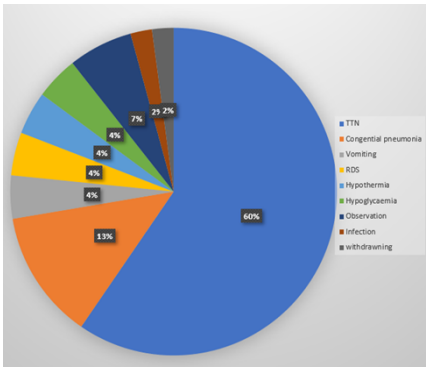
There are 10 Safety Actions as part of CNST, Saving Babies Lives Care Bundle is Safety Action 6. We are required to demonstrate implementation of 70% of interventions across all 6 elements and implementation of at least 50% of intervention in each element. This percentage will be calculated within the national implementation tool WHT has achieved the minimum 50% in each element with an overall compliance of 70% across the 6 elements.

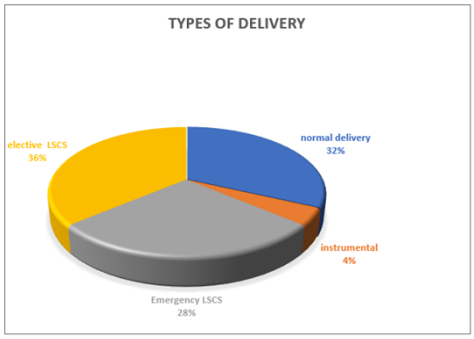
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	89%	CNST Met

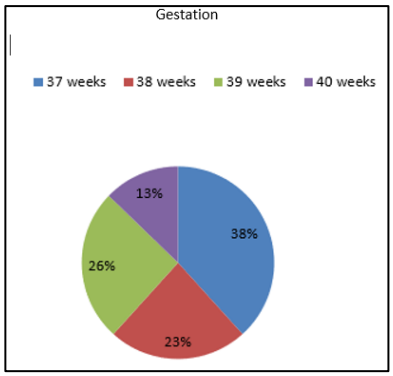
3.5

Avoiding Term Admissions to Neonatal Unit (ATAIN)

The number of admissions for this quarter is 47 babies and the total percentage admissions for this Q3 is 5.25 **%** which is slightly above the national target of **5%**.







All cases of term (>37/40) are reviewed by the perinatal team, the largest reason for babies going to NNU remains transient tachyphemia of the newborn (TTN). Our local tertiary unit has commenced short term high flow oxygen on the maternity unit and postnatal ward to reduce separation of mother and baby. Feedback from our Walsall neonatal team is that babies that have respiratory concerns after delivery, instead of having low threshold to go to NNU instead have an ANNP/SHO/registrar use PEEP for up to 30 minutes and then re-assess. The neonatal team are scoping the possibility to commence this at WHT.

4.0 **Developing and sustaining a culture of safety, learning, and support**

4.1 **Maternity services have been engaging in work to enhance culture with the service.**

The Perinatal Culture & Leadership Development Programme is designed for the perinatal quadrumvirate, or 'QUAD, group of senior leaders from each site in the organisation (including senior midwifery, obstetric, neonatal, and operational representation) to attend together. The first meeting from the QUAD at WHT has been attended and this is a year long programme. The QUAD also meet with the board level maternity safety champions monthly to discuss any the service and provide support with any ongoing concerns identified. The QUAD and the board level champions also undertake safety walks on a monthly basis within the clinical area where service users and staff have an opportunity to discuss successes and challenges within the service.

4.2 **Perinatal Equality Surveillance Dataset**

Provides a format whereby perinatal data is collated in the same space to better see trends in variables that impact on staff and data (see attached). The data set also allows the service to triangulate data to analyse trends and themes. Previously this was presented throughout the entirety of the Trust Management, Quality Committee and Trust Board Reports the format has moved to a single spreadsheet to support review of the service as a whole.

Item	Number	Themes
Claims	0	
Formal Complaints	1	Communication
Moderate Incidents	7	Haemorrhage, out of area Neonatal Death, Allergy to Medication

Walsall Healthcare NHS Trust

Trust Board Meeting – to be held in Public On 14th February 2024		
Title of Report:	Chief Medical Officer Report	Enc No: 8.9
Author:	Dr Manjeet Shehmar – Chief Medical Officer manjeet.shehmar@nhs.net	
Presenter/Exec Lead:	Dr Manjeet Shehmar – Chief Medical Officer manjeet.shehmar@nhs.net	

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

Recommendations:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or approval.

Implications of the Paper:			
Risk Register	Yes ☒ No ☐ Risk Title: 2439 *CYP Mental Health quality of care Score 12* 2581 *CYP Mental Health delays in access to Tier-4 bed score 12* 3002 *Adult Mental Health quality of care score 16* 2737 *Trust-wide: Medicines Management* score 12 3012 *360 whole practice appraisals and medical governance* score 4 3078 *Reputational and financial damage due to adverse publicity score 6* 3238 *Trust-wide: Trust guidelines score 6* 3031 Non-patient safety issues within the HEE Improvement Plan Score 9 3347 *Temporarily suspension of manufacturing of intravenous chemotherapy and monoclonal antibodies by the Pharmacy Department impacting cancer treatment provisions*		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	Workforce: Costs for pharmacy workforce business case		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well led, responsive, effective, caring
	NHSE	Yes☒No☐	Details: Specialised Commissioning
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☒No☐	Details: Responsible Officer Regulations
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☒No☐	Details: GMC, ICS
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
Equality and Diversity Impact	NA		

Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: TMC Sept 2023, MMG Sept 23
	Board Committee	Yes☒No☐	Date: F&P Sept 23, QPES Sept 23
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☒No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- The most recent published SHMI value for the 12-month rolling period (published by NHS Digital September 2023 for the period August 2022 to July 2023) is 0.9933 which is within the expected range (this relates to the acute Trust excluding palliative care). Please note - this is the most up to date data available at the time of writing the report. HMSR for this period is lower than the national average (98.61) and continues to show a steady reduction. The Trust has no current Preventing Future Deaths Notices
- During July - December 2023 there was 57 Mental Health Act Assessments. Following the Mental Health Act Assessments, 8 patients were detained to WHT with the remainder to Mental Health Trust Beds or discharged home.
- There have been no deaths of patients held under the Mental Health Act in the Trust.
- The Trust continues to manage Safety alerts in line with Trust policy.
- 1 National Clinical Audit outcomes has been released in Q2 – No actions required all standards were met

Advise

- 62% of GPs are now signed up to the community ME process. All remaining GP practices have been contacted and provided with Data Sharing Agreement to ensure process in place before April 2024.
- A pharmacy establishment business case has been approved in principle and requires ICS review for investment. In the meantime, temporary staff have been deployed to cover key areas of the service. Joint Business Continuity Plan for aseptics being developed by Black Country Chief Pharmacists
- Recruitment and career progression of staff continues in pharmacy.
- Off contract medication purchases and biosimilar cost efficiencies are being reviewed.
- The annual Controlled Drug Accountable Officer Report has been received by MMG and can provide assurance against the standards set out under Statutory Instrument 2013 no.373 “The Controlled Drugs (Supervision of Management and Use) Regulations 2013.”
- 78% of the NICE issued in Q2 have been clinically reviewed for applicability and work continues to address
- In a small number of audits there is concern over participation / data submission / case ascertainment

Alert

- WHCT does not have a clear roue to a Responsible Clinician as part of the Mental Health Act which is a requirement to meet CQC mental health provider status.
  Escalation has been made to the ICS of this risk and the CMO has met with executives from BC MHT to address.
- Mental health liaison team do not have a full-time consultant psychiatrist and are reliant on locum section 12 approved psychiatrists again being addressed by CMO discussions with escalations.
  The number of outstanding SJRs for the period of this report is 27, which is consistent with the previous report, however this is expected to reduce as a new process for community division SJRs has been agreed and reviewers are being trained. There is also a new lead for surgery who is currently reviewing the backlog.
- Currently the aseptic unit at WHT does not meet the specific requirements to manufacture chemotherapy therefore, this activity has been suspended on a temporary basis.

This is being reviewed on an ongoing basis based on microbiology results and the air handling unit performance. The Chief pharmacist has taken on the role of the accountable pharmacist in the interim.

- Medicine reconciliation levels remain at have reduced over the past month due to staffing issues and are still below 60%. These continue to remain low due to the under establishment of pharmacy staffing,
- Aseptics workforce capacity- is over capacity- staff are being recruited to support this.
- Bank and agency spend has seen an increase over the past two months due to increased capacity wards opening and winter pressures.
- Delay in obtaining the Home office controlled drugs licence due to delays with the home office.
- There is no “responsible Clinician” assigned to the organisation and this is a requirement to meet CQC mental health provider status.
- Mental health liaison team do not have a full-time consultant psychiatrist and are reliant on locum section 12 approved psychiatrists.
- Reviewing and responding to National Audit Reports remains a concern in WHT with only 50% of reports issued being reviewed and a GAP analysis being completed, there is a focus to address.

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

Walsall Healthcare NHS Trust

Chief Medical Officer Report

Report to Trust Board Meeting to be held in Public – 14th February 2024

EXECUTIVE SUMMARY

This report summarises the key highlights of the Chief Medical Officers' portfolio. This includes quality, learning from deaths, medical workforce, mental health, medicines management, medical professional standards, research & development and medical education.

1.0 Upper Limb Surgery Patient Recall

A separate paper has been submitted for discussion and decision.

2.0 Controlled Drugs Accountable Officer Annual Report

- The responsibility for medicines management within the Trust rests with the Chief Medical Officer with delegated responsibility to the Chief Pharmacist who is also the Controlled Drugs Accountable Officer (CDAO) for the Trust.

- The legal accountability for the management of controlled drugs within any designated body providing healthcare services is described by the Statutory Instrument 2013 no.373 "The Controlled Drugs (Supervision of Management and Use) Regulations 2013." The Statutory Instrument (SI) requires that NHS Trusts appoint a designated Controlled drugs Accountable Officer (CDAO) and that this is notified to the CQC who maintain a national register of CDAOs. At Walsall Healthcare NHS Trust the CDAO is Sonia Chand Chief Pharmacist.
- The statutory responsibilities of the CDAO are set out in the SI and include:
  1. To establish and operate arrangements for the safe management and use of controlled drugs and regularly reviews those arrangements.
  2. To establish appropriate arrangements for the monitoring and auditing of the management and use of controlled drugs.
  3. To ensure that staff involved in the handling and use of controlled drugs are performing to an agreed standard.
  4. Where staff are not performing to an agreed standard - to determine if incidents require investigation, investigate, and to take appropriate action with regard to well-founded concerns.
  5. To provide to the Regional CDAO a quarterly occurrence report providing details of concerns or declaring that there are no concerns.

  Regular controlled drugs audits are carried out via Tendable and reported to MMG and Patient Safety Group. The most common themes in relation to controlled drugs are a failure to follow process; these incidents relate to poor record keeping, which gives rise to discrepancies, and incorrect doses being administered. Another theme is CDs not being delivered or ordered in time for administration. These are addressed at local level.

It is important to note that whilst there are a low number of harm incidents, those which relate to discrepancies are almost always classified as "no harm," whereas the nature of the discrepancy itself may be of significance. In many instances, the discrepancy can be explained upon investigation, there has been one instance where the advice of the West Midlands Police was sought. The West Midlands Police were invited to visit this area and identified that the ward area did not meet the legal requirement to hold controlled drugs. The ward has since then ordered the correct cabinets for controlled drugs storage.

Where an individual has made an error in relation to a controlled drug, this is reported to their professional line manager. The individual is required to complete a reflection on the incident. Further education and training are offered depending on the nature of the incident.

A breakdown of CD incidents by harm categorisation for the year 2023 up to and including 14/12/23

Level 5 - Fatal	0
Level 4 - Severe harm	0
Level 3 - Moderate harm	0
Level 2 - Low harm	1
Level 1 – No harm	43
Level 0 – Near miss	13
Total	58

3.0 Medicines Management

- The Trust has had to temporarily suspend the manufacture of intravenous chemotherapy and monoclonal antibodies within the Pharmacy aseptic suite whilst the associated quality assurance process is reviewed. As a result of this, the aseptic unit are now purchasing these products from external suppliers which means the aseptic team require prescriptions with doses five days in advance of the expected treatment date.

  Pharmacy will continue assessing the potential risk to any delay of treatment or any proposed changes in chemotherapy regime within the five days of treatment. In addition, a risk has been added to the risk register 3347.

- Funding has been secured for the electronic patient record which includes electronic prescribing.
- Culture and Civility training is being implemented through the Medicines Improvement Programme
- E- Learning for health – Prescribing module: Target 90% Compliance 86% ↑6%
- Annual awareness CD training: Target 90%; Compliance 59% ↓6%
  Drug chart video: Target 90%: Achieved 95% ↑1% from previous month (October 23).

- Ward storage audits continue to be conducted across the trust via the Tendable platform. A total of 97 weekly audits have been conducted across the divisions in November. Average 96% ↑0.5%compliance. See f*ull details within section 8.1 of the report.*
  CD audits completed by pharmacy: 9 audits, average compliance 72.3%.
  Areas requiring improvement: CD Register documentation, receipt of controlled drugs, signing twice daily CD checks. *See full details in section 8.2 of the report.*

  Current risk score has been reduced to **12** Severity x4 Likelihood x3. Forecasted risk score for this month will remain the same. The corporate risk was reduced as per planned trajectory end of September 2023.

4.0 Learning from Deaths

- A thematic review of stillbirths and neonatal deaths for the period May to July 2023 was completed on 24th August 2023. Issues identified included; increase in pre-eclamptic mothers. In view of the further increase in stillbirth rates following this review, an external review was recommended and supported by LMNS. The Divisional Director to identify external reviewer for perinatal cases. Improvemnet actions have been agreed including the dissemination of learning.

- Learning from the Disabilities Review of Deaths Report is being addressed via the BC ICS. Locally there is focus on aspiration in people with learning disabilities.
- Number of completed SJRs with scores of 1-3a Q3 rate 1.1%

5.0 Outlier alert: Colorectal Cancer

- The colorectal improvement programme continues on track with better sight through a clinical outcomes dashboard showing positive movement.
- The CMO office leads an improvement group to understand and address the actions required to improve clinical outcomes. Focus is needed on medical workforce establishment following concerns around educational opportunities and rota issues which prioritise on call and ward cover.

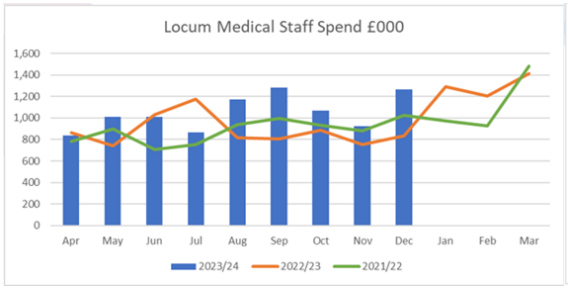
Cancer - Resections/ Colostomys/ Other colorectal cancer surgery											
	NBOCA-National Average published July 2023	Figures presented by project team 01/01/2022 -31/05/2023 (Based on only major resections)	surgery 01/05/2023 - 31/07/2023	Varience	surgery 01/06/2023 - 31/08/2023	Varience	surgery 01/07/2023 - 31/09/2023	Varience	surgery 01/08/2023 - 31/10/2023	Varience	surgery 01/09/2023 - 30/11/2023
Proportion of patients having emergency surgery	14%	39.20%	68.75%	-5.59%	63.16%	-15.54%	47.62%	-9.78%	37.84%	-4.50%	33.33%
Adverse event rate following elective colorectal surgery		14.50%									
Adverse event rate following elective rectal surgery		29.40%									
Length of stay >5 days	<60%	73.40%	71.88%	1.81%	73.68%	-2.26%	71.43%	-3.86%	67.57%	-4.23%	63.33%
30-day post-op mortality	1.70%	6.30%	3.13%	-3.13%	0.00%	0.00%	0.00%	2.70%	2.70%	0.63%	3.33%
90-day post-op mortality	2.80%	10.90%	6.25%	-6.25%	0.00%	4.76%	4.76%	8.75%	13.51%	6.49%	20.00%
30-day readmission excluding 0 days LOS	12.50%	14.10%	12.50%	11.18%	23.68%	2.51%	26.19%	6.24%	32.43%	-2.43%	30.00%
30-day readmission including 0 days LOS		21.90%	25.00%	14.47%	39.47%	-1.38%	38.10%	-0.26%	37.84%	-7.84%	30.00%
30-day unplanned return to theatre (URTT)	<6.8%	6.30%	6.25%	-3.62%	2.63%	2.13%	4.76%	0.64%	5.41%	1.26%	6.67%
Ileostomy formation rate at time of anterior resection		56.70%	25.00%	15%	40.00%	5.45%	45.45%	-1.01%	44.44%	-6.94%	37.50%
Trust rectal cancer surgical volume		20	8	-	10		14	-	12	-	9

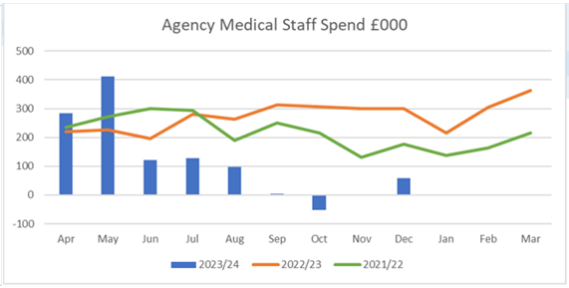
6.0 Medical Workforce

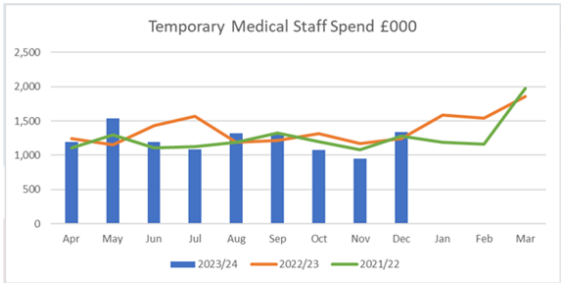
Temporary spend on medical staffing are overspent by (£8,812k) YTD, driven by Locum Bookings (£8,420k) and Agency Bookings (£1,150k). Overall spend on Medical Staffing is overspent by (£8,812k) which the rest of the position not made up of temporary staffing is related to Strike bookings, (£611k) offset by Medical vacancies, (£759k).

Main drivers for bookings against Agency and Locums relates to:

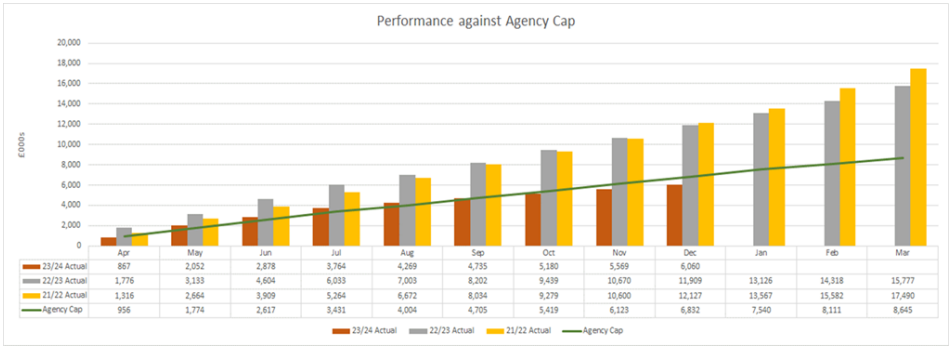
- Vacancy Bookings over and above agreed budgets (£4,618k YTD, £280k in month)
- Demand Bookings (£1,561k YTD, £116k in month)
- Sickness (£731k YTD, £79k in month)
- Strike Bookings (£611k YTD, £60k in month)







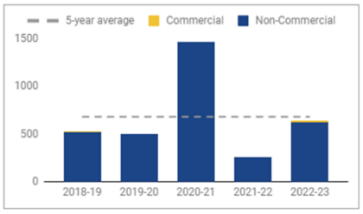
Performance remains below the agreed agency cap with stronger sign off processes.



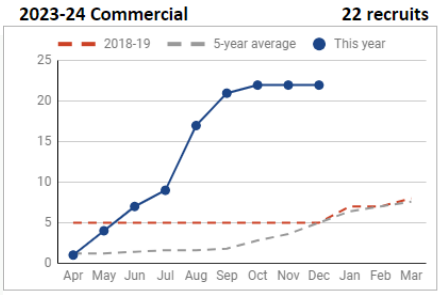
7.0 Research and Development

Aseptic pharmacy support for research studies currently on hold, working in collaboration with the Director of Pharmacy to rectify this issue, non-aseptic pharmacy support has been rectified.

We currently have a good variation in specialities undertaking research. Diversity of studies now expanding with new Principle Investigators identified in Rheumatology, Urology and ENT. Recruitment to commercial continues to improve across specialties with more contacts for support made to the R&D team.

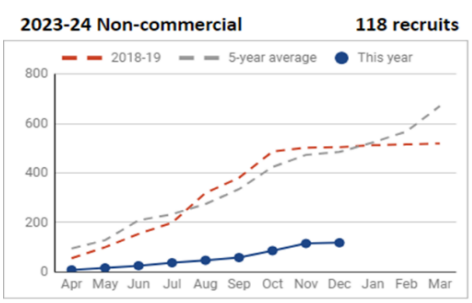


Average 679 per annum



2018-19	8
5-year average	8

Pro rata to end of last month
340% ahead of 2018-19
511% ahead of 5 year average



2018-19	520
5-year average	672

Pro rata to end of last month
77% behind 2018-19
76% behind 5 year average

8.0 Mental Health

There is no formal process or agreement in place that supports the 'Responsible Clinician' (RC) under the MHA. This is a direct requirement for any patient detained, predominantly under section 3 MHA for 'treatment'. Without a RC the organisation would not be complying with the regulations of the MHA and code of practice. The CMOs from the Black Country Acute Trusts have met positively with the interim CMO Mental Health Trust to address.

Approved Clinicians and Responsible Clinicians (AC/RC)

An approved clinician is a mental health professional approved by the secretary of state or a person or body exercising the approval function of the secretary of state. Some decisions under the Mental Health Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

WHCT has not yet signed a MOU with the MHT due to ongoing discussions around the RC and appropriate cover to meet the requirements of our patients for Core 24 and older people.

The Trust still has risks around mental health which have been formally escalated to the ICS. Those mitigations that are within our control have been implemented and are reviewed via patient safety group in the monthly Mental Health Report.

RECOMMENDATIONS

To note the contents of the report.

Reading Room Information/Enclosures

- Medicines Safety Officer (MSO) Report
- Chief Pharmacist Report
- Controlled Drugs Accountable Officer (CDAO) Report
- Safe High Quality Care Report
- Reduction in Temporary Medical Staffing Spend Report
- Research & Development Report
- Learning from Deaths Report
- Mental Health Report

NHS
Walsall Healthcare
NHS Trust

Paper to the Public Trust Board – to be held in Public on 14th February 2024		
Title of Report:	**Medication Safety Officer Report**	Enc No: 8.9.1
Author:	Dr Sonia Chand/Monique Sinclaire	
Presenter/Exec Lead:	Dr Sonia Chand: Interim Director of Pharmacy	

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

Recommendations:

The Trust Board are asked to note the contents of the report and in particular the items referred to the Board for approval.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Risk of actual or potential patient harm, Trust reputational damage, and breach of Regulatory Compliance, due to; gaps in acceptable practice in relation to storage, prescribing and administration of medicines, which were not prevented as a result of clinical practice falling below the required standards. On Risk Register: Yes☒No☐ Risk Score (if applicable): 12		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☒No☐	Details: Controlled drugs
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

Walsall Healthcare NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert

Assure

Medicines Management Improvement Group (MMIG)

- Medication error policy: This will be a WHT policy, no longer a joint policy with Royal Wolverhampton Trust. Draft policies have been disseminated; comments are being collated.

Medicines Management Training

- E- Learning for health – Prescribing module: Target 90% Compliance 87% ↑1%
- Annual awareness CD training: Target 90%; Compliance 57% ↓2%
- Drug chart video: Target 90%: Achieved 95% remains static.

Ward Storage Audits

- Ward storage audits continue to be conducted across the trust via the Tendable platform. A total of 96 weekly audits have been conducted across the divisions in December Average 96% compliance remains static. See f*ull details within section 8.1 of the report.*

Controlled Drugs audit

CD audits completed by pharmacy: 7 audits, average compliance 86% ↑14%.
Areas requiring improvement: CD Register documentation, receipt of controlled drugs, signing twice daily CD checks is a consistent theme across theatres for the month of December. *See full details in section 8.2 of the report.*

Medication Safety Officer (MSO)

New MSO is due to start in February 2024. Currently, the Interim Chief Pharmacist is the MSO.

Risk Register

Current risk score has been reduced to **12** Severity x4 Likelihood x3. Forecasted risk score for this month will remain the same. The corporate risk was reduced as per planned trajectory end of September 2023. Care groups and Divisions continue to update their risk registers accordingly.

Advise

Medication error Incidents: Total of 117 incidents were reported in December 23 a decrease of 7 incidents reported as per previous month (Nov 23). See sections 1-2 of report for full details and themes of incidents per division.

Trust wide Safety index

The total number of incidents reported by Walsall Healthcare Trust is below the national average therefore, this elevates the percentage harm for the trust. WHT report 19% a decrease of 5% as per previous month. (National average: 11.69%).

CAS Alerts: See section 6.

Alert

Pharmacy Outpatients

From Monday 19th January 2024 the outpatient pharmacy will close. All outpatients' medicines will be dispensed from the main pharmacy.

Sodium Valproate update

Organisations are required to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.
To be implemented by the end of January 2024. Currently standard operating procedures are being developed for the prescribing, administration and dispensing of valproate. A local group will need to be set up to identify whether these SOPs are in operation and are being used to provide assurance back to the ICB.

Natpsa_2023_013_ MHRA (1).pdf

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement. • Prioritise the treatment of cancer patients. • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels. • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing. • Improve overall staff engagement. • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities

Effective Collaboration	• Improve population health outcomes through provider collaborative. • Improve clinical service sustainability. • Implement technological solutions that improve patient experience. • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Walsall Healthcare NHS Trust

Medication Safety Officer Report

Report to Public Trust Board on 14th February 2024

EXECUTIVE SUMMARY

The purpose of this report is to inform the Trust Board of the medication incidents within Walsall HealthCare NHS Trust for the month of December 2023.

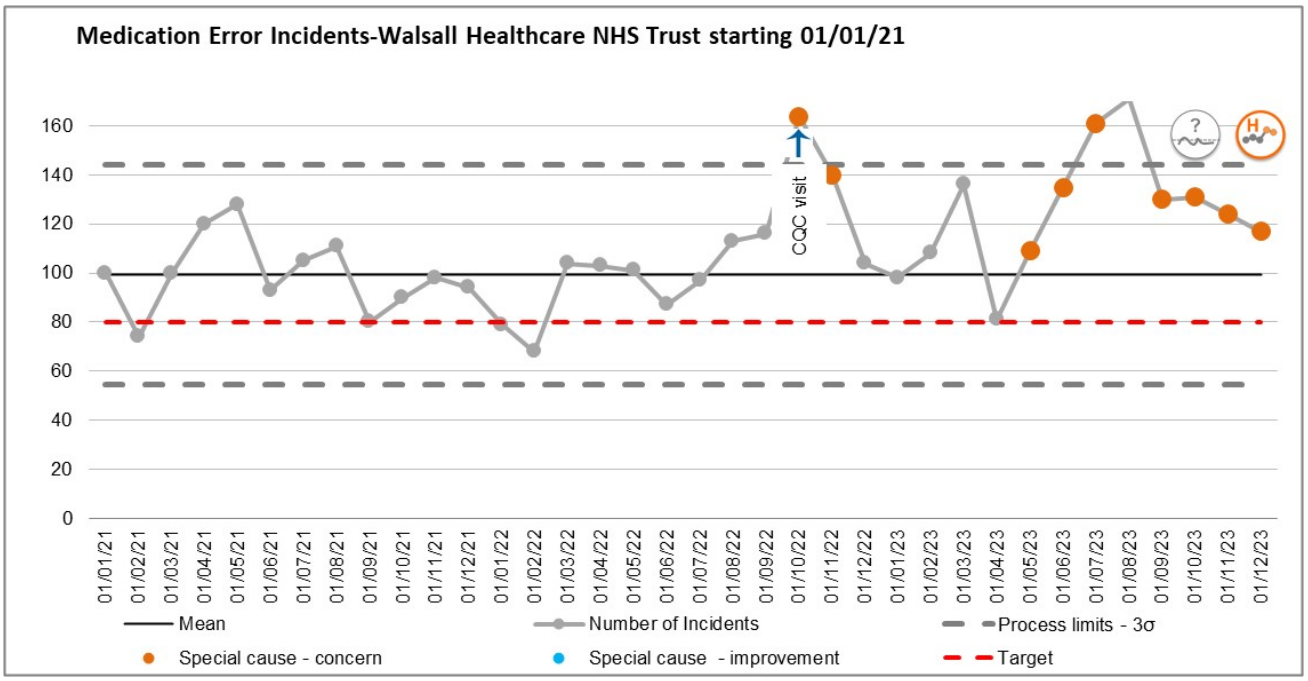
This report will provide updates on areas of concern in relation to medicines management; for the Trust Board to be cited and be made aware of issues and track progress on medicines safety.

All medication incidents are reviewed, and data cleansed by the Medication Safety Officer and pharmacy governance team to identify themes and levels of harm. The divisional medicines management teams are responsible for ensuring that the learning from these incidents is implemented.

The report details the number of incidents reported, themes, trends, learning and levels of harm to influence strategic change and improvement in the development of training and learning within medicines management and evidence divisional and care group assurance.

1. Overview of Incidents: Jan 2021- December 2023

SPC chart 1: Total number of incidents reported from 1/01/2021 to 31/12/2023.



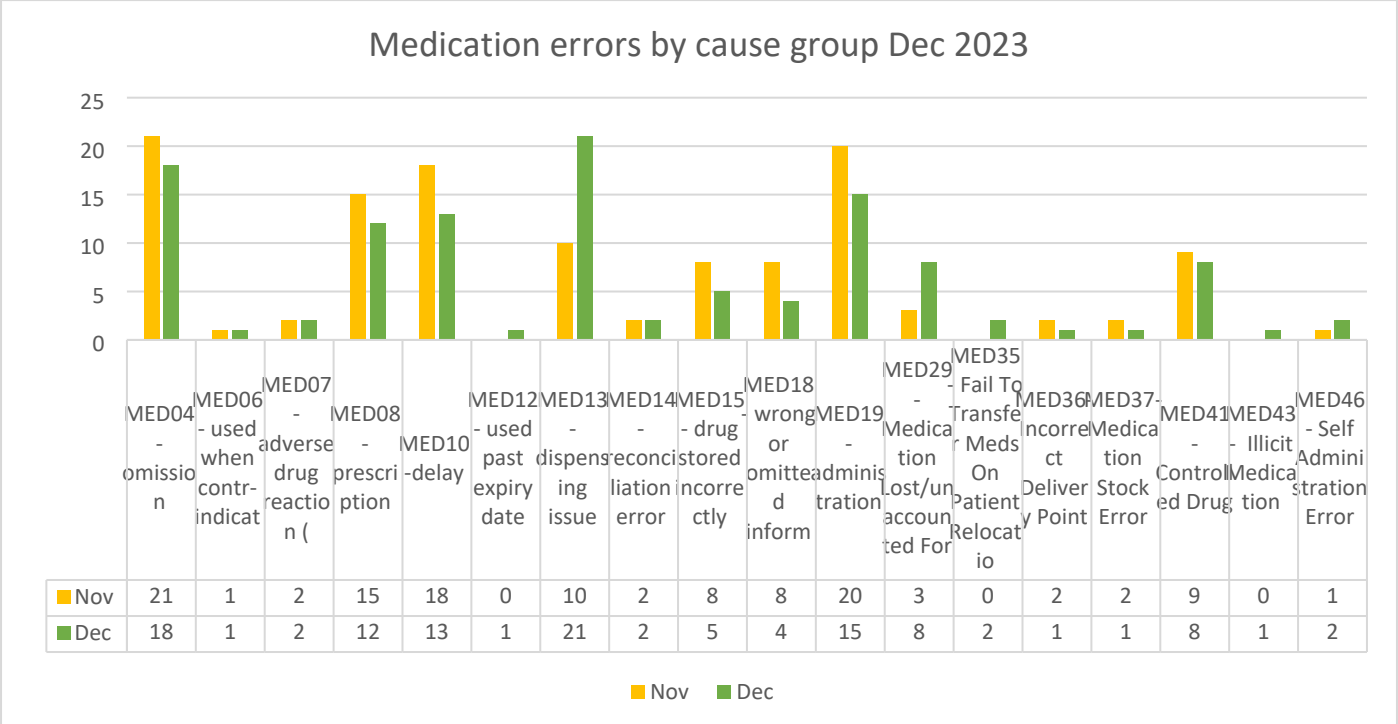
A total of 117 medication incidents were reported in December 2023. The SPC chart indicates over the last 6 months the variation remains a cause for concern. Ongoing work continues in terms of medicines management across the Trust via MMIG and Divisional Medicines Management meetings.

Table 1: Total number of medication incidents 2023

Quarter	Month	Number of incidents
1	April	81
	May	109
	June	135
2	July	161
	August	171
	Sept	130
3	October	131
	November	124
	December	117

2. Medication Error Incidents by cause groups

Dec 2023
Table 2



A total of 117 medication errors incidents were reported in December 2023. There has been a reduction in errors for omissions, prescriptions errors, delays, and administration. Dispensing errors for this month have increased, this has been escalated to the Dispensary Pharmacy Manager for review and to be discussed that the Pharmacy Error Monitoring Group.

Omission of medicines - ↓2
Prescription errors - ↓3
Medicines delay - ↓5
Administration of medicines - ↓5
Dispensing errors - ↑11

Common themes for each division are presented in sub sections 5.1 - 5.3. The actions are being managed through the divisional medicines management groups.

(See divisional reports and MSG action plans for assurance)

Table 2: Number of medication error incidents per division:

Division	April 2023	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Medicine	26	33	61	82	65	70	49	51	47
Surgery	16	18	26	37	59	23	35	21	23
WCCSS	23 NNU/Paeds=5 Maternity=3 Pharmacy=15	36 Maternity: 6 Paeds: 7 Pharmacy: 23	31 Maternity 1 Paeds: 7 Pharmacy 23	27 Maternity 4 Sexual Health 1 Paeds 3 Pharmacy 19	27 Maternity 2 Sexual health 1 Paeds 8 Pharmacy 16	23 Paeds 4 Pharmacy 16	29 Paeds 6 Women's 5 Pharmacy 18	29 Paeds 7 Women's 5 Pharmacy 17	25 Paeds 5 Pharmacy 20
Community	14	19	16	11	18	10	16	17	17
Corporate/other	2	3	1	4	1	4	2	1	3

3. Incidents: Level of harm

Table 3: Level of harm

Level of Harm	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
0- Near Miss	23	15	39	42	23	33	26	21	24
1- No harm	38	68	69	93	120	60	76	71	70
2- Low harm	18	25	26	25	26	34	28	30	21
3- Moderate harm	2	1	1	1	2	2	Nil	2	1
4- Severe						1	1	Nil	Nil

- *No harm themes:* Prescription, administration, dispensing and omission errors, reconciliation errors.
- *Near miss themes:* Prescription errors, medication delay, omission, dispensary errors, medication stock error, failure to transfer meds on patient relocation, wrongly prepared.
- *Low harm themes:* Omissions, medication delay, prescription errors, administration, medicines stored incorrectly and dispensing errors.
- *Moderate:* Prescription error.

All medication errors moderate harm and above are discussed at weekly divisional safety huddles. In addition, medications below level can be discussed at weekly safety huddles as required for a multi-disciplinary approach to managing medication error incidents.

Percentage medication incidents reported as causing low, moderate, or severe harm or death as a proportion of all medication errors are reported to Learn from Patient Safety Events service (LFPSE). Below is a table representing the trust wide safety index 19% of medication incidents resulting in harm in December reported to Quality Committee.

Table 4: Trust Wide Safety Index %

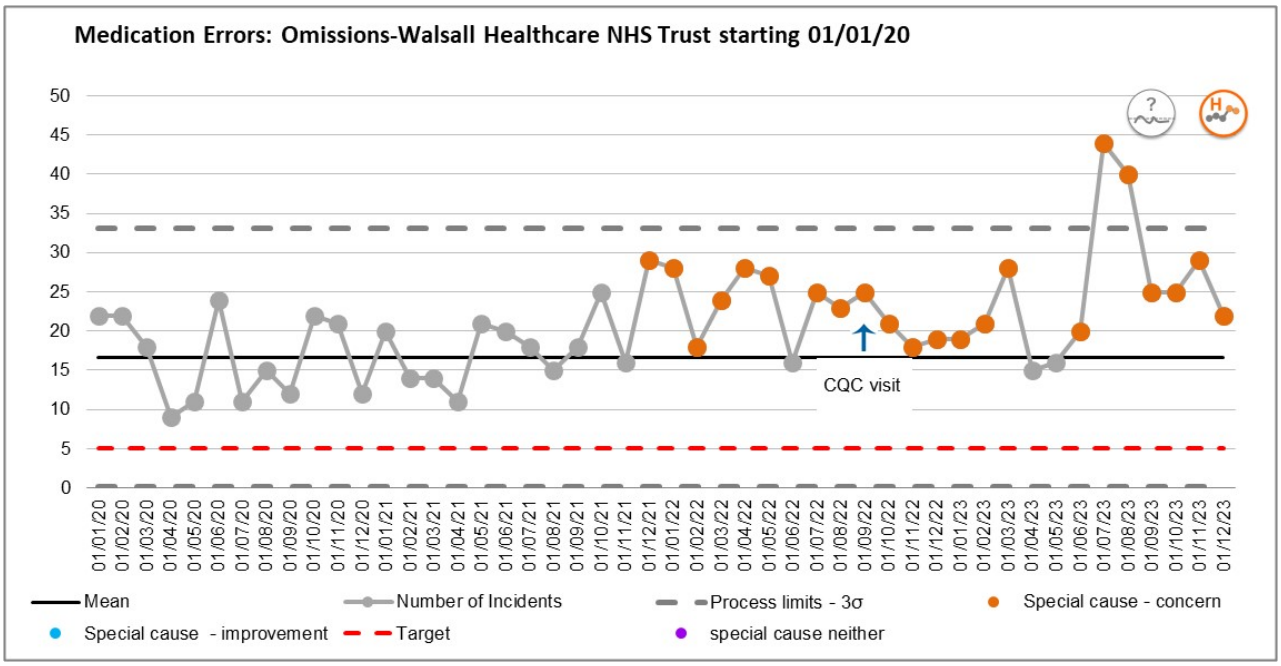
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar 23	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Trust-wide Safety Index - % of medication incidents resulting in harm	20%	17%	20%	21%	23%	22%	25%	24%	20%	16%	19%	28%	22%	24%	19%
No. of reported medication incidents level 3, 4 or 5	0	0	0	0	3	2	2	1	1	1	2	3	1	2	1

4. **Incidents for discussion –** See alerts section page 1.

5. SPC Charts
- **Omissions**
- **Prescriptions**
- **Controlled Drugs**

5.1

SPC Chart 2: Omissions Dec 23



A total of 22 omission error incidents were reported in December 2023 a decrease of 7 incidents as per previous month (November 23).

Walsall Healthcare NHS Trust

Below are omission themes per division.
Safeguard extract Dec 23 – not an exhaustive list

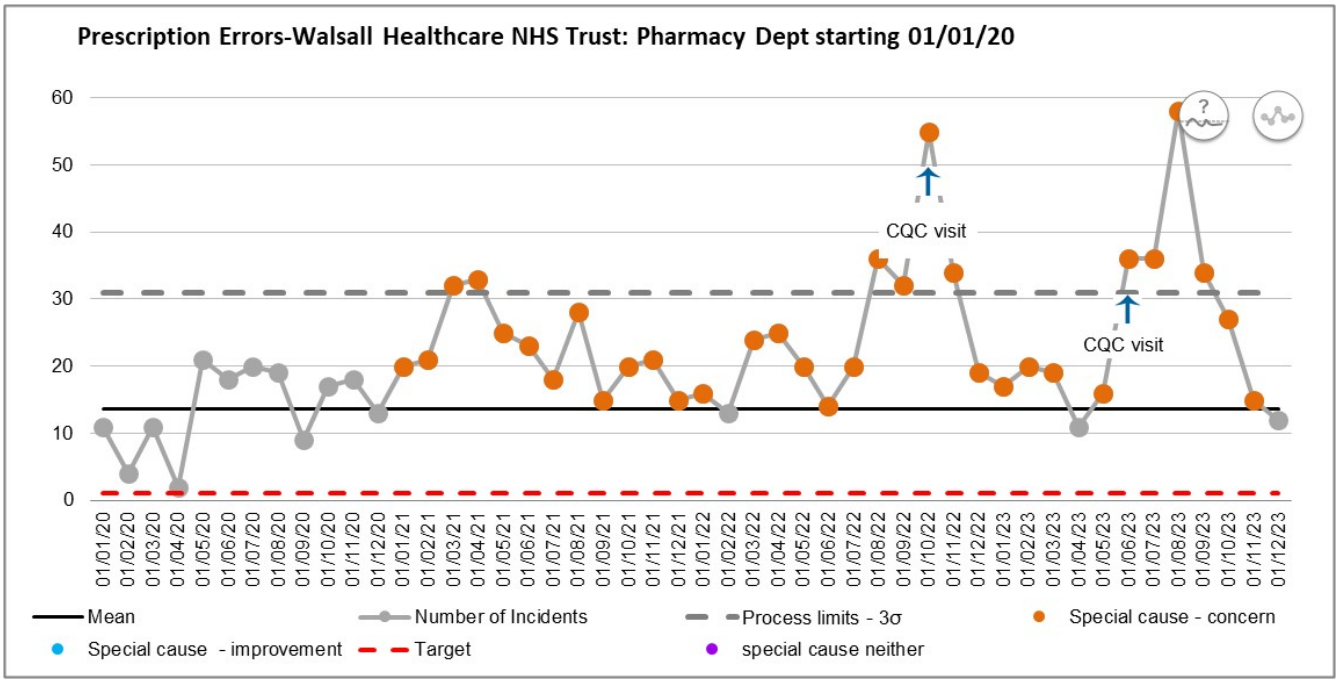
Themes	Outcome	Action
Community		
• Missing medicines from discharge from external provider	• No harm: Resolved as re dispensed	• Contacted the external provider to obtain medicines
• Insulin omission	• No harm: Nurse visited the next day	• Insulin checklist not completed- teams have been informed
• Morphine MR- no evidence of administration	• No harm: Confirmed patient missed the dose	• Written reflection and verbal discussion completed with staff nurse Learning outcome: Staff member has adjust practice and checks medication charts at the end of each shift for her team to mitigate against any further omission.
• External care company failed to administer medicines to a community patient	• No harm: Quality concern raised	
MLTC		
• Delay in obtaining IVIG from pharmacy	• Low	• delay was due to funding not be authorised by the panel as per IViG Policy.
• Patient too drowsy to have medicines administered	• No harm	• Medical team informed of the incident and to review the patient
• Discrepancy with discharge medication – omission of zomorph and oramorph and sent home with cocodamol	• Near miss	• Upon review not sure if these are clinically appropriate.
• Furosemide not administered	• low	• Requested statement and reflective account from Nurse involved. PEF team will supervise and support her to complete the oral drug administration competencies. Patient reviewed by medical team.
• Fosfomycin not administered	• No harm	• Nursing colleague reminded to contact the oncall pharmacist for urgently required medications out of hours.

• Antiepileptic medicines not administered, patient experienced a seizure	• Low harm	• Drugs were available in several locations, timeline of events to be completed by the ED matron.
• Failure to omit time critical medicines as the patient was nil by mouth	• Low	• Nursing colleagues informed not to omit time critical medicines when NBM.
• Oxycontin omitted unintentionally	• No harm	• SN was unable to locate due to being unfamiliar with the medicine. Advised to refer BNF /NICE to improve her knowledge and understanding . Discussed the escalation process to her. Asked to complete reflection and CD drug competency.
• Medications not sent to care home on discharge, confusion in pharmacy that this was a new care home placement.	• No harm	• Medicines dispensed by pharmacy
Surgery		
• Magnesium asparate not administered • Enoxaparin not administered • Several discrepancies between drug chart and EDS	• Low • Low • Near miss	• Patient was off the ward hence not given • Nurse informed to double check doses • Medical team reviewed and corrected on pharmacy advice
• Lantus omitted	• Low	• Incident discussed with the registered nurse responsible for the patient, educated on the importance of administering the long acting insulin. She has demonstrated understanding of this and also documenting correctly when omitting drugs. Extra support currently being provided for the member of staff, PDR done with review

		dates set to ensure safe practice is performed.
WCCSS		

5.2

SPC Chart 3: Prescription Errors: Dec 2023



A total of 12 prescription errors were reported in December 2023 ↓3 reported incidents reported as per previous month (November 23). The SPC chart indicates over the last 6 months the variation has now reached mean level. Ongoing medicine management audits continues across the Trust.

Below are prescription error themes per division.
Themes: Safeguard extract Dec 2023: not an exhaustive list

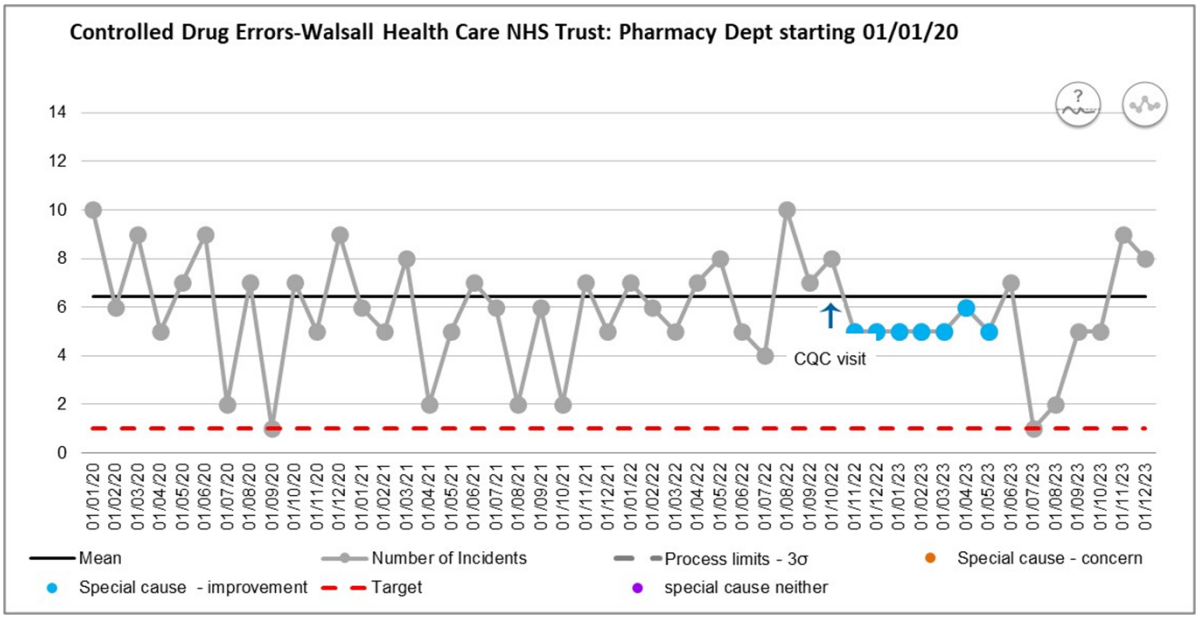
Themes	Outcome	Actions
Community		
• Semglee missing in error from prescription	• Near miss	• Community pharmacist and GP surgery to resolve.
MLTC		
• Dispensing error from external trust	• low • near miss	• quality concern to be raised with the external hospital. • Identified by pharmacy

• Medicines reconciliation error- citalopram 100mg prescribed instead of 10mg • Incorrect dose of enoxaparin prescribed 200mg instead of 60mg in renal impairment. • Lantus insulin prescribed twice daily instead of once daily • No oxygen given to the patient • Errors with the drug chart identified by pharmacy on discharge apixaban and digoxin had not been prescribed therefore, were omitted. • Virtual ward patient- bisoprolol not prescribed • Regular medicines have not been prescribed or administered in ED	• no harm • no harm • no harm • No harm • classified as moderate- likely to be low harm	• Patient aware of the error that had been made with regards to clexane prescription prior to coming for his test & I have apologised to patient on behalf on the department and assured that the prescriber and department will take learning from this to try & prevent similar incidents occurring to other patients in the past. Prescriber has reflected on the incident The endoscopy pre-assessment team will be updating their documentation & as part of that will need to include eGFR so that will be always available for prescriber if asked to complete CLexane prescription . • No update • Manager to review • Ward consultant to remind doctors completing EDS to double check medical notes/plans and drug charts to make sure both corollate. • Clinician to be contacted to feedback • Manager to review
Surgery		
• Incorrect dose of insulin prescribed for a patient	• Low • low	• Consultant to laise with the prescriber about the error • Prescribers informed

• Regular medicines not prescribed for a patient		
WCCSS		
• Pharmacy dispensing errors	• Near miss but left pharmacy	• Correct medicine dispensed.

5.3

SPC chart 4: Controlled Drug errors: Nov 23



A total of 8 CD incidents were reported in December 2023 a decrease of 1 incident as per previous month (November 23).

6. CAS/MHRA Alerts

CAS alerts are received and actioned via safeguard in line with the CAS alert policy. An email is sent to all relevant clinicians informing them of the alerts and any actions that are required.

Table 5: MHRA/CAS Alerts

Class 1	Pose a serious risk, and require recall immediately (including out of hours) from all stock locations in the hospital, and may also require recall from patients
Class 2	May pose a serious risk and require recall, usually within 48hrs, from all stock locations in the hospital
Class 3	Unlikely to cause harm to the patient, recall usually within 5 days
Class 4	Caution in use notice, recall not required, though extra information may need to be given with drug

MHRA Drug Alert Ref	Date	Drug	Class	Actions taken
EL23-A40	04/12/2023	Caramet 25/100mg CR Tablet Teva brand	4	email sent out for information only. Physical stock check completed no stock found
EL23-A41	06/12/2023	Strandhaven Ltd t/a Somex Pharma Tramadol Hydrochloride 50mg Capsules, Hard	4	Pharmacy computer system checked and found pharmacy do not stock the affected brand of capsules.
EL23 -A42	06/12/2023	Strandhaven Ltd t/a Somex Pharma Clarithromycin 250mg film-coated tablets	4	Email sent to teams for awareness
Natpsa_2023_014_NHSPS (1)	07/12/2023	Potential serious risks to patient safety have been identified with the use of Magentus Software Limited's Euroking maternity information system	CAS alert	Email sent to teams for awareness
NatPSA/2023/01	08/12/2023	UKHSA is investigating an outbreak of Burkholderia cenocepacia involving individuals across the UK. This is an emerging issue and, following testing, B. cenocepacia was recovered from some lubricating carbomer eye products.	CAS alert	Pharmacy have quarantined all affected batches and all ward stocks have been checked.
NatPSA/2023/016/DHSC	08/12/2023	A Medicine Supply Notification issued on 24 May 2023, detailed a shortage of Tresiba® (insulin degludec) FlexTouch® 100units/ml solution for injection 3ml pre-filled pens.	CAS alert	Previous alert in May disseminated. CAS alert sent via email for information purposes.

MHRA alert: December 2023: Drug Safety Update: December 2023 (govdelivery.com)

7. Risk Register

Corporate Medicines Management Risk 2737
Current risk score has been reduced to **12** Severity x4 Likelihood x3. Forecasted risk score for this month will remain the same. The corporate risk was reduced as per planned trajectory end of September 2023. Care groups and divisions continue to update their medicines management risks accordingly.

Risk score **12** Severity x4 Likelihood x3.

Corporate	**2737**	**12**

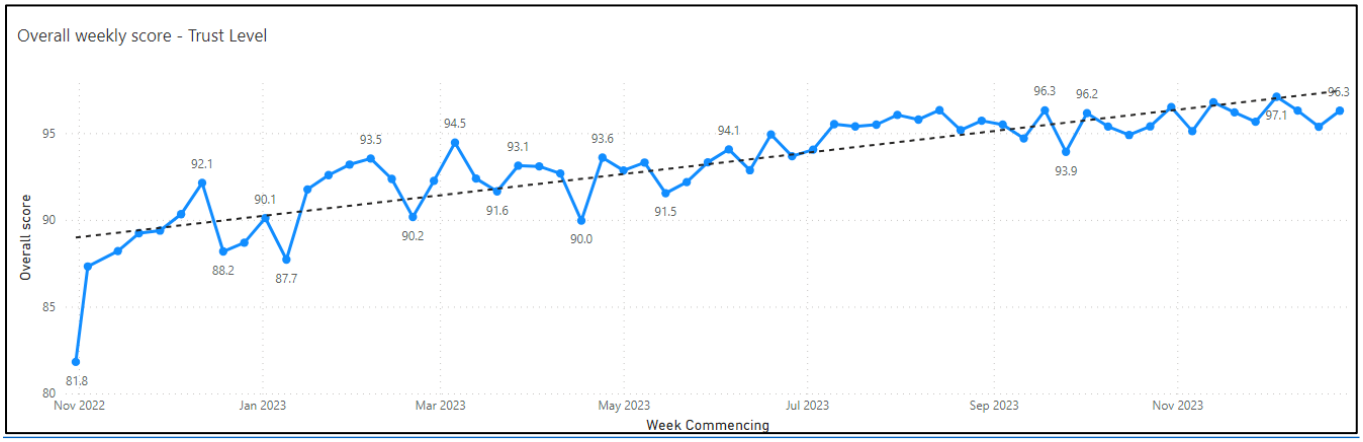
Division	Risk Number	Risk score
Medicine	**2782**	**12**
Surgery	**3097**	**9**
WCCSS	**3095**	**12**
Community	**3096**	**12**

8. Audits

8.1 Ward Storage

A total of 96 weekly audits have been conducted by the nursing team across the divisions. Average 96.4%

Table 1: Summary of Medicines Management audits between November 2022 – December 2023



Over the last 12 months there has been a significant improvement from an average 81.8% increasing to 96.4% to date.

Table 2: December 2023

Overall score, Medicine room / CD, Does patient have a wrist band insitu with appropriate allergy status?, Patient prescription charts have detail...

BY WEEK COMMENCING

Week Commencing	Overall score	Medicine room / CD	Does patient have a wrist band insitu with appropria te allergy status?	Patient prescription charts have details of name, date of birth and hospital number or NHS number?	Is allergy status documente d on the prescription chart?	Is the ture 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 on the prescription chart signed with name printed in black caps / stamp?	Are all the medications within their expiry date?(5 random medications checked)	Average of Controlled drugs
Monday, December 25, 2023	96.29	97.42	94.29	100.00	99.21	87.03	100.00	100.00	85.12	87.14	100.00	92.14	100.00	97.44
Monday, December 18, 2023	95.37	97.50	99.17	99.17	98.33	73.95	87.50	90.00	93.15	86.58	97.50	89.49	98.33	94.45
Monday, December 11, 2023	96.30	98.06	95.15	100.00	97.06	82.17	91.48	89.29	94.50	90.40	98.25	94.09	100.00	94.59
Monday, December 04, 2023	97.09	97.52	100.00	100.00	97.86	87.78	96.88	96.88	94.29	92.14	99.29	93.09	100.00	98.08
Monday, November 27, 2023	95.65	97.40	99.15	100.00	98.46	69.09	96.75	91.65	95.30	91.07	99.23	88.46	100.00	93.06
Monday, November 20, 2023	96.20	96.83	99.05	100.00	100.00	79.71	97.54	96.88	90.42	90.80	100.00	94.50	100.00	96.05

Table 2 indicates an improvement regarding recording of allergy status compared to the previous month, see table 3.

Table 3: November 2023

Overall score, Medicine room / CD, Does patient have a wrist band insitu with appropriate allergy status?, Patient prescription charts have detail...

BY WEEK COMMENCING

Week Commencing	Overall score	Medicine room / CD	Does patient have a wrist band insitu with appropriate allergy status?	Patient prescription charts have details of name, date of birth and hospital number or NHS number?	Is allergy status documented on the prescription chart?	Is the ture 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 on the prescription chart signed with name printed in black caps / stamp?	Are all the medications within their expiry date?(5 random medications checked)	Average of Controlled drugs
Monday, November 27, 2023	95.65	97.40	99.15	100.00	98.46	69.09	96.75	91.65	95.30	91.07	99.23	88.46	100.00	93.06
Monday, November 20, 2023	96.20	96.83	99.05	100.00	100.00	79.71	97.54	96.88	90.42	90.80	100.00	94.50	100.00	96.05
Monday, November 13, 2023	96.78	97.91	97.02	99.47	100.00	77.84	92.19	96.88	94.15	96.20	99.47	96.84	100.00	94.91
Monday, November 06, 2023	95.11	95.36	98.57	100.00	99.52	77.47	94.01	92.54	85.54	94.47	99.52	97.14	100.00	96.05
Monday, October 30, 2023	96.50	97.19	100.00	100.00	98.57	88.25	96.30	93.48	85.00	93.93	99.29	87.14	100.00	98.08
Monday, October 23, 2023	95.39	95.77	98.82	98.82	97.35	79.84	88.89	97.44	90.98	92.44	100.00	97.45	100.00	91.11

Allergy Status remains an area of improvement.

Ongoing weekly audits continue throughout the Trust. See proposed recommendation below:

Recommendation: *Review frequency of weekly audits, Following the Audit Cycle and other methods of monitoring and assurance to enhance learning, i.e., using multiple methods to identify medicines-related patient safety incidents e.g., quarterly health record reviews, patient surveys and direct observation of medicines administration. Approach locally and review arrangements regularly to reflect local and national learning. This method will add more depth, context, and qualitative data for analysis.*

NB: Themes for improvement are captured within divisional medicines management meetings, escalations continue to be addressed via the Medicines Safety Group.

In addition, a meeting is planned with the quality team around the implementation of pharmacy hospital audits (see enc.1) These audits are evidenced based and in line with CQC inspections, MMG to be updated in due course.

8.2 Controlled Drugs

Controlled Drugs Audits conducted by Pharmacy: 3 monthly audits Dec 2023

CD audits completed by pharmacy: 7 audits.
Tendable extraction 4/1/2024

		Inspection Type
		Controlled Drug Audit-Pharmacy
	Area	
1	Theatre 10	67%
2	Theatre 11	100%
3	Theatre 5	100%
4	Theatre 6	100%
5	Theatre 8	78%
6	Theatre 9	78%
7	Ward 3	82%

Themes for improvement below red/amber.

Question Text	Answer score (%)
C3 Low - Is Documentation correct?	43%
C1 Medium - Is the CD register (Ward CD & POD register) checked against the CD stocks twice a day and a record kept of this check in the ward daily CD stock check folder?	57%
B1 High - Are there signatures and dates in the ward Controlled Drugs Order Book to demonstrate receipt of Controlled Drugs from Pharmacy? NB. All receipts in the order book should be signed	71%
C2 High - Are quantities stated in the CD Register & POD CD Register reconciled with the CD stock items in the cupboard as correct?	100%
C4 High - Are calculations of the running balance correct and reconcilable?	100%
C5 High - Are CDs that are Patients' Own Drugs recorded in the Patients' Own Controlled Drugs Register?	100%
D1 High - Do entries in the register confirm that two practitioners designated by the medicines policy check and administer Controlled Drugs?	100%
D2 Low - Check up to 5 recent entries in the CD register against patients' charts currently on the ward to reconcile entries with administrations?	100%
E1 High - Do entries in the register confirm that two practitioners designated by the medicines policy sign and witness any controlled drugs wasted?	100%
A2 High - Is the key to the Controlled Drugs Cupboard kept on the appointed nurse in charge of the ward or a delegated nurse acting as Deputy?	100%
B2 High - On checking is there a representative sample of requisitions coincides with the register?	100%

Audit results/outcomes are shared with wards/departments and accessible via Tendable. Anomalies are highlighted by the pharmacy team for wards/departments to action.
New audit standards for pharmacy auditing are due to be implemented in the next quarter, this will look at reviewing 100 entries and calculating a percentage compliance figure for each standard.

Themes are to be addressed by divisional care groups with escalation to the Medication Safety Group (MSG) meetings, action plans to be formed, reviewed, and discussed linking into the Medicines Management Group.

9. Pharmacy Interventions

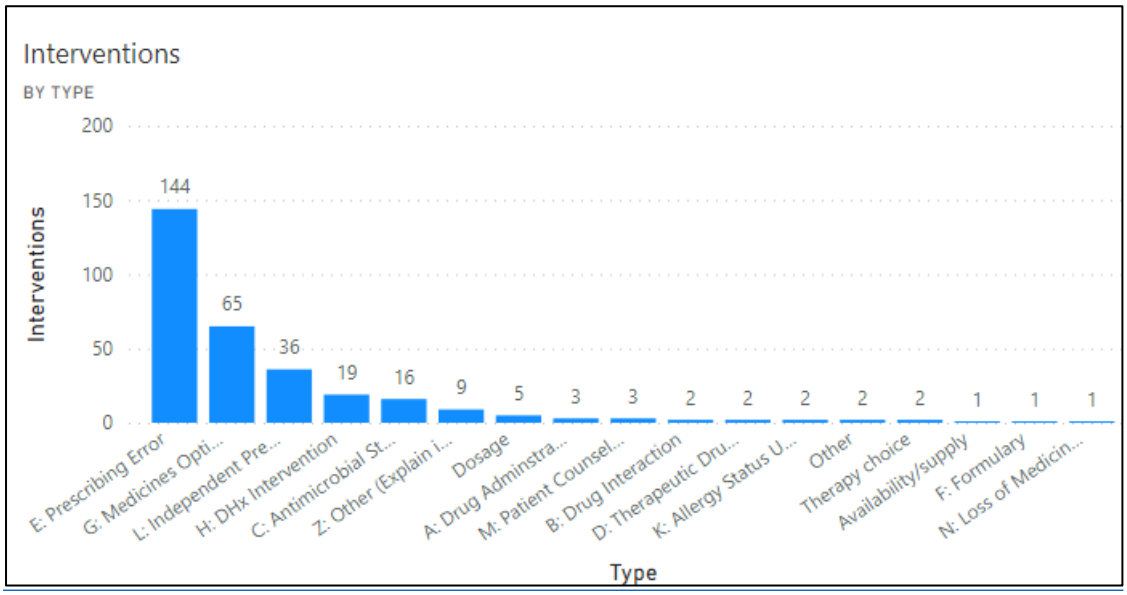
Pharmacy interventions are defined as "any activity undertaken by a pharmacist which benefits the patient. A recommendation initiated by a pharmacist in response to a drug related problem in an individual patient occurring in any phase of the medication process".

Walsall Healthcare NHS Trust

Table 1 below highlights the recurrent theme which is prescription errors. Therefore, preventing harm/near miss to patients due to prescription/prescribing errors.

Table 1: Interventions by Type

Prescribing errors continue to be the highest, pharmacy intervention. This has decreased by 55 from previous month possibly due to the festive period bank holidays.



Intervention synopsis: not an exhaustive list Dec 2023

Date	Type	Response	Level	Contact	Time Taken	Reason	Stage	Notes	Ward
12/30/2023 5:01:33 PM	Z: Other (Explain in Comments)	Information only	0: No Harm (Near Miss)	Other (Add in comments)	< 5 minutes	Safety	Clinical Check-Inpatient	informed team op ordered this morning however pt going home only require 3 days - reordered with amount required asked ward team (Moncy) to return OP to pharmacy	WARD 15
12/30/2023 4:58:38 PM	Z: Other (Explain in Comments)	Information only	0: No Harm (Near Miss)	Other (Add in comments)	< 5 minutes	Safety	Clinical Check-Inpatient	ward made aware if bevespi stock issue - requested ward to ask nok to bring medication from home	WARD 17
12/30/2023 4:57:33 PM	Z: Other (Explain in Comments)	Information only	0: No Harm (Near Miss)	Junior doctor	< 5 minutes	Safety	Clinical Check-Inpatient	Advice required from community nurse in regards to pt storing medication in fridge - advised as per spc - 6.4 Special precautions for storage Store below 25 C. Do not freeze. safe to use as long frozen - to check the injection as should be clear	
12/29/2023 4:16:47 PM	E: Prescribing Error	Information only	0: No Harm (Near Miss)	Pharmacist - Walsall Trust	< 5 minutes	Safety	Medicines Reconciliation	Missing weight and category of infection	Ward 29
12/29/2023 3:46:13 PM	E: Prescribing Error	Advice followed	0: No Harm (Near Miss)	Pharmacist - Walsall Trust	< 5 minutes	Safety	Medicines Reconciliation	Prednisolone tablets prescribed on the regular prescription and on PRN drugs.	WARD 17
12/29/2023 3:00:19 PM	H: DHx Intervention	Advice followed	0: No Harm (Near Miss)	Junior doctor	< 5 minutes	Safety	Clinical Check-Inpatient	Regular medication gabapentin not prescribed along with temazepam	WARD 3
12/29/2023 2:45:49 PM	E: Prescribing Error	Unknown	1: Low	Consultant	Over 20 minutes	Safety	Clinical Check-Inpatient	Enoxaparin dose needs to be increased to BD due to patient's weight	Ward 29
12/29/2023 2:13:25 PM	E: Prescribing Error	Information only	0: No Harm (Near Miss)	Pharmacist - Walsall Trust	< 5 minutes	Safety	Medicines Reconciliation	Missing - Category of infection	WARD 4
12/29/2023 1:37:56 PM	E: Prescribing Error	Information only	0: No Harm (Near Miss)	Pharmacist - Walsall Trust	< 5 minutes	Safety	Medicines Reconciliation	Missing VTE assessment.	DISCHRGE
12/29/2023 1:15:18 PM	E: Prescribing Error	Unknown	3: Moderate	Consultant	10 to 20 minutes	Safety	Clinical Check-Inpatient	Buprenorphine patch at home - morphine patched prescript on chart (not administered)	Ward 29
12/29/2023 1:13:39 PM	E: Prescribing	Advice followed	3: Moderate	Consultant	10 to 20	Safety	Clinical Check-	enoxaparin dose needed reducing due to	Ward 29

10. Patient Group Directives (PGDs)

A total of **77** authorised PGDs are on the Trust Registry. **10 due to expire within 90 days.**
See PGD report for full details.

"Medicines Management is Everyone's Business"

Join the conversation Twitter @rpharms @MHRAmedicines

#medicinessafety

CQC: Medicines in health & Social Care: Learning from risks and sharing good practice for better outcomes:
https://www.cqc.org.uk/sites/default/files/20190605_medicines_in_health_and_adult_social_care_report.pdf

Hyperlinks
https://yellowcard.mhra.gov.uk
Medicines - Infohub (xwalsall.nhs.uk)

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Quarterly Chief Pharmacist Report	Enc No: 8.9.2
Author:	Sonia Chand, Chief Pharmacist Sonia.chand3@nhs.net	
Presenter/Exec Lead:	Manjeet Shehmar, Chief Medical Officer manjeet.shehmar@nhs.net	

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

Recommendations:

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

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: The main risks identified are concerned with the level of compliance with the Medicine Policy which is managed through Corporate risk 2737 and associated Divisional and Care Group risks. Risk Description: Divisional Risk 3201: Pharmacy Aseptic isolators need replacing due to end of usage life. Air handling unit is also at the end of usage life and due replacement. Risk 3347: temporarily suspension of manufacturing of intravenous chemotherapy and monoclonal antibodies by the Pharmacy Department impacting cancer treatment provisions On Risk Register: Yes☒No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	Resources will be required for purchase of further electronic drug storage units, an electronic prescribing system, clinical staff for implementation and Controlled Drug management software, if supported in principle by TMC. Business cases to follow.		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details:
	NHSE	Yes☒No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

NHS
Walsall Healthcare
NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert

Assure

- Joint Business Continuity Plan for aseptics being developed by Black Country Chief Pharmacists
- Reduction is vacancy rate
- Increased progressional posts in pharmacy from band 4 to 5 and band 6 to 7 to 8a.
- Homecare pharmacist recruited and in post

Advise

- The establishment business case for Pharmacy in progress.
- Outpatient pharmacy is due to close on the 19th January 24 and service is to be repatriated to main pharmacy Route 239. Close engagement with the communication and voluntary services to support this transition.

Alert

- Currently the aseptic unit at WHT does not meet the specific requirements to manufacture chemotherapy therefore, this activity has been suspended on a temporary basis. This is being reviewed on an ongoing basis based on microbiology results and the air handling unit performance. The Chief pharmacist has taken on the role of the accountable pharmacist in the interim.
- Medicine reconciliation levels remain at have reduced over the past month due to staffing issues and are still below 60%. These continue to remain low due to the under establishment of pharmacy staffing,
- Aseptics workforce capacity- is over capacity- staff are being recruited to support this.
- Bank and agency spend has seen an increase over the past two months due to increased capacity wards opening and winter pressures.
- Delay in obtaining the Home office controlled drugs licence due to delays with the home office.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations

Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Walsall Healthcare NHS Trust

Chief Pharmacist Report - Quarterly Report

Report to Trust Board Meeting – 14th February 2024

1. PURPOSE OF REPORT

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

2. PHARMACY AND MEDICINES MANAGEMENT

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

The Medicines Management Group (MMG) is the group which has oversight of medicines management and usage. The MMG is chaired by the Chief Medical Officer or by the Director of Nursing in the absence of the Chief Medical Officer.

The MMG reports directly into the Clinical Effectiveness Group on a quarterly basis.

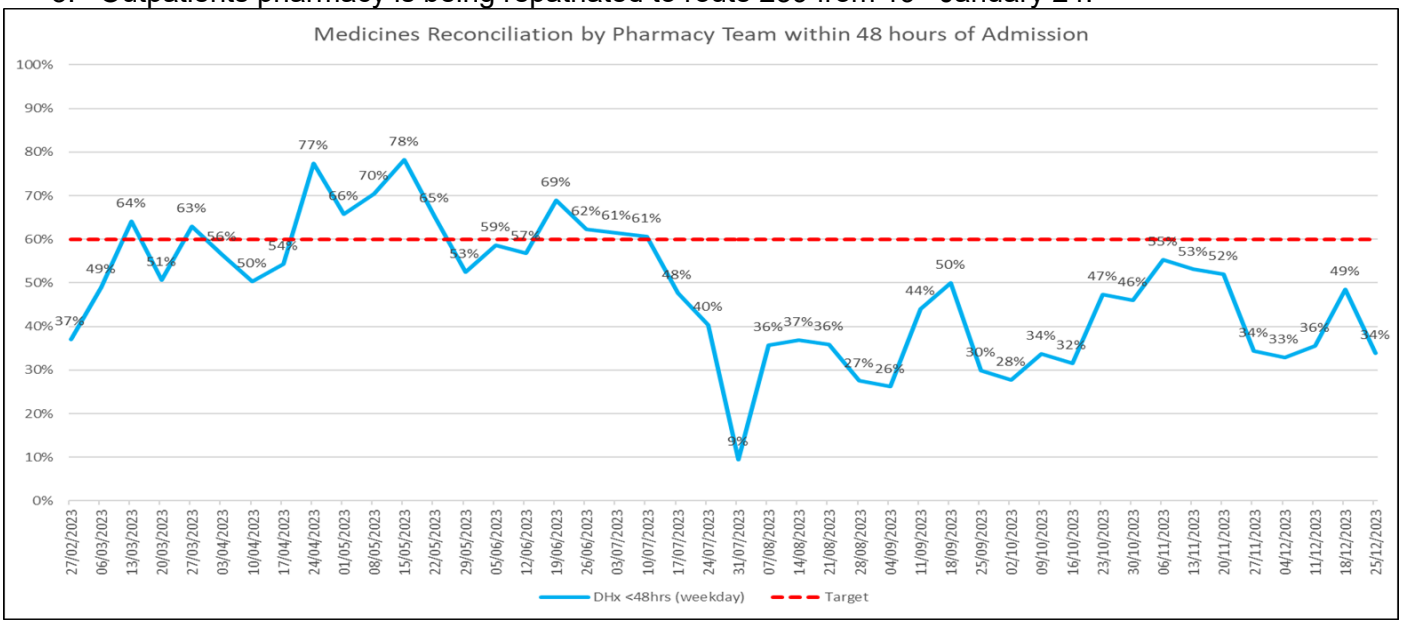
Medicines Management Improvement Group key updates:

1. Medicine Policy review

There is currently a short life working group set up to manage the review of the Medicines Policy in line with the recommendations from the specialist advisor in response to the Section 29a notice. Due to be completed by Jan 24.

Escalations December 23

1. Aseptics unit has been temporarily closed to manufacturing of chemotherapy.
2. Medicines reconciliation levels are not reaching the threshold due to staffing (46% overall)
3. Outpatients pharmacy is being repatriated to route 239 from 19th January 24.



4. Aseptic workforce capacity- extra resource is being put into this service to meet the requirements to manufacture- this will be at a cost pressure.
    - Quality assurance
    - Validation of the unit
    - Continual monitoring

Pharmacy workforce

The business case for pharmacy establishment was presented to investment group in November 23 and no route to finding identified. In the meantime, key pharmacy ward-based roles have been identified and submitted to the Director of Finance to continue the temporary spend required to support.

New appointments:

Medication safety officer 8B (1WTE)- due to start Feb 24
Aseptic Principal Pharmacist (8B)- locum in place to cover the service- Chief Pharmacist to undertake the role of the accountable pharmacist until the locum has become substantive.

New posts in advertising:

Deputy Chief Pharmacist- interviews 15th Jan 24
Band 6 Junior Pharmacist
Pharmacy care group Manager – awaiting approval

Agency spend- this has seen an increase over the past two months due to extra capacity wards opening and winter pressures.

Financial

There is currently work being undertaken around reviewing off contract purchases for medicines.

Medicines Management Dashboard

A dashboard of key medicines management metrics has been set up on the Trust Intranet. The info hub is now available for staff to use.

Risk Register

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

New risk entered onto the pharmacy risk register.

Risk 3347:
temporarily suspension of manufacturing of intravenous chemotherapy and monoclonal antibodies by the Pharmacy Department impacting cancer treatment provisions

Ward storage

As discussed above, wards are required to use the Tendable app to complete ward storage audits which provide evidence towards divisional care group medicines management risk. The information is available on a weekly basis on the Medicines Management dashboard and form the basis for discussion at care group and divisional safety huddles and Medicines Management Groups.

Audits

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

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

3. REGULATORY

No inspections due.

4. RECOMMENDATIONS

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

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

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Controlled Drugs Accountable Officer Annual Report	Enc No: 8.9.3
Author:	Sonia Chand, Chief Pharmacist Sonia.chand3@nhs.net	
Presenter/Exec Lead:	Manjeet Shehmar, Chief Medical Officer manjeet.shehmar@nhs.net	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The Board is asked to be informed and assured of this report in relation to controlled drugs management across WHT.			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: The main risks identified are concerned with the level of compliance with the Medicine Policy which is managed through Corporate risk 2737 and associated Divisional and Care Group risks. On Risk Register: Yes☒No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	Resources will be required for purchase of further electronic drug storage units, an electronic prescribing system for controlled drugs, clinical staff for implementation and Controlled Drug management software, if supported in principle by TMC. Business cases to follow.		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details:
	NHSE	Yes☒No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

Walsall Healthcare NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert
Assure A separate controlled drugs policy has been developed due to be ratified in Feb 24. This is a multiprofessional review of the policy that will allow for easier access to the information required by staff when they need it.
Advise
Alert Controlled Drugs Police Liaison Officer has identified area where the storage of controlled drugs does not meet the legislative requirements. The CDAO has informed the Divisional Director of Nursing for these areas to take action and assure the CDAO.

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

Walsall Healthcare NHS Trust

Controlled Drugs Accountable Officer Report

Report to Public Trust Board Meeting on 14th February 2024

1. PURPOSE OF REPORT

The purpose of this report is to inform and assure the Board on the management of controlled drugs during 23/24.

2. CONTROLLED DRUGS MANAGEMENT

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

The legal accountability for the management of controlled drugs within any designated body providing healthcare services is described by the Statutory Instrument 2013 no.373 "The Controlled Drugs (Supervision of Management and Use) Regulations 2013." The Statutory Instrument (SI) requires that NHS Trusts appoint a designated Controlled drugs Accountable Officer (CDAO) and that this is notified to the CQC who maintain a national register of CDAOs.

At Walsall Healthcare NHS Trust the CDAO is Sonia Chand Chief Pharmacist.

The statutory responsibilities of the CDAO are set out in the SI and include:

1. To establish and operate arrangements for the safe management and use of controlled drugs and regularly reviews those arrangements.

2. To establish appropriate arrangements for the monitoring and auditing of the management and use of controlled drugs.

3. To ensure that staff involved in the handling and use of controlled drugs are performing to an agreed standard.

4. Where staff are not performing to an agreed standard - to determine if incidents require investigation, investigate, and to take appropriate action with regard to well-founded concerns.

5. To provide to the Regional CDAO a quarterly occurrence report providing details of concerns or declaring that there are no concerns.

1. To establish and operate arrangements for the safe management and use of controlled drugs and regularly review those arrangements.

A stand-alone Controlled Drugs Policy was written in 2023. Prior to this the management of CDs was included in the Trusts Medicines Management Policy. This policy details the legislative and regulatory requirements and provides the governance framework for the prescribing, ordering, supply, secure storage, administration, recording and disposal of controlled drugs. The Controlled Drugs Policy provides the definitive description for staff on how to safely manage and use controlled drugs within the Trust.

All staff who handle controlled drugs in the course of their duties are expected to have a working knowledge of the sections of the Policy relevant to controlled drugs. As a supplement to the Policy, the Medicines Management Handbook is available on the intranet. The Pharmacy is registered with the General Pharmaceutical Council and is subject to periodic inspection.

A controlled drugs audit is carried out by members of the pharmacy team on a quarterly basis. The findings of the audit are recorded on Tendable (the Trusts audit system) and reported back to the ward manager or equivalent for learning and action as required.

Any serious concerns are escalated to the controlled drugs accountable officer (CDAO).

2. To establish appropriate arrangements for the monitoring and auditing the management and use of controlled drugs.

All wards and departments holding controlled drugs are audited on a quarterly basis. The findings are reported to the Medicines Safety Group, the Medicines Management Group and through senior nursing forums.
The standards for the audit have been devised by the West Midlands Medicines Safety Group and have been adopted as local practice at WHT.
The standards include:

	Standard
A1	Has the action plan from the previous audit been completed and signed off? (ie have all previous anomalies been closed in Adios?)
A2	Key to Controlled Drugs cupboard is kept on the appointed nurse in charge of the ward or a delegated nurse acting as deputy
B1	There are signatures and dates in the ward Controlled Drugs order book to demonstrate receipt of Controlled Drugs from Pharmacy. NB. All receipts in the order book should be signed
B2	A representative sample of requisitions coincides with the register on checking.
C1	CD register (Ward CD & POD register) is checked against the CD stocks twice a day and a record kept of this check in the ward daily CD stock check folder.
C2	Quantities stated in the CD Register & POD CD Register are reconciled with the CD stock items in the cupboard as correct.
C3	Documentation is correct. There are no crossings out. Any errors in the register (Ward CD & POD register) are appropriately amended with square brackets, signed, dated and witnessed.
C4	Calculations of the running balance are correct and reconcilable. Check 50% of entries since last audit.
C5	CDs that are Patients' Own Drugs are recorded in the Patients' Own Controlled Drugs Register.
D1	Entries in the register confirm that two practitioners designated by the medicines policy check and administer Controlled Drugs.
D2	Check up to 5 recent entries in the CD register against patients' charts currently on the ward to reconcile entries with administrations. Ward staff to provide drug charts. (Theatres exempt).
E1	Entries in the register confirm that two practitioners designated by the medicines policy sign and witness any controlled drugs wasted

For escalation

The most non-compliant standard is standard **C3- Documentation is correct.**

C3 Documentation is correct. There are no crossings out. Any errors in the register (Ward CD & POD register) are appropriately amended with square brackets, signed, dated and witnessed.

There is a planned review of the controlled drugs audit to include a percentage error rate to identify the significance of failing this standard for a particular area.

3. **To ensure that staff involved in the handling and use of controlled drugs are performing to an agreed standard.**

Where the agreed standards for the management of controlled drugs are not met, this is reported on the Trusts incident management system and investigated in line with Trust policy. As with all medication related incidents, a review by the Medication Safety Officer is undertaken and any concerns are escalated to the CDAO. The most common themes in relation to controlled drugs are a failure to follow process; these incidents relate to poor record keeping, which gives rise to discrepancies, and incorrect doses being administered. Another theme is CDs not being delivered or ordered in time for administration.

Education and training

A controlled drugs training video was produced by the pharmacy department in 2022. This has been mandated for all registered nurses to watch and complete an assessment in relation to the management of controlled drugs. This video was developed to support the controlled drugs policy and pertaining standard operating procedures.

4) **Where staff are not performing to an agreed standard - to determine if incidents require investigation, conduct an investigation, and to take appropriate action with regard to well founded concerns.**

For the incident referred to in section 3 above, there was a degree of suspicion regarding one individual. The issue was raised with the ward matron and the divisional director of nursing. Actions that took place:

- Oramorph was handled as a schedule 2 controlled drug.
- Only the nurse in charge of the ward to hold the controlled drug keys.
- Double witnessing of all controlled drug areas

The West Midlands Police were invited to visit this area and identified that the ward area did not meet the legal requirement to hold controlled drugs. The ward has since then ordered the correct cabinets for controlled drugs storage.

A breakdown of CD incidents by harm categorisation for the year 2023 up to and including 14/12/23 is provided below:

Level 5 - Fatal	0
Level 4 - Severe harm	0
Level 3 - Moderate harm	0
Level 2 - Low harm	1
Level 1 – No harm	43
Level 0 – Near miss	13
Total	58

By area

Department	Number of incidents
AMU	3
Community Childrens Nursing	3
Complex Case Managers	1
Discharge Lounge	2
District Nurses East	1
District Nurses West	1
Emergency Department	5
Goscote Hospice	2
ICU	6
Pharmacy	4
Theatres	3
Ward 1	1
Ward 10	2
Ward 11	1
Ward 14	3
Ward 15	3
Ward 16	1
Ward 17	1
Ward 27	1
Ward 29	3
Ward 3	3
Ward 4	3
Ward 7	1
Ward 20a	2
Nursing Homes Enhanced Case Mgt	1
Ward 21	1

It is important to note that whilst there are a low number of harm incidents, those which relate to discrepancies are almost always classified as “no harm”, whereas the nature of the discrepancy itself may be of significance. In many instances, the discrepancy can be explained upon investigation, there has been one instance where the advice of the West Midlands Police was sought.

Where an individual has made an error in relation to a controlled drug, this is reported to their professional line manager. The individual is required to complete a reflection on the incident. Further education and training is offered depending on the nature of the incident.

5) **To provide to the Regional CDAO a quarterly occurrence report providing details of concerns or declaring that there are no concerns**.

The CDAO is a regular attender at the Regional CD Local Intelligence Network (CD LIN) and provides a quarterly report in the required format. No concerns were reported to the CD LIN in Quarters 1,2 & 4, the incident in the area above (ward 14) was reported as a concern in Q3.

3. RECOMMENDATIONS

The programme of work that is overseen by the Medicines Management Improvement Group will continue throughout 2024.

A business case is supported by the Trust for investment in the Pharmacy service but requires identification of a route to funding. Without this investment there will be a continued reliance on locum staff to maintain a safe service and will limit the ability to deliver on identified service improvements.

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Safe High-Quality Care Oversight Report	Enc No: 8.9.4
Author:	Caroline Whyte – Deputy Chief Nursing Officer caroline.whyte3@nhs.net	
Presenter/Exec Lead:	Lisa Carroll – Chief Nursing Officer lisa.carroll5@nhs.net	

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

Implications of the Paper:			
Risk Register	Yes ☒ No ☐ Risk Title: **208** - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks (Risk Score 16). **2325** – Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes (Risk Score 15). **2439** - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety' (Risk Score 12). **2581** – Internal risk for patients awaiting Tier 4 hospital admission (Risk Score 12). **2587** - Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks (Risk Score 9). **2601** - Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6 (Risk Score 8). **3043 –** Suboptimal paediatric staffing - Paediatric nursing establishment is currently maintaining minimal compliance to expected national standards for paediatric nursing. This is further exacerbated by increased demand on service and sickness/maternity (Risk Score 16).		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Registration and licensing Well led.
	NHSE	Yes☒No☐	Details: Related standards
	Health & Safety	Yes☒No☐	Details: Health & Safety Act
	Legal	Yes☒No☐	Details: Duty of Candour, Claims and Litigation
	NHS Constitution	Yes☒No☐	Details: Constitutional Standards
	Other	Yes☒No☐	Details: Professional registration issues

CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Equality and Diversity Impact	None identified within the report		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: TMC 26/10/2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- Safeguarding adult and children's training is achieving the Trust target for levels 1 and 2 training.
- Falls per 1000 bed days was 3.09 in November and 3.30 in December 2023.
- Agency cessation plans continue to see a minimal usage of agency nursing staff, with a robust risk assessment process in place for the agreement of agency usage.
- The timeliness of observations for November and December 2023 was 88.63% and 87.01% including ED, the compliance excluding ED was 91.79% and 91.28%.
- Data from November and December 2023 demonstrates a consistent level of pressure ulcer incidents.
- Clinical accreditation reviews of ward areas continue with Goscote Hospice achieving the first sapphire rating for WHT.
- An update paper is an appendix to the main report covering the National Patient Safety Alert regarding avoidable serious injury and deaths associated with medical beds, trolleys, bed rails, bed grab handles, and lateral turning devices.

Advise

- Within the Emergency Department 81.96% of patients received antibiotics within the first hour in November 2023 and 79.86% in December 2023.
- Mental Capacity Act data has been collected via the Tendable Audit (Respect) since June 2023, and results for November 2023 are 86.91% and 86.21% for December 2023.
- For adult inpatients, 73.63% of patients received antibiotics within the first hour in December 2023, an increase from 67.11% in November
- The nursing and midwifery vacancy rate is just under 6% in December 2023, a slight increase from just over 4% in October 2023.
- The occupational health team have been identifying staff who are not vaccinated against measles and are offering the MMR vaccine.
- The IPC team are currently scoping a process for contact tracing and administration of immunoglobulin for clinically high-risk patients / visitors in the trust who may come into contact with a measles case.

Alert

- A total of 5 C. *diff* toxin cases were reported in November 2023 and 7 in December 2023.
- VTE compliance for November 2023 was 90.19% and 88.47% for December 2023,

- There is considerable pressure on the ED department from Mental Health patients who need assessment and potential treatment. A Memorandum of Understanding has been provided to the Trust from the Black Country Healthcare, which has yet to be agreed upon due to the lack of provision for the 'Responsible Clinician'.
- Level 3 adults and children's safeguarding training remains below trust target.

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

Reference Pack

QUALITY DATA

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

1.0 Excellence in care

1.1 Falls

- The number of Trust falls recorded for November and December 2023 was 54 and 60 respectively, a decrease from 62 in October 2023 (Chart 1).
- The Royal College of Physicians' mean average performance of 6.1 falls per 1000 occupied bed days has been achieved continuously for the past 34 months (Chart 2).
    - Falls per 1000 bed days was 3.09 in November and 3.30 in December 2023. (3.46 in October 2023).
- The Falls Steering Group continues to implement an enhanced risk assessment for patients at high risk of falls.

Chart 1 - Total Falls

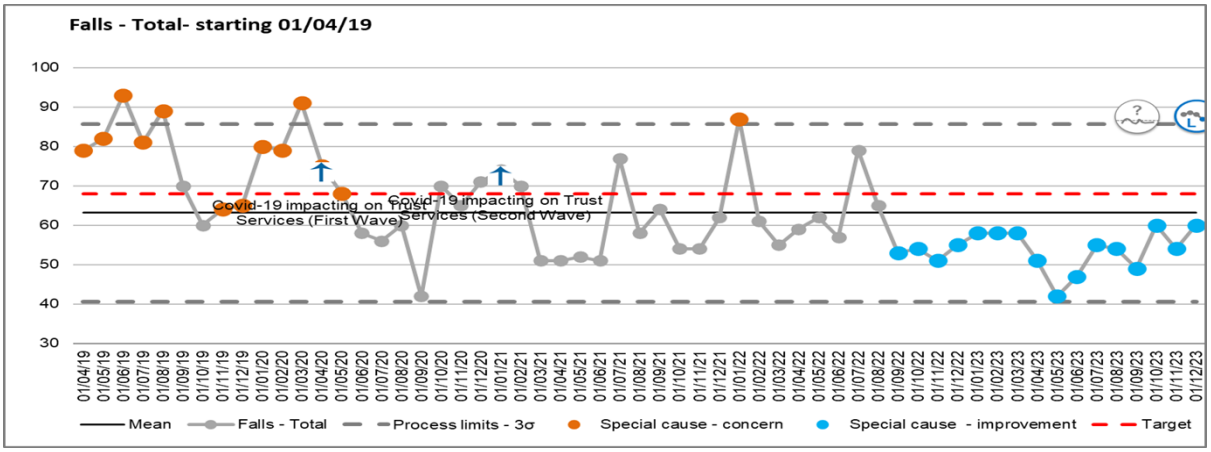
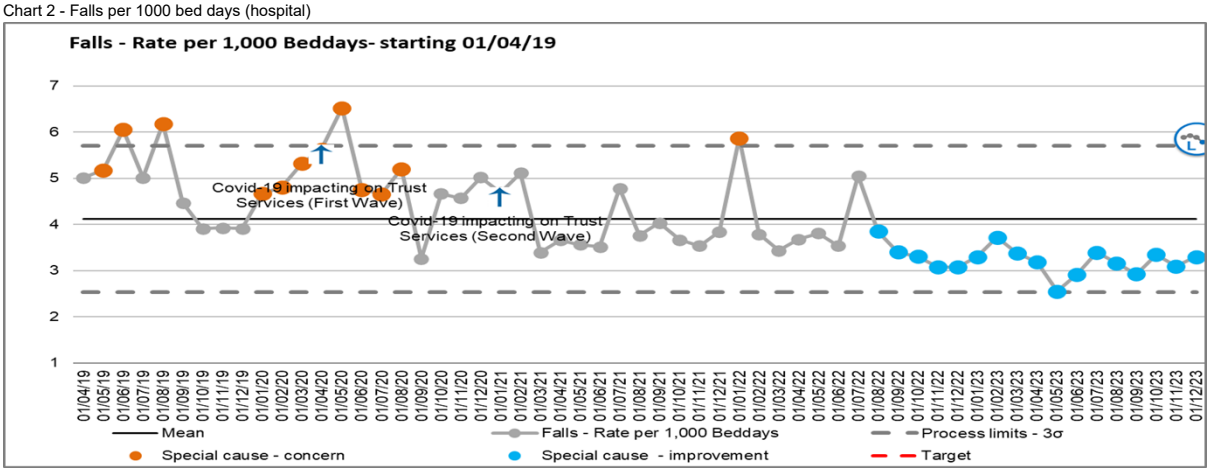


Chart 2 - Falls per 1000 bed days (hospital)



1.2 Tissue viability

- Data from November and December 2023 demonstrates a decrease in pressure ulcer incidents (Chart 3); with reductions in both hospital and community acquired pressure ulcers (Charts 4 & 5).

Chart 3 - Total Pressure Ulcers Hospital and Community

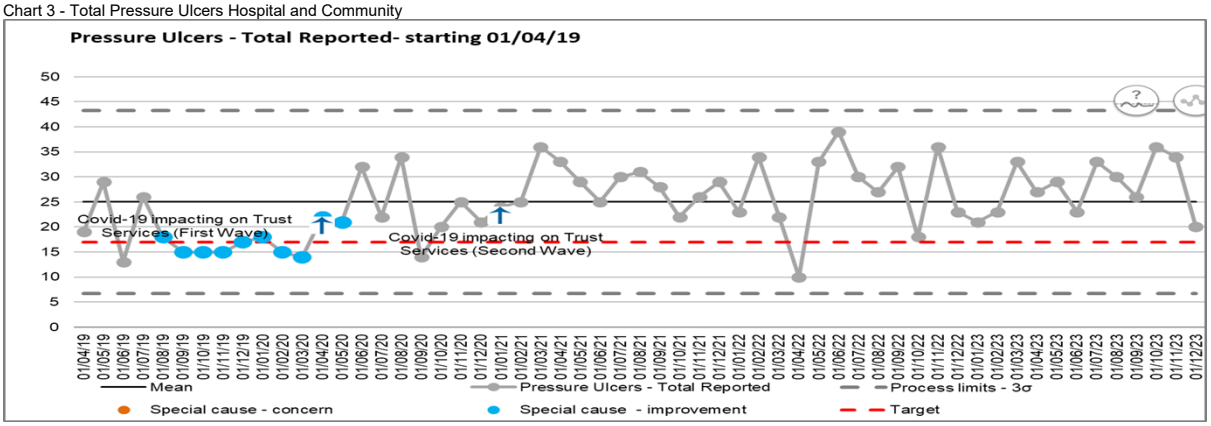


Chart 4 - Community Pressure Ulcers

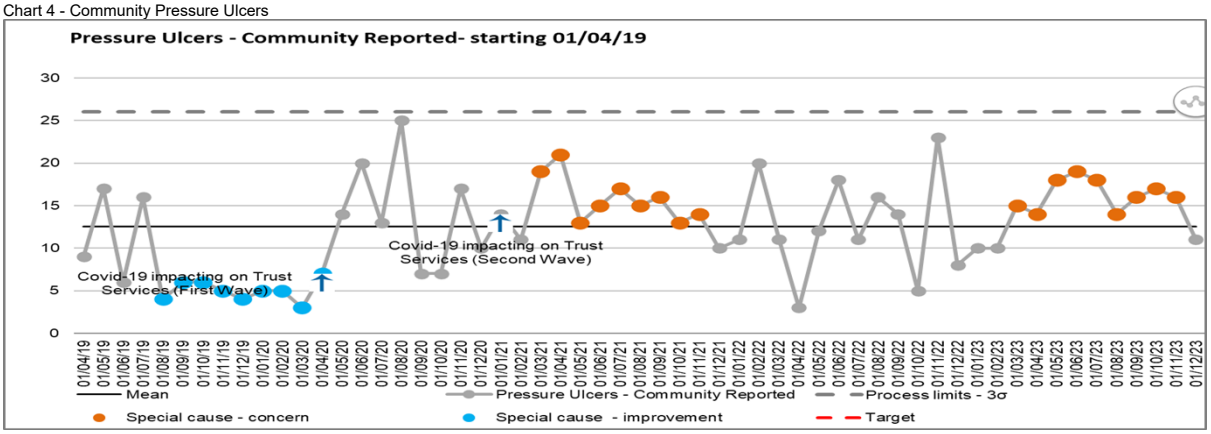
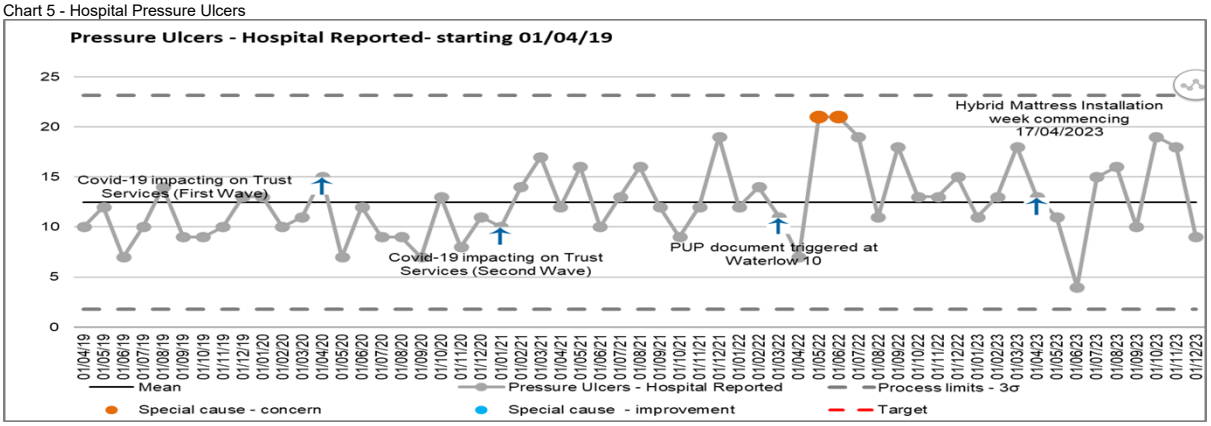


Chart 5 - Hospital Pressure Ulcers



- The trust has responded to a recent CQC request and provided assurance of the extensive quality improvement work over the past year. The skin assessment and Intervention plan has been edited to include a body map. The document will also include darker skin tone guidance, to aid identification of skin changes for all wound types and infection. The operational challenges associated with the electrical supply on some bed spaces continue and mitigating actions are in place until the electrical supply is resolved.

- MASD incidents remain low. There are plans to review continence support in acute to improve continence management.
- A draft process for managing tissue viability related incidents has been produced and will be checked with the patient safety lead prior to sharing with other key stake holders.

Moisture Associated Skin Damage (MASD)

- MASD incidents remain low. There are plans to review continence support on the hospital site to improve continence management (Charts 6 & 7).

Chart 6 - Hospital MASD

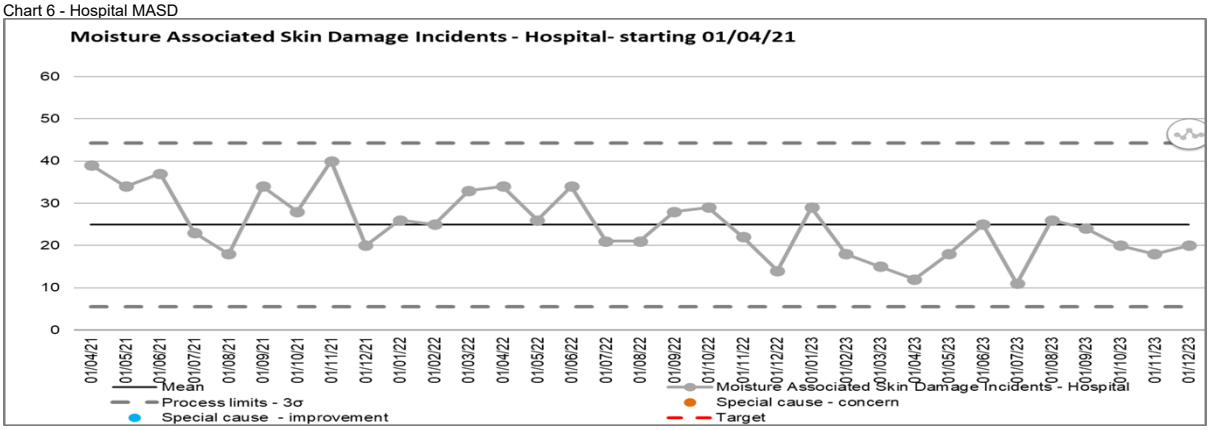
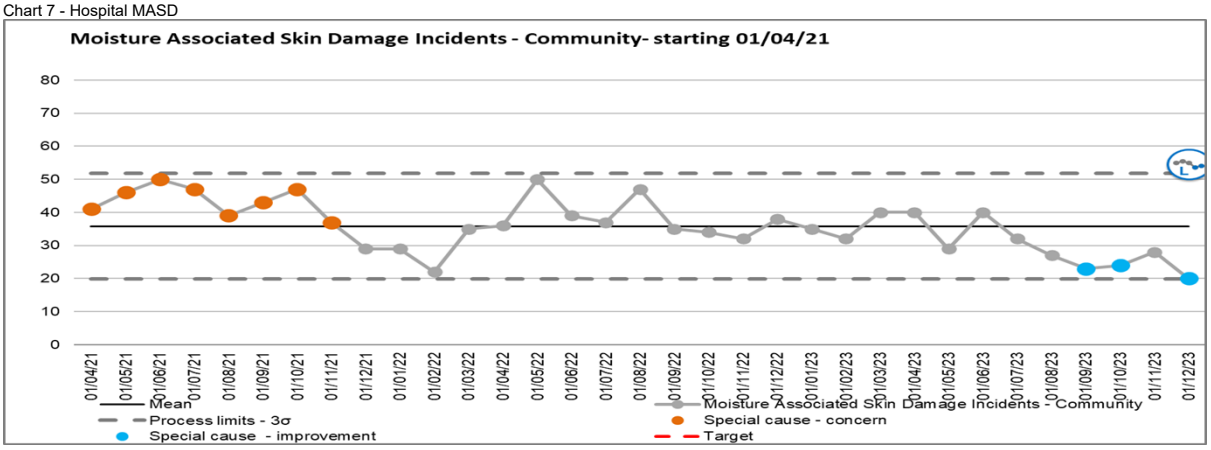


Chart 7 - Hospital MASD



Wound Formulary

- The wound formulary is at its final stages once updated following feedback from the Black Country Trusts prior to sending to the relevant Trust groups for approval. Final stage will be ICB prescribing approval prior to launch.

Surgical wounds

- A new low profile but absorbent dressing (Mepilex) plans to be evaluated on non-elective Trauma & Orthopaedic (T & O) patients from mid-January 2024 to align standards with local T & O providers.

1.3 Observations on time

- The timeliness of observations for November and December 2023 was 88.63% and 87.01% (October 88.52%), including ED (Chart 8) and the compliance was 91.79% and 91.28% for November / December 2023 (October 92.24%), excluding ED (Chart 9).
- 17 out of 28 clinical areas achieved the 90% target in December 2023, a reduction from 25 in October 2023 and 21 in November 2023. There has been a reduction in scores within MLTC which has seen changes of leadership within the division.

Chart 8 - Patient Observations on Time

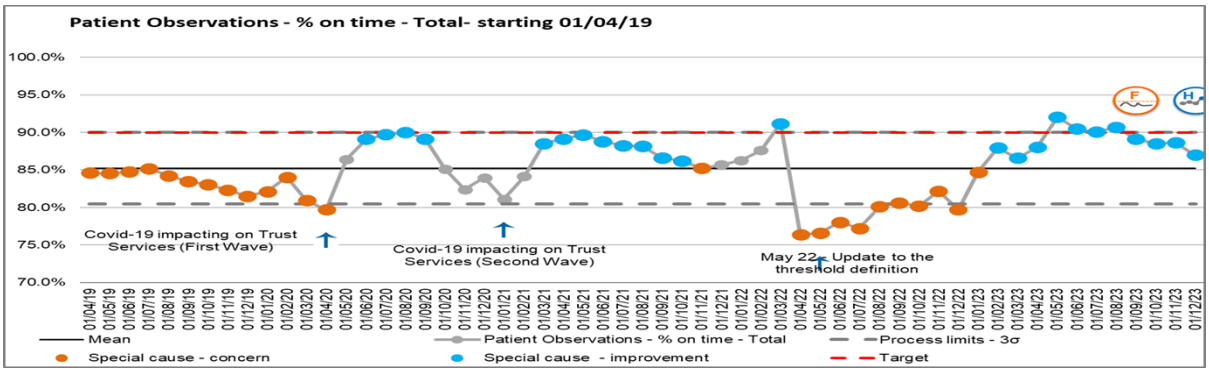
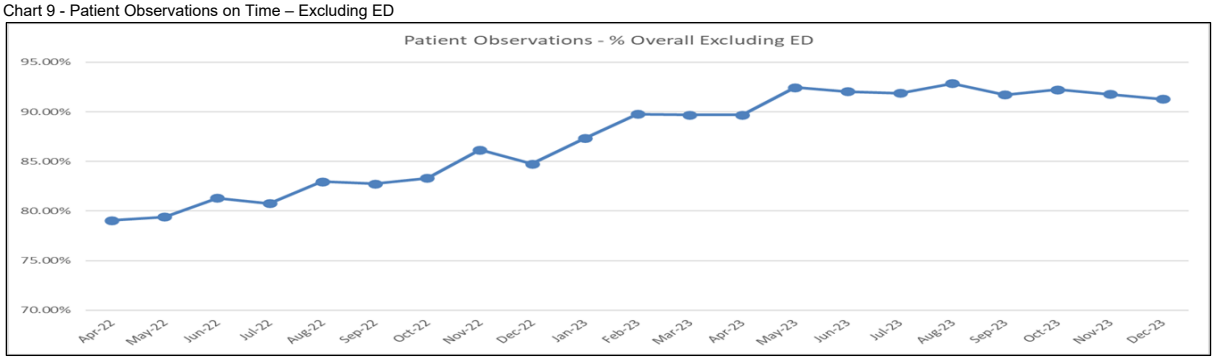


Chart 9 - Patient Observations on Time – Excluding ED



1.4 Quality and Safety Enabling Strategy 2023 - 2026

- The quality and safety enabling strategy was launched in April 2023.
- This joint strategy is our commitment to quality and safety and ensuring we collaborate with staff and patients as our joint partners to improve patient outcomes and their experience.

1.5 Wider quality activities

- The Clinical Accreditation Scheme was launched at the beginning of April 2023. A Clinical Accreditation Board and Shared Professional Decision-Making council for Clinical Accreditation have been established.
- 18 wards have been reviewed since April 2023 (Table 1). 12 wards have been accredited, 4 ward areas have been awarded Emerald, 7 areas awarded Ruby and 9 areas 'Working Towards Accreditation' to date. 9 wards have received their second accreditation visit. 4 ward accreditation visits await ratification of outcomes at Clinical Accreditation Board.
- Goscote Hospice is the first Trust area to be awarded a sapphire accreditation.

Table 1 – Accreditation results

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

15/9/2023	Ward 12	Ruby		
4/10/2023	Hollybank	Emerald		
13/10/2023	Goscote	Sapphire		
01/11/2023	Ward 14	Working Towards Accreditation		

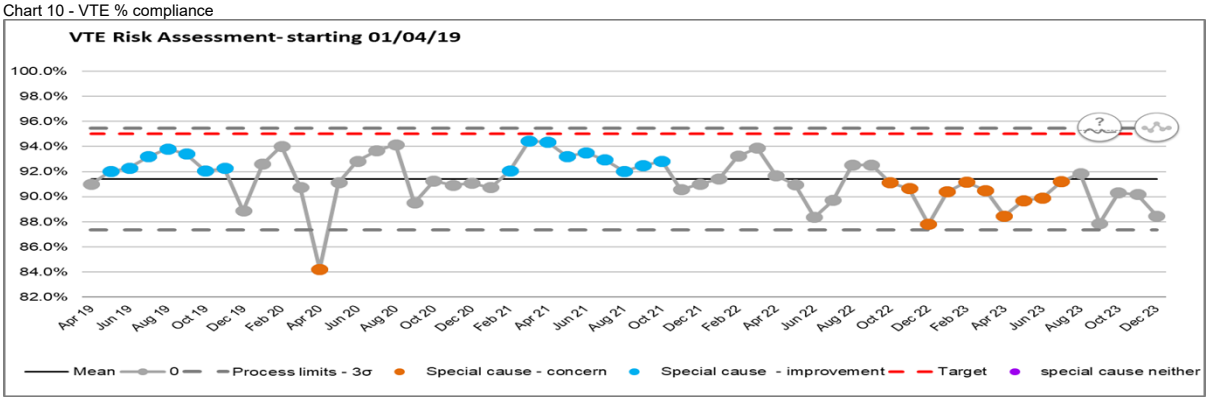
Themes from Clinical Accreditation Visits include:

- Storage of medical notes when not in use and quality of storage containers locks often not working.
  - Action - Escalation to relevant ward managers.
- NG Competency completion in addition to e-learning package.
  - Action – work on-going with nutrition nurse and team FORCE regarding an updated policy and competency.
- MUST Screening compliance at both organisations.
  - Action - Rapid improvement event planned for January 2023 and competency developed with a train the trainer approach with dietitians.
- Quality of meal service for both organisations.
  - Meal survey audit has taken place and work in in place with estates team.
- Reposition adherence on intervention charts documented relieving pressure points.
  - Action - Highlighted in clinical accreditation reports for individual wards/departments, Tissue Viability team incorporating into their training.

1.6 Venous Thromboembolism (VTE) Compliance

- VTE compliance for November 2023 was 90.19% and 88.47% (Chart 10) for December 2023, (October 2023, 90.31%).
- A PowerBI report is sent to the Divisions on a monthly basis and is available on the Trust intranet. Divisions have action plans in place to increase compliance, and this is reported in the Divisional Quality Board each month and directly to the Deputy Chief Medical Officer.
- NHS England are proposing to reintroduce the national VTE risk assessment data collection. There is an additional request for a monthly audit, however the Trust does not have the processes in place to complete this (a manual audit will be required) and a response will be sent to the National Team highlighting this.

Chart 10 - VTE % compliance



1.7 Deteriorating Patient

- The critical care outreach team continue to identify all patients placed onto Scale 2 for appropriateness of use.
- A business case is being developed to support a 24/7 sepsis outreach service.
- Interviews are due to take place for a sepsis and outreach team Matron in February 2024.
- As of December 2023, 51.7% of clinical staff had completed the NEWS2, Royal College of Physicians e-Learning package (an increase from 45.48% in November 2023). Scale 2 training has now been linked to the NEWS2 e-Learning package on My Academy
- All incidents reported as moderate harm related to deteriorating patients are subject to review and oversight by the Deteriorating Patient Group.

1.8 Sepsis

- Within the Emergency Department (ED), 81.96% (Chart 11) of patients received antibiotics within the first hour in November 2023 and 79.86% in December 2023 (83.07% in October 2023).
- For adult inpatients, 73.63% (Chart 12) of patients received antibiotics within the first hour in December 2023, an increase from 67.11% in November. Previous decrease in performance has been discussed at deteriorating patient group where sepsis performance and actions to improve are overseen.
- Sepsis compliance in accordance with local audits remains high at 96% across PAU and Ward 21 (Chart 13). Oversight in both areas provides evidence of good practice on the safety standards and an understanding of what training needs required.
- Paediatric ED Sepsis Performance stood at 68.75% (52.17% in November 2023). There remains an issue with sepsis checklists being opened but not closed. The Lead Paediatric Nurse and Sepsis Team is working with ED colleagues to make improvements to process.

Chart 11 - ED Sepsis Performance

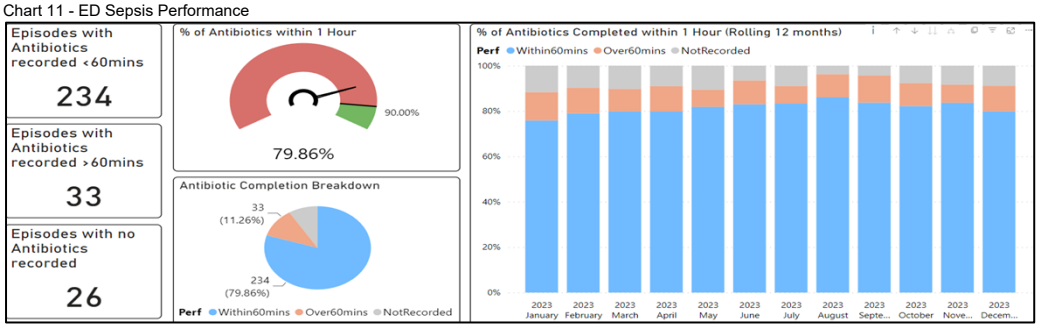


Chart 12 - Adult Inpatient Sepsis Performance

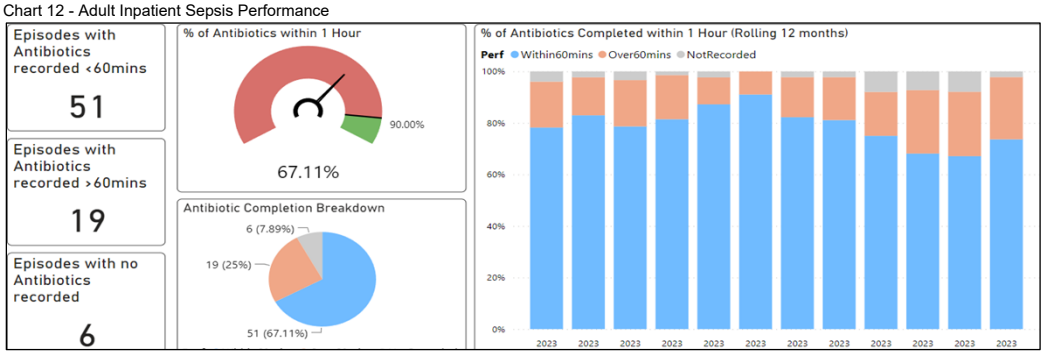
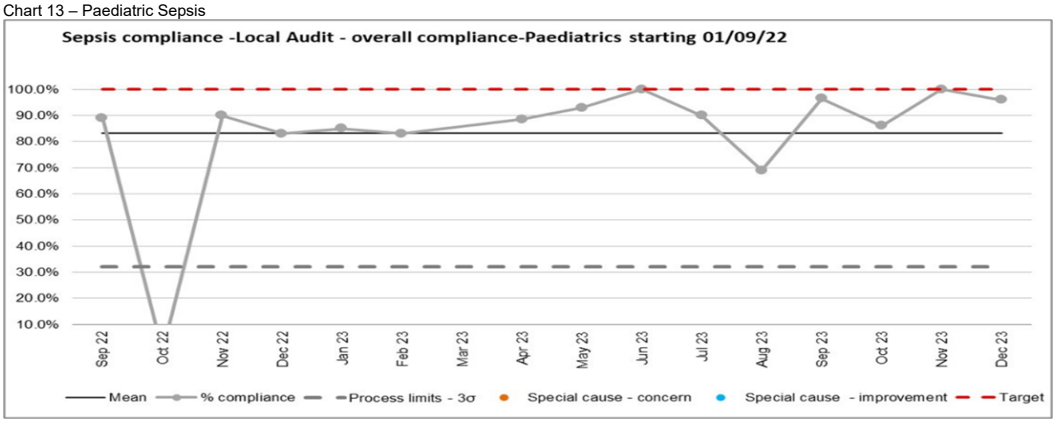


Chart 13 – Paediatric Sepsis



1.9 Nursing Quality Audits

Performance remains relatively consistent and monthly divisional confirm, challenge and support meetings, where audit results are discussed, and action plans produced to improve results and celebrate successes are established across the Trust. The table below details the audit results from January 2023 to date (Table 2).

Table 2 - Trust overall – Audit Compliance

	CARE OF THE DYING	CATHETER AUDIT	CONTINENCE	DETERIORATING PATIENT & SEPSIS	DOCUMENTATION	ENVIRONMENT	FALLS & DECONDITIONING	IPC	MEDICINES MANAGEMENT	NUTRITION & HYDRATION	ORAL CARE	PAIN MANAGEMENT	PATIENT EXPERIENCE	TISSUE VIABILITY
JANUARY	95.7%	67.5%	83.2%	77.8%	91.7%	93.7%	78.8%	95.0%	91.7%	91.2%	89.4%	95.7%	88.0%	79.5%
FEBRUARY	95.9%	82.3%	93.4%	97.5%	92.3%	92.5%	87.6%	95.3%	92.0%	89.2%	96.1%	98.1%	95.8%	96.0%
MARCH	93.1%	87.0%	82.4%	98.9%	86.4%	92.9%	85.7%	94.2%	92.8%	92.0%	88.8%	97.2%	95.8%	90.6%
APRIL	99.6%	91.5%	80.1%	99.0%	88.0%	93.2%	89.4%	95.7%	92.8%	90.5%	91.8%	94.5%	95.6%	88.1%
MAY	90.4%	81.5%	77.7%	97.0%	87.3%	91.8%	90.6%	95.2%	93.1%	89.8%	87.8%	96.4%	96.7%	91.2%
JUNE	96.9%	85.7%	90.7%	95.8%	92.3%	92.6%	90.7%	95.8%	94.3%	84.3%	95.4%	95.4%	96.8%	89.9%
JULY	97.7%	84.6%	89.6%	98.8%	87.8%	94.0%	89.2%	96.5%	95.1%	88.8%	94.0%	95.0%	97.8%	94.6%
AUGUST	95.1%	82.6%	92.4%	99.2%	91.7%	95.7%	88.1%	94.9%	95.6%	90.8%	90.6%	93.4%	95.7%	96.2%
SEPTEMBER	96.2%	88.7%	84.9%	97.6%	92.3%	95.6%	91.3%	96.9%	95.0%	91.8%	91.2%	91.7%	96.0%	98.0%
OCTOBER	89.1%	90.8%	76.9%	98.7%	93.4%	95.1%	90.3%	97.4%	95.9%	86.1%	91.6%	83.8%	96.6%	91.7%
NOVEMBER	94.9%	88.9%	84.6%	90.0%	94.7%	94.7%	92.4%	97.3%	95.5%	93.5%	95.2%	91.3%	94.4%	95.3%
DECEMBER	93.2%	92.7%	67.4%	88.9%	93.5%	94.9%	85.2%	90.5%	96.2%	89.7%	85.7%	90.8%	97.8%	94.1%

1.10 Medicines Management

- A total of 124 medication incidents were reported in November 2023 a decrease of 6 incidents from previous month (October 2023). Most incidents were reported as near misses to no harm (n=92), 30 incidents were low harm and 2 incidents caused moderate harm (2), there were no severe harm incidents.
- There has been a reduction in errors for omissions, prescriptions errors and dispensing errors in November 2023.
- A total of 97 weekly audits have been conducted by the nursing and midwifery teams across the divisions. The average weekly score for compliance of medication standards of ward storage is 96%.
- A total of 9 Controlled Drug (CD) incidents were reported in November 2023
- CD audits completed by pharmacy: 9 audits took place in November 2023, average compliance was 81% which is a slight decrease from 84% in October 2023.
- Themes for improvement continue to be documentation within the CD register, signing receipt of receiving controlled drugs, twice daily stock check, running balance within CD register and patients own drugs being recorded within CD Patients Own Drug register.
- Work continues with the senior nursing team and pharmacy to ensure the audit tool is reflective of the practice within clinical areas.

1.11 Mental Health (MH)

There is still considerable pressure on our ED department from Mental Health (MH) patients who need assessment and potentially treatment. A Memorandum of Understanding (MOU) has been provided to the Trust from the Black Country Healthcare Foundation Trust (BCHFT) which has still yet to be agreed. The MOU needs to adequately provide for the Responsible Clinician (for patients held under a MH Section and MH Assessment) and provide KPIs for the Mental Health Liaison Service on the WHT sites. A meeting between the CMO for both RWT and WHT with the CMO at BCHFT is scheduled to take place at the end of January 2024 to discuss this issue.

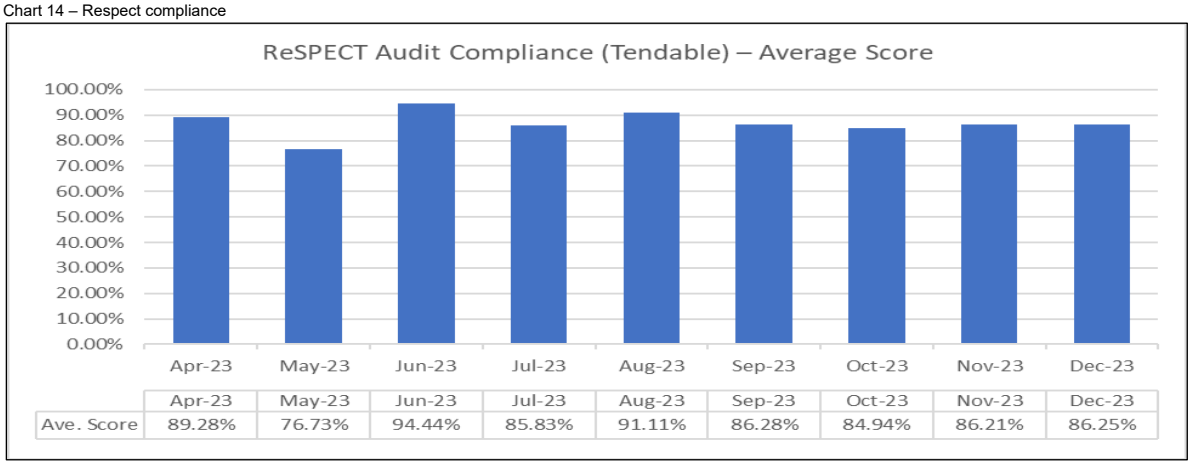
1.12 RESPECT including MCA

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

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

The data has been collected in Tendable Audit (Respect) since June 2023 and results for November 2023 and December 2023 are 86.21% and 86.25% respectively (84.94% in October 2023, Chart 14).

Chart 14 – Respect compliance



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Ave. Score	89.28%	76.73%	94.44%	85.83%	91.11%	86.28%	84.94%	86.21%	86.25%

1.13 Adult and Children Safeguarding and Associated Training

Current Training Compliance – adult and children's levels 1 and 2 remain above Trust target.
Adult Safeguarding Level 3 = 83.24% (80.50% November 2023).
Child Safeguarding Level 3 = 79.24% (76.97% November 2023).

Further review has taken place to work through stafing competencies, ensuring staff roles align with the intercollegiate guidance. A paper outlining this is due to safgeuarding committee in February 2024.

1.14 Infection prevention and Control

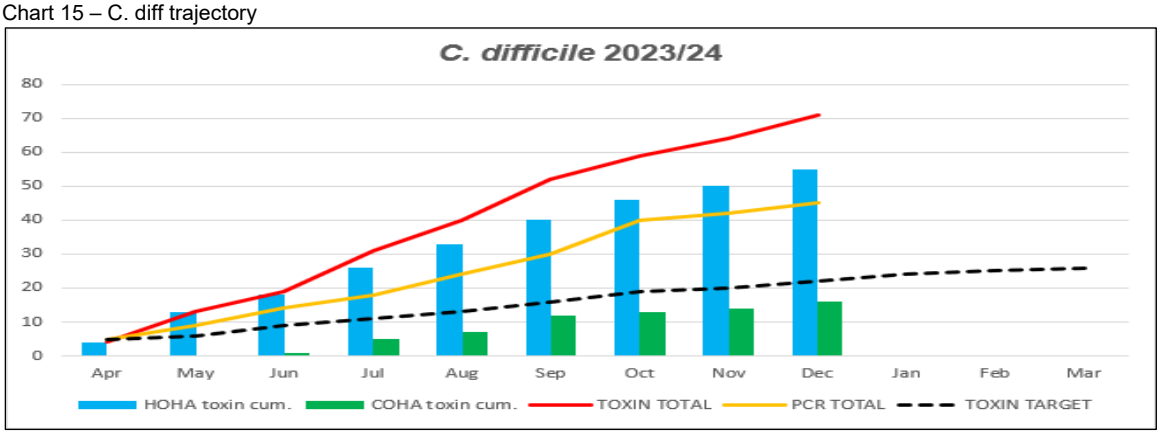
Clostridiodes difficile (C. diff)

- A total of 5 C. *diff* toxin cases were reported in November 2023 and 7 in December 2023 (Table 5). Of the November 2023 cases, 4 were deemed avoidable and 1 unavoidable. In December 2023, 3 were avoidable and 4 were unavoidable.
- The National Trust target for 2023/24 has been set at 26 which is a reduction of one on 2022/23 target – Table 3 provides the current trajectory given this new target.
- The graph showing trajectory against cases is illustrated in chart 15.

Table 3 - C. Diff cases

2023/24	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Max Cases per Month	2	2	2	2	2	2	2	2	3	3	2	2
Actual cases per month	4	9	6	12	9	12	7	5	7			
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	26
Acute Cumulative actual	4	13	19	31	40	52	59	64	71			

Chart 15 – C. diff trajectory



Actions in progress:

- Individual antibiotic prescribing practice being followed up via incident reports when identified by the Infection Prevention & Control (IPC) team. Antimicrobial stewardship (AMS) KPIs overall demonstrate improvement and demonstrate better performance than other providers in the region, which is reported through IPC committee.
- No regular support for preventing incidence of pneumonia (i.e. mouth care team) - A business case has been approved in principle but requires source to funding. The IPC team and quality team provide education to higher risk areas on fundamentals of mouth care and incorporate in the eat, drink, dress, move to improve initiative.
- Not enough side room facilities to meet isolation demand - Risk is being mitigated through the IPC team and operations centre risk assessing prioritisation on a daily basis.
- Limited treatment options for patients with 1st episode of *C.difficile* infection and relapse - IPC and AMS team currently reviewing options for faecal microbiota transplant capsule pathways.
- Blood culture contaminants as part of the sepsis pathway. Intermittent improvements based on educational competency focus sessions in ED.
- No routine ability to deep clean used beds - The decant deep clean programme has been paused during utilisation of the decant ward for winter capacity, but with intentions to reconvene the programme once winter capacity stepped down.

Measles

- Measles is highly infectious, the most infectious of all diseases transmitted through the respiratory route. Measles can be severe, particularly in immunosuppressed individuals and young infants. It is also more severe in pregnancy, and increases the risk of miscarriage, stillbirth, or preterm delivery.
- After briefly achieving endemic measles elimination in 2016 and 2017, by 2018 measles virus transmission had re-established in the UK, at a time when the whole of Europe was experiencing large epidemics. Measles activity reduced dramatically during the Covid-19 pandemic due to the implementation of wide ranging societal and travel restrictions. This interrupted transmission and has resulted in measles elimination status technically being regained, in the UK in 2023 (reflecting 2022 surveillance data). However, the incidence has increased again in England during 2023, as it has globally, with large outbreaks currently underway in multiple countries, so this is unlikely to be sustained.
- Measles vaccinations are not mandated within the NHS, but the occupational health team have been identifying staff who are not vaccinated and are offering the MMR vaccine. This has commenced with clinical areas where a measles case is likely to present, i.e. ED and paediatrics. Contact with a patient suffering from measles, could mean a 21-day isolation period for a member of unvaccinated staff, not wearing the correct PPE.
- The IPC team are currently scoping a process for contact tracing and administration of immunoglobulin for clinically high-risk patients / visitors in the trust who may come into contact with a measles case.

1.15 Local Safety Standards for Invasive Procedures (LocSSIPS)

- LocSSIPs are a set of guidelines developed by the National Patient Safety Agency to improve patient safety during invasive procedures.
- LocSSIPs cover a range of invasive procedures, including surgery, radiology, and endoscopy. The guidelines include a step-by-step process for assessing the risks associated with each procedure, identifying potential hazards, and implementing appropriate measures to minimize those risks.
- The aim of LocSSIPs is to ensure that healthcare professionals have a systematic approach to managing risk during invasive procedures, which will help to reduce the likelihood of adverse events and improve patient safety. The guidelines also encourage communication and collaboration between healthcare professionals involved in the procedure, as well as with the patient and their family or carers, to ensure that everyone is informed and involved in the decision-making process. (Table 4).

Table 4 – LocSSIPS

Division	Area	Apr Compliance	May Compliance	Jun Compliance	Jul Compliance	Aug Compliance	Sep Compliance	Oct Compliance	Nov Compliance	Dec Compliance
Community	Community - CIT				100%	Not Received	100%			Not Due
Community	Community - Podiatry	100%	100%	100%	100%	100%	100%	100%	100%	100%
Community	Community - Diabetes-Podiatry	100%								
Community	Community - Children's	100%	100%	100%	100%	100%	100%	100%	Not Received	Not Due
MLTC	Cardiac Intervention Suite	100%	100%	100%	100%	100%	100%	100%	100%	100%
MLTC	Emergency Department	48%	43%	63%	40%	54%	31%	28%	50%	52%
MLTC	Endoscopy	100%	100%	100%	100%	100%	100%	100%	100%	100%
MLTC	Gastroenterology (Ward 16)	100%	100%	100%	100%	100%	100%	100%	100%	100%
MLTC	Ward 15	100%				100%	100%		100%	Not Due
MLTC	Pleural Procedures Clinic	100%	88%	92%	100%	100%	100%	100%	100%	100%
MLTC	AMU	73%	50%	50%	100%	66%	88%	67%	100%	Not Due
Surgery	Chemotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgery	Maxillofacial / Dental	100%	100%	100%	100%	100%	100%	100%	100%	Not Due
Surgery	Intensive Care Unit	74%	80%	94%	70%	100%	100%	Not Received	71%	71%
Surgery	Ophthalmology	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgery	Outpatient - Vascular	100%	100%	100%	67%	100%	100%	100%	50%	Not Due
Surgery	Outpatient - Dermatology	78%	100%	100%	100%	100%	100%	100%	100%	Not Due
Surgery	Foot and Ankle Steroid Injection	100%	86%	95%	95%	100%	100%	100%	100%	Not Due
Surgery	Outpatient - Orthopaedic				80%				100%	100%
Surgery	Urology	100%			100%			Not Received	Not Received	Not Due
WCCSS	Imaging	94%	90%	94%	95%	97%	94%	100%	100%	Not Due
WCCSS	Gynaecology		100%				100%			Not Due
WCCSS	Maternity	93%	86%	65%	100%	66%	100%	100%	100%	Not Due
WCCSS	Paediatrics/Neonates	100%	100%	62%	100%	82%	50%	100%	Not Received	Not Due
Trust Wide - % of Audit Returns Received		100%	100%	100%	100%	96%	100%	92%	88%	Not Due
Trust Wide - % of LocSSIPs fully completed		88%	84%	92%	86%	90%	87%			Not Due

Actions taken:

- A task and finish group has been established for ED, this has resulted in slight improvements to the completion of the LocSSIPs. The team have reached out to RWT to provide information pertaining to their LocSSIP compliance. The procedures currently audited are under review in line with NatSSIP 2 recommendations.
- A task and finish group has been established for AMU with a revised audit process established that is seeing improved results across the area.
- The Vascular team have noted issues with elements of the consent form completion and action has been taken to address these shortfalls and ensure improvement within the next reporting schedule.

1.16 Patient Safety Group (PSG) – Divisional Escalations

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

WCCSS

- Concerns in paediatric Urgent & Emergency Care Centre (UECC) area relating to staff and impact on patient safety – work is now underway to ensure increased Paediatric visibility and support.
- HSDU - October 2022 to October 2023: 10 incidents with No Harm /Low Harm. Themes include missing instruments/swabs from trays before surgery and missing instruments after surgery.
- Aseptic Unit - Due to multiple points of failure (equipment, staffing, processes, trend of growth), aseptic unit been temporarily suspended in producing Chemotherapy. Communication shared with Oncologist and haematologist re minimum 5 days chemotherapy prescription and pharmacy team will continue purchasing chemotherapy from other providers. Ongoing work with estate and IPC teams to address concerns around aseptic unit and actions captured through risk register 3201 and 3347.

Surgery

- ILS training in theatres, additional training being scoped with FORCE team.

- Cluster of 4 infections in elective orthopaedic patients requiring return to theatre. Elective implant surgery halted, and IPC investigation undertaken. Ring fencing on 20A reinforced and antibacterial suture use commenced
- The review process into hands and wrist patients has nearly been completed.
- The colorectal improvement programme continues – daily consultant ward rounds in place and audited.
- There have been 15 patients breaching 104 days for September 2023 (latest available data).
    - All 15 cases have been reviewed by the lead cancer nurse with independent support from ICB Lead Nurse.
    - Of these patients, 3 urology, 1 head & neck, 1 lung, 1 gynaecology, 1 skin, 1 haematology, 2 upper gastrointestinal and 5 colorectal (1 patient histology confirmed primary colorectal but was treated surgically under specialist peritoneal centre).
- Outstanding SI actions - as of 12/11/2023, (target date taken as 31/10/2023) Surgery has a total of 52 actions, which is a reduction of 4 from the previous month, with 13 sitting outside the Division with 8 sitting under urology.

MLTC

- 38 beds are open on the Winter Escalation Ward, based across Wards 5 and 6. This exceeds the planned Winter capacity (21 beds) both in terms of number of beds and duration they are open (funding provided for 12 weeks, due to cease in December 2023).
- VTE assessment within 24 hours is at 84.42% and 92.92% during the admission. A VTE audit has been completed which will inform further improvements required.
- A total of 4 C diff toxin cases were reported during November 2023, following a review of the cases three cases were deemed avoidable due to prescribing of multipole antibiotics (one with a delayed stool sample).
- Surveillance of water testing has found quite high counts of Legionella pneumophila in shower on Ward 2 ensuite. Currently controlling measures are in place by using filters, implementing extensive flushing, and changing valves.
- Face Fit mask testing compliance for two or more masks has reduced to 38%, train the trainer of 5 staff members in ED is underway (particular importance in ED due to current Measles outbreak).
- Antibiotics within 1 hour has dramatically reduced to 57.69% on medical wards and 87.01% in ED (96% manual audit). Escalation of concern regarding number of documents able to be opened at one time and so delay in fully closing a document.
- Timely patient observations have reduced to just below the KKPI of 90% to 86.43%, three areas within the Division require additional oversight (ED, AMU, Ward 14 and Ward 29).

Community

- BLS and Patient Handling compliance are both below trajectory however it has been noted that MyAcademy is still not correct as the detail within the Manager view is different to that of the individual staff member. Community based sessions have also been arranged for both competencies from January 2024.

1.17 Digital and Innovation

- Clinical Narrative Enhancement:
  Requirement for Careflow PAS Update*:* The progression from Clinical Noting to Clinical Narrative necessitates an update to the Careflow Patient Administration System (PAS). This requirement represents a new development in our digital
- ***Impact on Timeline***: The introduction of this new requirement has implications on our timelines, leading to delays in the transition process. It's essential to assess and manage these changes effectively to minimise disruptions to clinical workflows.

Vitals Software Upgrade (Version 4.2 to 4.3):

- ***Upgrade Schedule***: The scheduled upgrade to Vitals 4.3 is set for the 6th of February. This upgrade is a commitment to keeping our systems current and efficient with improved performance for all users.

- ***Preparation and Approval**:* The localisation document, a crucial component of this upgrade, was signed off on Friday in collaboration with the Chief Clinical Information Officer (CCIO). This step ensures that the software is tailored to the specific needs of our Trust.

Patient Experience Portal Development:

- ***Preparatory Phase Completion**:* The initial phase of the Patient Experience Portal project, encompassing essential preparatory work, has now been concluded. Healthcare Communications (Healthcare Comms) will continue to engage with the Trust to advance configuration and business analysis activities.
- ***Collaboration and Insights**:* Insights gathered from a recent meeting with colleagues from Russell Hall Hospital (DGH) have highlighted the importance of effective patient communication. These insights will be presented to the Design Advisory Group for consideration and subsequent ratification by the Board.
- ***Implementation Timeline**:* Despite the additional considerations, the 'Go Live' date for the Patient Experience Portal remains on target for the end of March 2024. This commitment reflects our dedication to enhancing patient engagement and experience through digital means.

1.18 Patient experience
Quarterly Report reporting to committee this month.

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

Table 5 – Guideline position

Guideline overview	In Date	Due for Renewal in next 3 Months	Due for Renewal in next 6 Months	Past the review date	New Guidelines	Total
October – 23	133			95	4	232
	57%			41%	2%	
November – 23	130			102	2	234
	56%			43%	1%	
December -23	126			103	2	231
	55%			45%	1%	

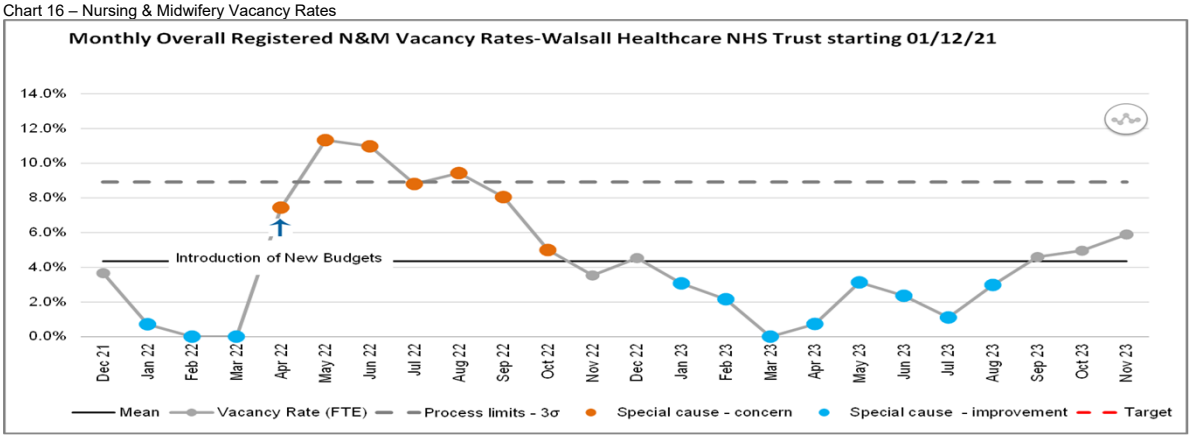
1.20 Briefing on NatPSA Bed Rails Alert
The NatPSA/2023/010/MHRA is a National Patient Safety Alert regarding avoidable serious injury and deaths associated with medical beds, trolleys, bed rails, bed grab handles, and lateral turning devices. It emphasises the danger of death and serious injuries due to entrapment or falls. A separate paper is available as appendix 3.

2.0 Workforce

2.1 Nursing and Midwifery Vacancies

- In December 2023, the total number of Registered Nurse/Midwife vacancies increased to just under 6% (Chart 16). An increase was seen within MLTC as a result of Ward 17 vacancies being advertised.

Chart 16 – Nursing & Midwifery Vacancy Rates



2.2 Agency Cessation

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

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

Chart 17 – Tier 1 agency usage

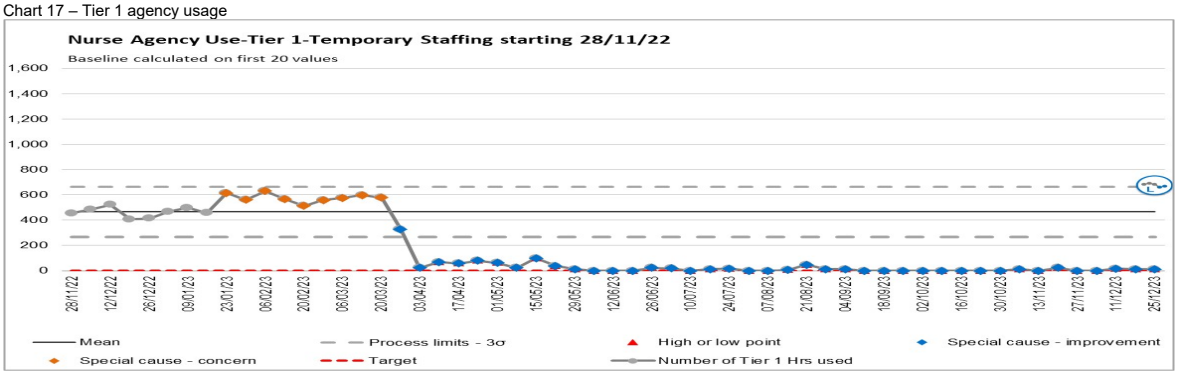


Chart 18 – Tier 2 agency usage

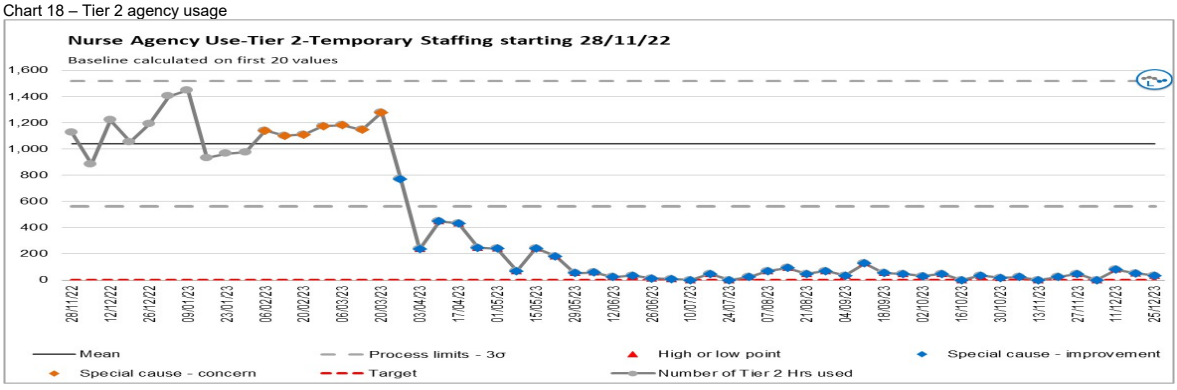
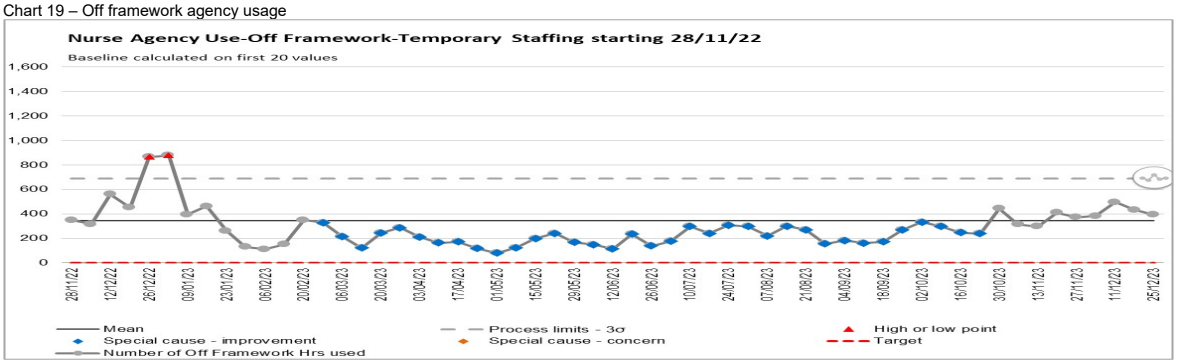


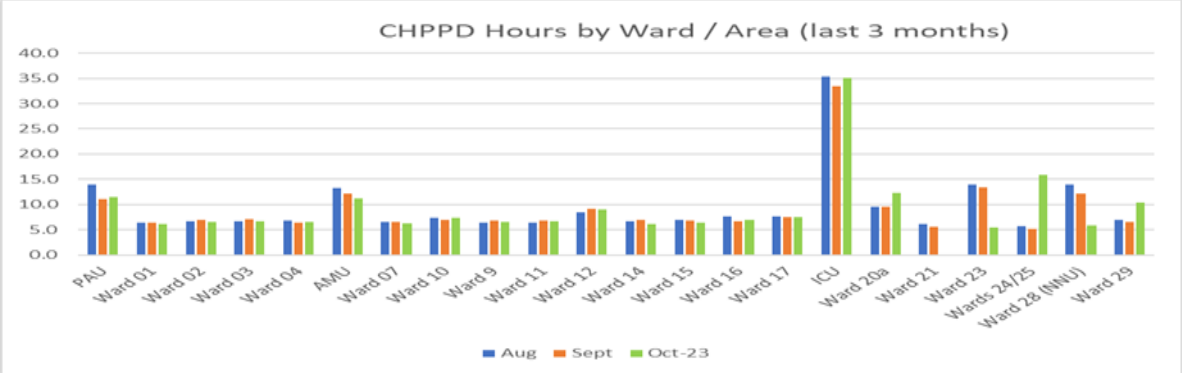
Chart 19 – Off framework agency usage



2.3 Care Hours per Patient Day (CHPPD)

- The CHPPD trust average for December 2023 was 9.4 (November 2023 was 9.1). CHPPD per ward are illustrated in chart 20. The national overall CHPPD average for May 2023 (latest data) was 9.77.

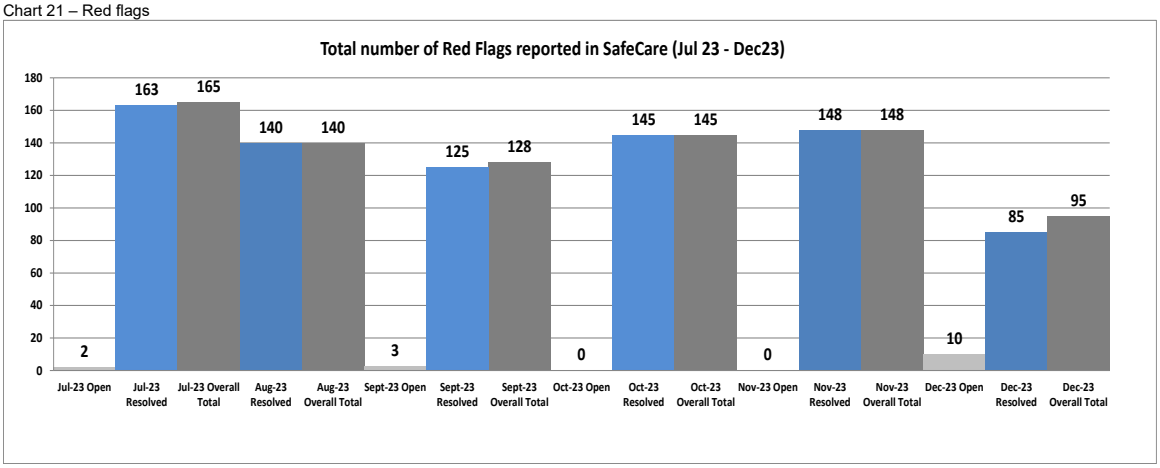
Chart 20 - Care Hours Per Patient Day by Area



2.4 Red Flags

- There were no open Red Flags reported in November, and in December 2023 10 red flags remained opened.
- 148 red flags were opened and resolved in November 2023, and 95 red flags were reported in December 2023 and 85 were resolved (Chart 21).
- Red flags that remained open in December 2023 were in relation to increased patient acuity, patients requiring one to one care.

Chart 21 – Red flags



3.0 Education

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

- Standards for Student Supervision and Assessment S(SSA) training compliance in November 2023 is at 67% and has increased to 78.3% in December 2023 which is a significant increase in compliance and reflects recent focus on this element of training. Communication via the matrons has been provided to ensure that staff complete this training.
- 83% of Clinical Support Workers (CSW) have completed their care certificate and increase from 63% in November 2023.
- A new band 5 nursing development programme is due to commence at the end of January 2023 in collaboration with RWT.

End of Report

Appendices

Appendix 1
QPES Committee Dashboard

Appendix 2
Quality Dashboard

Appendix 3
NatPSA/2023/010/MHRA - National Patient Safety Alert update paper

		Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2023/24 YTD	2023/24 Target	2022/23 YTD	2022/23 Target	SPC Assurance	SPC Variation
SAFE, HIGH QUALITY CARE													
No.	Sleeping Accommodation Breaches	5	5	0	0	0	0	10	0	0	0		
No.	HSMR (HED) nationally published in arrears	106.33	69.21	70.57					100		100		
No.	SHMI (NHS Digital) (12 Month Rolling Position) - Manor Hosp Site	0.9933							1		1		
Rate	Crude Mortality Rate (HED)	2.71	1.62	0.94									
No.	Number of Deaths in Hospital	92	91	97	107	117	104	908		1304			
%	% of patients who achieve their chosen place of death	70.77%	50.94%	53.33%	63.79%	55.38%	64.00%	61.24%		60.99%			
No.	MRSA - No. of Cases	1	0	0	0	0	0	2	0	1	0		
No.	Clostridium Difficile - No. of cases	12	9	12	7	5	7	71	26	50	27		
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Adults	86.48%	87.11%	86.92%	84.30%	87.01%	79.93%		90.00%		90.00%		
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Paeds	29.41%	55.56%	31.25%	52.17%	42.86%	68.75%		90.00%		90.00%		
%	Sepsis - % of patients screened who received antibiotics within 1 hour - Inpatients (E-Sepsis Module)	74.14%	73.64%	66.10%	60.82%	68.27%	72.07%	72.92%	90.00%	70.64%	90.00%		
%	Deteriorating patients: Percentage of observations rechecked within time	89.92%	90.72%	89.10%	88.52%	88.63%	87.01%	89.35%	90.00%	80.98%	90.00%		
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	0.88	0.94	0.6	1.06	1.03	0.49						
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.62	0.48	0.55	0.59	0.55	0.38						
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	15	16	10	19	18	9	115		180			
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	18	14	16	17	16	11	143		145			
No.	Falls - Total reported	55	54	49	60	54	60	472		709			
Rate	Falls - Rate per 1000 Beddays	3.4	3.16	2.93	3.34	3.09	3.3				6.1		

		Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2023/24 YTD	2023/24 Target	2022/23 YTD	2022/23 Target	SPC Assurance	SPC Variation
No.	Falls - No. of falls resulting in severe injury or death	1	0	0	0	0	0	11	0	8	0		
%	VTE Risk Assessment	91.21%	91.87%	87.87%	90.31%	90.19%	89.13%	89.90%	95.00%	90.65%	95.00%		
No.	National Never Events	0	0	0	0	0	0	0	0	2	0		
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	6	3	3	4	1	0	37		76			
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	0	0	0	1	0	0	2		4			
No.	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	24	29	22	37	36	27	262		317			
No.	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	5	0	1	3	0	4	20		28			
%	% of total incidents resulting in moderate, severe harm or death	1.80%	1.56%	1.57%	2.25%	2.13%	2.10%	2.00%		1.97%			
%	Trust-wide Safety Index - % of medication incidents resulting in harm (one month in arrears)	16.00%	28.00%	28.00%	22.00%			23.21%		19.30%			
No.	No. of reported medication incidents level 3, 4 or 5 (one month in arrears)	1	3	3	1			12	0	7	0		
Rate	Midwife to Birth Ratio	25.8	29.2	29.6	24.4	25.4	26.9		28.0		28.0		
%	One to One Care in Established Labour	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
%	Instrumental Delivery	7.53%	8.41%	8.47%	6.45%	9.80%	9.97%	8.94%	10.00%	8.84%	10.00%		
%	Induction of Labour	36.68%	33.22%	37.62%	35.53%	36.88%	30.90%	35.57%		38.32%			
%	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.54%	11.05%	11.84%	11.85%	11.87%		11.36%	10.00%	11.64%	10.00%		
%	Electronic Discharges Summaries (EDS) completed within 48 hours - Inpatients	81.79%	80.31%	79.80%	81.14%	81.82%	81.71%	80.75%	100.00%	82.98%	100.00%		
%	ReSPECT Audit Compliance - Average Score	85.83%	91.11%	86.28%	84.94%	86.21%	86.25%		90.00%				
%	Complaints - % responded to within agreed timescales	88.89%	90.70%	84.21%	85.37%	76.47%	76.47%	86.74%	80.00%	81.74%	80.00%		
No.	Longest Wait for an Open Complaint	100	120	119	116	139	126						

		Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2023/24 YTD	2023/24 Target	2022/23 YTD	2022/23 Target	SPC Assurance	SPC Variation
No.	Clinical Claims (New claims received by Organisation)	37	45	18	29	21		199		167			
%	Workforce - Vacancy Rates - Nursing Staff	1.94%	3.36%	4.60%	4.96%	5.89%			7.00%				
%	Workforce - Vacancy Rates - Medical Staff	6.05%	4.12%	-1.15%	-1.12%	0.30%			7.00%				
%	Workforce - Vacancy Rates - AHP Staff	3.27%	3.91%	1.55%	3.08%	4.86%			7.00%				
%	Workforce - Vacancy Rates - Overall	4.99%	5.57%	4.80%	6.06%	7.18%			7.00%				
%	Friends and Family Test - Inpatient (% Recommended)	88.00%	88.00%	88.00%	88.00%	89.00%	90.00%		96.00%		96.00%		
%	Friends and Family Test - Outpatient (% Recommended)	93.00%	91.00%	92.00%	92.00%	91.00%	91.00%		96.00%		96.00%		
%	Friends and Family Test - ED (% Recommended)	81.00%	80.00%	80.00%	75.00%	80.00%	82.00%		85.00%		85.00%		
%	Friends and Family Test - Community (% Recommended)	98.00%	99.00%	99.00%	99.00%	99.00%	99.60%		97.00%		97.00%		
%	Friends and Family Test - Maternity - Antenatal (% Recommended)	89.00%	86.00%	86.00%	88.00%	82.00%	90.00%		95.00%		95.00%		
%	Friends and Family Test - Maternity - Birth (% Recommended)	92.00%	79.00%	94.00%	87.00%	93.00%	96.00%		96.00%		96.00%		
%	Friends and Family Test - Maternity - Postnatal (% Recommended)	73.00%	87.00%	86.00%	89.00%	93.00%	95.00%		92.00%		92.00%		
%	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	80.00%	96.00%	94.00%	98.00%	97.00%	100.00%		97.00%		97.00%		
%	PREVENT Training - Level 1 & 2 Compliance	93.61%	95.12%	94.35%	94.35%	93.72%	94.26%		90.00%		90.00%		
%	PREVENT Training - Level 3 Compliance	90.19%	91.29%	92.60%	93.29%	93.36%	93.89%		90.00%		90.00%		
%	Adult Safeguarding Training - Level 1 Compliance	94.47%	94.67%	94.12%	94.14%	93.64%	95.11%		90.00%		90.00%		
%	Adult Safeguarding Training - Level 2 Compliance	90.94%	91.78%	93.46%	94.10%	94.55%	96.01%		90.00%		90.00%		
%	Adult Safeguarding Training - Level 3 Compliance	81.23%	78.73%	80.13%	80.42%	80.85%	83.64%		90.00%		90.00%		
%	Children's Safeguarding Training - Level 1 Compliance	93.39%	92.38%	91.78%	90.68%	89.41%	91.26%		90.00%		90.00%		

		Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2023/24 YTD	2023/24 Target	2022/23 YTD	2022/23 Target	SPC Assurance	SPC Variation
%	Children's Safeguarding Training - Level 2 Compliance	91.20%	91.10%	92.77%	93.46%	93.46%	94.72%		90.00%		90.00%		
%	Children's Safeguarding Training - Level 3 Compliance	73.48%	76.28%	76.25%	77.47%	77.80%	80.03%		90.00%		90.00%		
RESOURCES													
No.	Total Deliveries	289	307	303	304	301	288	2665	0	3604	0		

NHS Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust Quality Dashboard - December 2023

WARD/CLINICAL LOCATION	CARE OF THE DYING	CATHETER AUDIT	CONTINENCE	DETERIORATING PATIENT & SEPSIS	DOCUMENTATION	ENVIRONMENT	FALLS & DECONDITIONING	IPC	MEAL SERVICE	MEDICINES MANAGEMENT	MUST (NEXT DUE FEBRUARY)	NUTRITION & HYDRATION	ORAL CARE	PAIN MANAGEMENT	PATIENT EXPERIENCE	PHARMACY AUDIT (WARD & AREAS - pharmacy respomsiblity)	TISSUE VIABILITY	
SURGERY																		
CHEMOTHERAPY	N/A	N/A	N/A	N/A	100.0%	100.0%	N/A	N/D	N/A	96.9%	N/A	N/A	N/A	N/A	100.0%	N/A	N/A	
FRACTURE CLINIC	N/A	N/A	N/A	N/A	100.0%	93.3%	N/A	N/D	N/A	96.4%	N/A	N/A	N/A	N/A	90.0%	N/A	N/A	
ICU	N/D	97.5%	N/D	83.3%	N/D	N/D	93.3%	N/D	N/A	N/D	N/A	100.0%	100.0%	100.0%	100.0%	N/D	N/D	
MEDICAL DAYCASE UNIT	N/A	N/A	N/A	N/A	100.0%	100.0%	N/A	N/D	N/A	97.1%	N/A	N/A	N/A	N/A	100.0%	N/D	N/A	
OUTPATIENTS	N/A	N/A	N/A	N/A	80.0%	94.1%	N/A	N/D	N/A	95.4%	N/A	N/A	N/A	N/A	100.0%	N/D	N/A	
SACU	NAP	N/D	52.0%	N/D	84.4%	94.7%	N/D	N/D	N/A	100.0%	N/A	81.8%	100.0%	100.0%	100.0%	N/D	87.5%	
WARD 9	NAP	N/D	78.3%	NAP	N/D	N/D	N/D	N/D	72.4%	91.0%	N/A	N/D	N/D	71.9%	N/D	N/D	N/D	
WARD 10	NAP	N/D	95.0%	100.0%	N/D	98.9%	84.3%	N/D	N/A	96.4%	N/A	95.0%	85.2%	91.4%	N/D	N/D	98.0%	
WARD 11	91.7%	81.3%	N/D	71.4%	85.6%	N/D	83.0%	95.8%	77.1%	96.9%	N/A	89.8%	85.7%	100.0%	97.9%	N/D	95.0%	
WARD 12	96.4%	N/D	68.7%	100.0%	100.0%	94.7%	81.0%	N/D	N/A	97.0%	N/A	88.4%	83.3%	89.4%	96.2%	N/D	N/D	
WARD 20A	N/D	N/D	N/D	N/D	100.0%	N/D	89.1%	N/D	N/A	96.6%	N/A	100.0%	85.7%	N/D	N/D	N/D	100.0%	
MLTC																		
AMU	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/A	95.2%	N/A	N/D	N/D	N/D	N/D	N/D	N/D	
AEC	N/A	N/A	N/A	N/D	100.0%	100.0%	N/D	100.0%	N/A	N/D	N/A	N/D	N/D	N/D	100.0%	N/A	N/A	
FES	N/A	N/A	N/A	N/D	N/D	N/D	N/D	N/D	N/A	N/A	N/A	N/D	N/D	N/D	N/D	N/A	N/A	
CATH LAB	N/A	N/A	N/A	N/A	N/D	N/D	N/A	N/D	N/A	N/A	N/A	N/A	N/A	N/D	N/D	N/A	N/A	
EMERGENCY DEPARTMENT	N/D	N/A	N/A	91.7%	92.5%	N/D	100.0%	97.1%	N/A	94.4%	N/A	100.0%	N/D	100.0%	N/D	N/D	100.0%	ED SPECFIC AUDIT
ENDOSCOPY	N/A	N/A	N/A	N/A	N/D	N/D	N/A	N/D	N/A	N/A	N/A	N/A	N/A	N/D	N/D	N/D	N/A	
WARD 1	N/D	N/D	N/D	N/D	N/D	N/D	58.7%	N/D	63.6%	N/D	N/A	N/D	N/D	N/D	N/D	N/D	N/D	
WARD 2	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/A	99.1%	N/A	N/D	N/D	N/D	N/D	N/D	N/D	
WARD 3	N/D	N/D	N/D	N/D	N/D	N/D	77.0%	N/D	N/A	N/D	N/A	N/D	N/D	N/D	N/D	81.8%	N/D	
WARD 4	N/D	N/D	15.0%	N/D	N/D	N/D	72.9%	N/D	N/A	95.5%	N/A	61.1%	37.9%	N/D	N/D	N/D	70.9%	
WARD 7	NAP	N/D	65.0%	N/D	95.6%	92.2%	94.8%	83.3%	N/A	96.1%	N/A	98.0%	100.0%	92.7%	N/D	N/D	88.9%	
WARD 14	N/D	N/D	6.7%	N/D	N/D	N/D	71.2%	N/D	N/A	N/D	N/A	47.3%	48.6%	N/D	N/D	N/D	93.3%	
WARD 15	N/D	100.0%	N/D	100.0%	100.0%	N/D	N/D	N/D	N/A	98.0%	N/A	N/D	95.5%	100.0%	97.9%	N/D	N/D	
WARD 16	92.0%	N/D	100.0%	100.0%	97.5%	N/D	89.6%	93.0%	75.0%	99.2%	N/A	94.1%	100.0%	88.9%	97.9%	N/D	96.0%	
WARD 17	N/D	N/D	N/D	N/D	N/D	N/D	78.1%	N/D	N/A	94.7%	N/A	N/D	100.0%	N/D	N/D	N/D	N/D	
WARD 29	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/A	90.3%	N/A	N/D	N/D	N/D	N/D	N/D	N/D	
WOMEN & CHILDRENS																		
CCN TEAM	N/A	N/A	N/D	N/A	76.0%	93.8%	N/A	83.3%	N/A	N/A	N/A	N/A	NAP	N/A	90.9%	N/A	N/A	
GOPD / PRE-ASSESSMENT	N/A	N/A	N/A	N/A	93.8%	100.0%	N/A	100.0%	N/A	100.0%	N/A	N/A	N/A	N/A	N/D	N/A	N/A	
NNU	N/D	N/A	N/A	20.0%	98.8%	N/D	N/A	97.0%	N/A	95.7%	N/A	N/A	N/D	100.0%	N/D	N/D	N/A	
PAU	N/A	N/A	N/D	N/D	N/D	N/D	N/A	95.7%	N/A	95.6%	N/A	N/D	N/D	N/D	N/D	N/D	N/D	
SEXUAL HEALTH	N/A	N/A	N/A	N/A	N/A	N/D	N/A	N/D	N/A	N/D	N/A	N/A	N/A	N/A	N/D	N/A	N/A	
WARD 21	N/D	N/D	N/D	100.0%	78.0%	N/D	N/D	95.8%	N/A	88.8%	N/A	N/D	N/D	56.7%	N/D	N/D	N/A	
WARD 23	NAP	75.0%	100.0%	100.0%	100.0%	100.0%	94.4%	98.6%	N/A	97.9%	N/A	100.0%	100.0%	100.0%	100.0%	N/D	100.0%	
WARD 24 IF OPEN	N/D	N/D	N/D	N/D	N/D	72.7%	N/D	100.0%	N/A	N/D	N/A	N/D	N/D	N/D	N/D	N/A	N/A	
WARD 25	N/A	N/D	N/A	N/A	N/A	N/D	N/A	98.6%	N/A	89.4%	N/A	N/A	N/A	N/D	N/D	N/D	N/A	
WARD 27	N/A	N/D	N/A	N/A	N/A	83.3%	N/A	90.4%	N/A	100.0%	N/A	N/A	N/A	N/D	N/D	N/D	N/A	
ANC	N/A	N/A	N/A	N/A	N/A	N/D	N/A	N/D	N/A	99.0%	N/A	N/A	N/A	N/A	N/D	N/A	N/A	
COMMUNITY																		
EAST LOCALITY	100.0%	88.7%	75.0%	N/A	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
GOSCOTE HOSPICE	82.1%	100.0%	86.7%	100.0%	100.0%	100.0%	100.0%	97.1%	79.5%	99.6%	N/A	100.0%	63.6%	92.6%	N/D	N/D	100.0%	
HOLLYBANK STROKE TEAM	N/D	100.0%	N/D	100.0%	87.5%	100.0%	96.0%	94.4%	N/A	98.7%	N/A	100.0%	100.0%	77.8%	N/D	N/D	100.0%	
NORTH LOCALITY	90.0%	91.8%	70.0%	N/A	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
SOUTH LOCALITY	100.0%	100.0%	48.9%	N/A	N/A	N/A	N/A	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
WEST LOCALITY	N/D	N/D	82.5%	N/A	N/A	N/A	N/A	N/D	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

0.0% - 79.9%	50.0%
80.0% - 89.9%	85.0%
90.0% - 100.0%	95.0%
NOT APPLICABLE	N/A
NO APPLICABLE PATIENT	NAP
NOT DONE	N/D
WARD CLOSED AT TIME OF AUDIT	WC

NHS
Walsall Healthcare
NHS Trust

Paper for submission to the Trust Board on 14th February 2024		
Title of Report:	Briefing on NatPSA Bed Rails Alert Compliance at Walsall Healthcare NHS Trust (NatPSA/2023/010/MHRA)	Enc No:
Author:	Christian Ward – Deputy Chief Nursing Officer christian.ward@nhs.net	
Presenter/Exec Lead:	Lisa Carroll – Chief Nursing Officer lisa.carroll5@nhs.net	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The committee is asked to note the contents of the report and be sighted on actions completed and remaining actions to achieve compliance with the MHRA alert.			

Implications of the Paper:			
Risk Register	Yes ☐ No ☒ Risk Title: [Risk Pending		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	To be defined		
Report Data Caveats	The data in this report is partial and awaits the final audit result.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Registration and licensing Well led.
	NHSE	Yes☒No☐	Details: Related standards
	Health & Safety	Yes☒No☐	Details: Health & Safety Act
	Legal	Yes☒No☐	Details: Duty of Candour, Claims and Litigation
	NHS Constitution	Yes☒No☐	Details: Constitutional Standards
	Other	Yes☒No☐	Details: Professional registration issues
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based on individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Equality and Diversity Impact	None identified within the report		
Report Journey/Destination or matters that may have	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date:

been referred to other Board Committees	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • Walsall Healthcare NHS Trust has updated policies and risk assessments in accordance with NatPSA/2023/010/MHRA, ensuring compliance with national patient safety standards. • Awareness of policy changes and training adaptations is being integrated into the Trust's existing Manual Handling Training curriculum, focusing on bed assessments and bed rail training. • The Trust has completed an inventory of paediatric bed stock, identifying a need for compliant beds as per BS EN 50637:2017 standards. • WCCSS Division is developing a risk that highlights risk, controls, mitigations, gaps and actions.
Advise • The current adult bed stock, primarily older models, is expected to show significant non-compliance with the standard EN BS 60601-2052:2010+A1:2015, necessitating future procurement considerations. • Paediatric bed stock requires immediate attention, as all beds reviewed do not meet BS EN 50637:2017 standards, posing a risk to patients fitting the defined at-risk group. • The Trust is advised to be prepared to procure paediatric beds with integrated bed rails compliant with BS EN 50636:2017 to meet the diverse needs of Ward 21, Paediatric Day Case and PAU patients.
Alert • Failure to comply with the NatPSA requirements by March 1, 2024, may lead to regulatory action by the Care Quality Commission. • A significant gap in paediatric bed stock compliant with BS EN 50637:2017 is noted, with a current count of 9 compliant cots and no compliant beds. • The Trust is alerted to the need for bespoke bed provisions for adults with atypical anatomy, suggesting a cost-effective approach of specialist bed hire, as per current practices for bariatric patients.

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

The NatPSA/2023/010/MHRA is a National Patient Safety Alert regarding avoidable serious injury and deaths associated with medical beds, trolleys, bed rails, bed grab handles, and lateral turning devices. It emphasises the danger of death and serious injuries due to entrapment or falls. It outlines that chest or neck entrapment in bed rails is a recognised 'Never Event' in the NHS and highlights several factors contributing to these incidents, including inadequate risk assessment, maintenance issues, and the use of adult-designed beds for children and patients less than 40kg, less than 146cm in height or BMI less than 17.

Key actions required include updating policies and procedures, developing staff training plans, reviewing medical device management systems, implementing maintenance schedules, and prioritising risk assessments for children and adults with atypical anatomy. The document also specifies compliance with international standards for medical beds to reduce entrapment risks and stresses the importance of regular updates of risk assessments in light of changes in equipment or patient conditions.

The alert sets a deadline of March 1, 2024, for completing these actions and notes that failure to comply may result in regulatory action by the Care Quality Commission. The NatPSA also included statistics on the number of deaths (18) and serious injuries (54) reported between 2018 and 2022 related to these devices, primarily due to entrapment or falls.

Policy and Risk Assessments: Walsall Healthcare NHS Trust has successfully updated policies and risk assessments in line with the National Patient Safety Alert (NatPSA) on bed rails, medical beds, and related devices. This ensures compliance with the required actions highlighted in the NatPSA document.

Awareness and Training: We plan to integrate these policy changes into existing training methodologies. Adjustments will be made in the Trust's Manual Handling Training curriculum, explicitly focusing on bed assessments and bed rail training.

Audit of Adult Bed Stock: An audit is being conducted by EBME to assess the current bed stock at WHT. Preliminary expectations from common bed stock indicate a significant non-compliance with the standard EN BS 60601-2052:2010+A1:2015, primarily due to the age of the bed stock. Whilst EN BS 60601-2052:2010+A1:2015 is noted in the NatPSA, this is not a required action from the document but has been noted by Trust Procurement Specialists for any future procurement.

Compliance with EN BS 50637:2017: The NatPSA requires as an action the use of beds compliant with BS EN 50637:2017 for children and adults with atypical anatomy unless there is a reason for using a non-compliant bed.

This standard is a primary focus for required action in relation to the patient definition highlighted in the NatPSA. To reduce risk to the following patients defined as: less than 146cm in height, less than 40kgs in weight, or a BMI less than 17.

Audit of Paediatric Bed Stock: An inventory has been completed for paediatric areas; initial findings show that the current paediatric bed stock at WHT does not meet the BS EN 50637:2017 standard.

Regarding the current bed stock in paediatric services, we have nine compliant and eight non-compliant cots. The Trust has never purchased paediatric beds, and thus, all its beds are non-compliant.

The WCCSS are preparing a risk on the risk register to highlight risk severity, including mitigations/controls in place. In the medium term, there will be a requirement to procure paediatric beds with integrated bed rails that meet BS EN 50636:2017 and retain adult beds.

This will allow Ward 21/Paediatric Day Case/PAU and Paed ED to meet patient group bed needs based on an assessment of weight and size.

For information, on average, children exceed 40kgs and 147cm at 12-13 years of age in the UK.

Potential solutions for Adults with altered anatomy: Adults with altered anatomy will be best served by bespoke provision of a suitable bed meeting their requirements via specialist bed hire as we would do currently for a bariatric patient. This would be cost-effective and remove the need to purchase and securely store appropriate bed frames on-site.

Conclusion: Walsall Healthcare NHS Trust, in conjunction with RWT, has made significant progress in policy update and training integration; challenges remain in equipment compliance, particularly concerning the paediatric bed stock. Ongoing efforts are required to address these gaps to maintain patient safety and regulatory compliance.

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Reduction in Temporary Medical Staffing Spend	Enc No: 8.9.5
Authors:	Bradley Morris, Administrator – bradley.morris2@nhs.net	
Presenter/Exec Lead:	Dr Manjeet Shehmar, Chief Medical Officer – manjeet.shehmar@nhs.net	

Action Required of the Board			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The Trust Board members are to be informed of this report.			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: 2072 - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff) and undermines financial efficiency. On Risk Register: Yes☒No☐ Risk Score (if applicable):		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous 2 month's data.		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details:
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

Walsall Healthcare NHS Trust

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date: F&P Committee 24.01.24

Summary of Key Issues using Assure, Advise and Alert

Assure

- This paper updates the position and future actions of the reduction in Locum spend at Walsall Healthcare NHS Trust with actions to address.
- The finance team are working with Divisions to cost up a trajectory for reduction in spend.
- New sign off process implemented.

Advise

- Spend to date is illustrated in the report below.
- Focus on the Divisions of Medicine and Long-Term Conditions and Surgery review via Divisional Performance reviews is reported.

Alert

Temporary spend on medical staffing are overspent by (£8,812k) YTD, driven by Locum Bookings (£8,420k) and Agency Bookings (£1,150k). Overall spend on Medical Staffing is overspent by (£8,812k) which the rest of the position not made up of temporary staffing is related to Strike bookings, (£611k) offset by Medical vacancies, (£759k).

Main drivers for bookings against Agency and Locums relates to:

- Vacancy Bookings over and above agreed budgets (£4,618k YTD, £280k in month)
- Demand Bookings (£1,561k YTD, £116k in month)
- Sickness (£731k YTD, £79k in month)
- Strike Bookings (£611k YTD, £60k in month)

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards

Walsall Healthcare NHS Trust

Reduction in Temporary Medical Staffing Spend

Report to Public Trust Board to be held on 14th February 2024

REDUCTION IN LOCUM SPEND (NOVEMBER – DECEMBER 2023)

1. PURPOSE OF REPORT

The purpose of the reports is to assure members of a trajectory to reduce medical Locum spend across all Divisions.

2. BACKGROUND

As previously reported, temporary staffing expenditure above planned levels (£1.245m total pay variance) owing to use in emergency areas (ED & AMU predominantly) and maintaining additional capacity to service emergency demands (the Trust above the 30% agency cap on historic expenditure) and maintaining Elective Recovery.

It is more difficult for divisions to provide assurance on reduction in short term Locum use as this is dependent on cover needed for sickness, annual leave or cover periods prior to recruitment of substantive staff. It should be recognised that bank staff are utilised whenever possible to reduce Locum spend.

The Medical Directorate has asked for a plan and trajectory to reduce temporary medical spend in line with Trust strategy to improve quality, continuity of care and financial efficiency. In particular, a reduction of hourly and agency temporary medical staff is required and this is monitored by the AMD for Workforce and the Deputy Head of Financial Management through the Medical Workforce Group. The group are addressing Locum booking processes including sign off delegations, workforce planning, linkage with ESR validation, rota management and job planning. There is representation from medical staffing, divisional teams and recruitment.

3. MEDICAL STAFFING SPEND

Medical Staffing are overspent by (£8,812k) YTD, driven by Locum Bookings (£8,420k), Agency Bookings (£1,150k) and Medical over establishment and acting down payments (£759k).

Main drivers for bookings against Agency and Locums relates to:

- Vacancy Bookings over and above agreed budgets (£4,618k YTD, £280k in month)
- Demand Bookings (£1,561k YTD, £116k in month)
- Sickness (£731k YTD, £79k in month)
- Strike Bookings (£611k YTD, £60k in month)

Temporary Medical spend continues to follow the consistent pattern in year with of running on average (post-strike booking adjustments) at £1,207k which has been directly driven by booking to support activity related pressures and new junior medical rotas. The organisation as a whole continues to be above the Agency Cap, which Temporary Medical agency makes a significant contribution.

Table 1: Temporary Medical spend adjusted for Strikes Impact

Month	Actuals (£k)	Strike bookings (£k)	Actuals net of Strikes
Apr-23	1,190	84	1,106
May-23	1,539	3	1,537
Jun-23	1,196	76	1,119
Jul-23	1,081	155	926
Aug-23	1,321	151	1,169
Sep-23	1,331	71	1,260
Oct-23	1,078	11	1,067
Nov-23	948		948
Dec-23	1,335	60	1,276
Total	**11,019**	**611**	**10,408**

Figure 1: Temporary Medical staffing spend

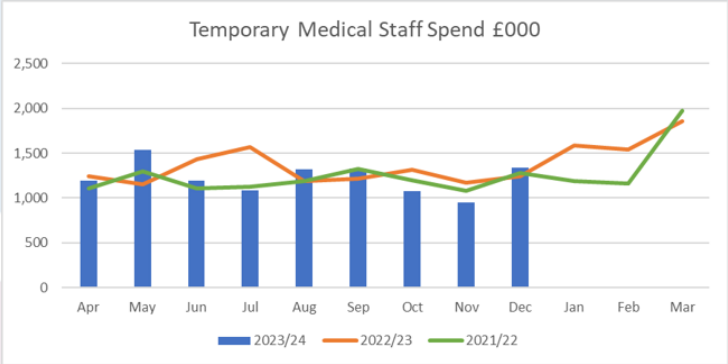


Figure 2: Locum Medical Staff Expenditure

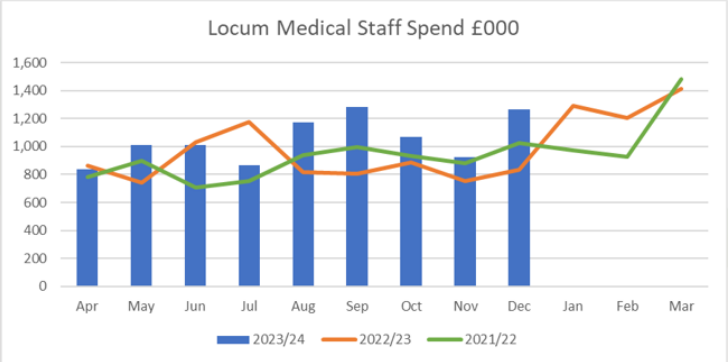


Figure 3: Agency Medical Staff Expenditure

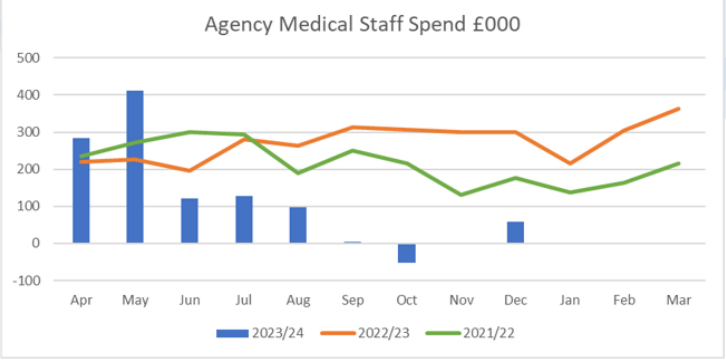
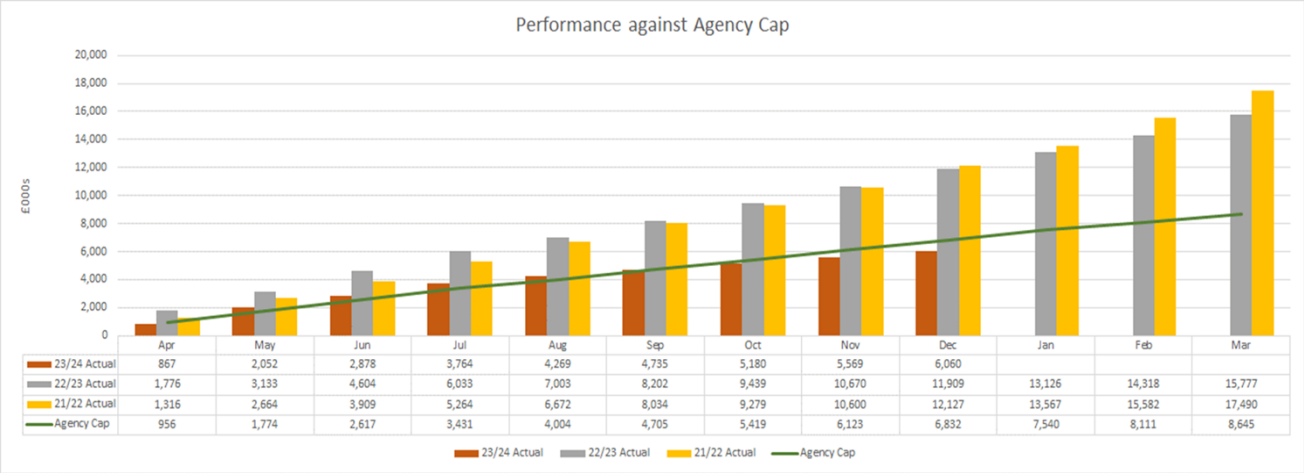


Figure 4: Performance against Agency Cap



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
23/24 Actual	867	2,052	2,878	3,764	4,269	4,735	5,180	5,569	6,060			
22/23 Actual	1,776	3,133	4,604	6,033	7,003	8,202	9,439	10,670	11,909	13,126	14,318	15,777
21/22 Actual	1,316	2,664	3,909	5,264	6,672	8,034	9,279	10,600	12,127	13,567	15,582	17,490
Agency Cap	956	1,774	2,617	3,431	4,004	4,705	5,419	6,123	6,832	7,540	8,111	8,645

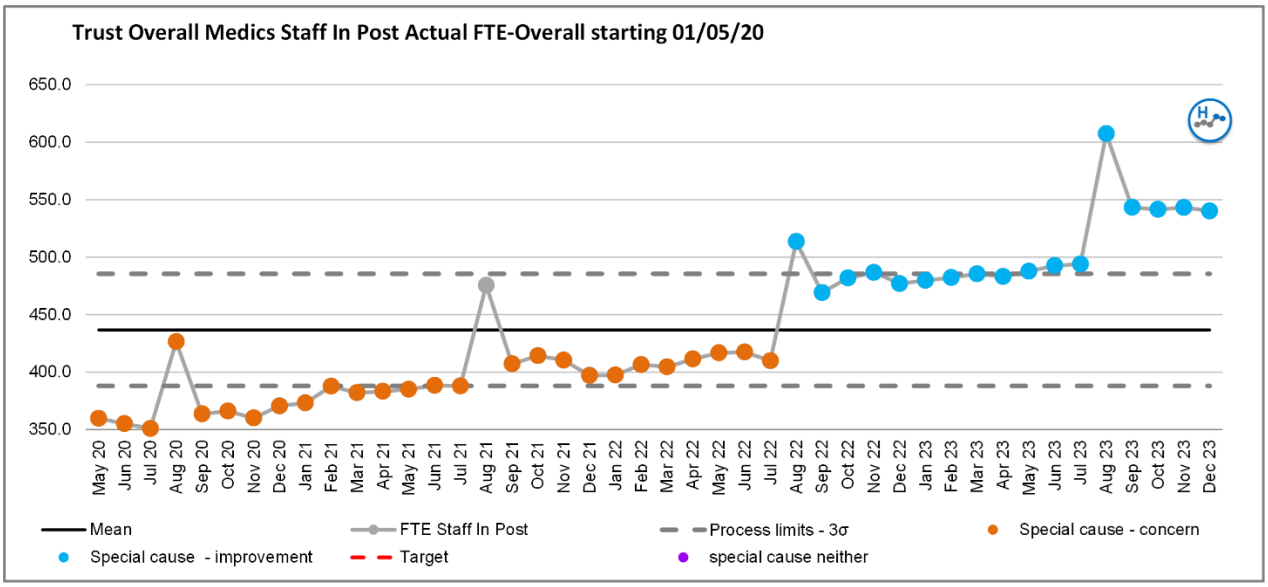
A new sign off process has been established and implemented for medical temporary staff authorisation to ensure closer control.

Table 2: Divisional Breakdown of Temporary Spend

Divisions continue to work to reduce their temporary spend, however the time period for this report covers November – December 2023, where Locum spend was higher due to both winter pressures and operational pressures caused by industrial action.

Care Group	April	May	June	July	August	September	October	November	December
Escalation Capacity	195,947	171,312	155,151	152,620	113,255	77,022	22,809	78,306	349,250
Emergency Care Group	240,244	341,755	323,457	235,181	210,882	168,563	171,725	102,403	155,923
Acute Medical Care Group	206,753	131,496	98,065	(52,105)	174,423	239,682	127,022	126,627	97,381
Elderly Care Group	84,665	156,604	94,856	102,254	196,299	161,032	113,597	127,919	96,816
RESPIRATORY CARE GROUP	20,507	31,998	529	17,483	24,608	34,376	22,806	7,592	12,507
Cardiology Care Group	1,135	23,938	22,497	3,077	2,206	16,451	29,644	4,714	9,602
DERMATOLOGY CARE GROUP	8,017	23,670	10,307	13,362	43,946	(33,256)	(10,689)	67,293	4,862
DIABETES & ENDOCRINOLOGY CG	13,474	(3,666)	7,113	17,181	436	9,938	35,249	(18,034)	4,570
Specialty Medicine Care Group	0	0	1,698	1,047	2,432	0	0	0	0
NEPHROLOGY CARE GROUP	(3,873)	0	0	0	0	0	10,110	(10,110)	0
MANAGEMENT - MEDICINE LTC	0	0	0	0	8,400	0	0	0	0
Gastro Care Group	77,170	95,746	31,352	88,978	(10,242)	61,152	(17,337)	28,652	(6,456)
	844,039	**972,852**	**745,026**	**579,079**	**766,646**	**734,958**	**504,935**	**515,361**	**724,454**
Theatre Crit Care and Anaes	68,521	101,571	158,332	135,422	196,827	198,918	185,061	125,229	236,867
General Surgery Care Group	86,734	157,369	73,850	123,924	121,764	124,146	122,627	71,264	94,885
Musculoskeletal Services Care	(1,979)	25,748	30,721	11,030	11,197	6,096	13,089	9,898	35,210
Head and Neck Care Group	4,126	27,685	24,509	7,920	7,211	(2,014)	17,005	23,891	26,765
Divisional Management	0	0	0	0	0	0	0	0	4,657
	157,402	**312,372**	**287,412**	**278,296**	**336,999**	**327,146**	**337,782**	**230,282**	**398,384**
Childrens and Family Services	85,875	105,183	101,050	132,167	122,575	210,101	133,666	125,481	119,719
Womens Services	36,797	36,618	50,981	34,502	47,025	5,924	39,040	51,080	58,308
Clinical Support Services	32,655	34,284	33,729	32,022	32,003	32,442	37,947	34,832	37,606
PHARMACY SERVICES	0	0	0	0	0	0	49	0	0
	155,326	**176,085**	**185,760**	**198,691**	**201,602**	**248,468**	**210,703**	**211,393**	**215,634**
	1,156,767	**1,461,309**	**1,218,198**	**1,056,066**	**1,305,246**	**1,310,572**	**1,053,420**	**957,037**	**1,338,472**

Figure 5: Full Time Equivalent Medical Staff Recruitment per month



Currently, Trust Medical WTEs and bookings continue to track above authorised budgets relating solely to Junior Medical lines. This has been driven by over establishments as well as bookings to unfunded Medical rotas.

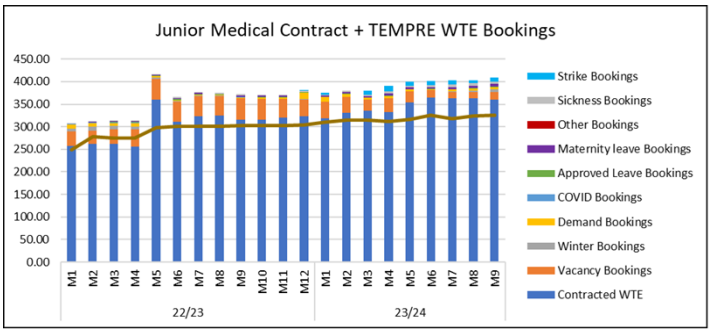
This by Division is broken down as being MLTC (47.79 WTE), WCCSS (14.41 WTE) & DoS (4.74 WTE). The majority of shifts in these areas have been booked as vacancies in all divisions. Controls are being put in booking reasons as well as focus on the reasons going forward. Medical Workforce Group has identified areas to focus upon for each division as well as actions to improve booking reasons recorded.

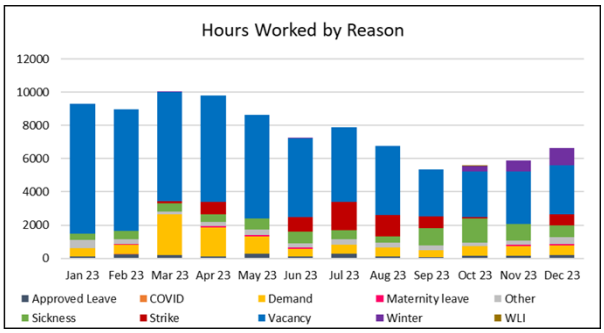
Table 3: Medical Vacancies by Division (as at Month 9)

Division & Categories	Budget WTE	Actual WTE	TempRE MPE	Combined Vacancies	Budget YTD £000	Actual YTD £000	Variance YTD £000
DIVISION OF SURGERY							
Medical Staff - Seniors	74.92	57.26		17.66	8,037	7,874	164
Locum Medical Staff - Seniors		5.60	4.38	(9.98)	29	1,680	(1,651)
Agency Medical Staff - Seniors			0.56	(0.56)	(10)	166	(176)
Medical Staff - Juniors	90.43	96.70		(6.27)	5,777	6,009	(231)
Locum Medical Staff - Juniors			5.59	(5.59)		572	(572)
Agency Medical Staff - Juniors						248	(248)
DIVISION OF SURGERY Total	**165.35**	**159.56**	**10.53**	**(4.74)**	**13,834**	**16,548**	**(2,715)**
MEDICINE AND LONG TERM CONDIT							
Medical Staff - Seniors	70.80	62.12		8.68	8,793	7,757	1,035
Locum Medical Staff - Seniors	2.31	8.80	2.88	(9.37)	251	3,039	(2,788)
Agency Medical Staff - Seniors	1.35		1.44	(0.09)	103	436	(333)
Medical Staff - Juniors	151.18	175.29		(24.11)	8,218	8,413	(195)
Locum Medical Staff - Juniors	4.34	-	27.24	(22.90)	519	2,303	(1,783)
Agency Medical Staff - Juniors					154	610	(456)
MEDICINE AND LONG TERM CONDIT Total	**229.98**	**246.21**	**31.56**	**(47.79)**	**18,038**	**22,558**	**(4,520)**
WOMENS CHILDRENS CLIN SUPT SER							
Medical Staff - Seniors	63.67	55.06		8.61	7,447	7,187	260
Locum Medical Staff - Seniors		7.00	0.98	(7.98)	212	959	(748)
Agency Medical Staff - Seniors						5	(5)
Medical Staff - Juniors	50.60	60.03		(9.43)	3,310	3,304	6
Locum Medical Staff - Juniors		-	5.34	(5.34)		842	(842)
Agency Medical Staff - Juniors						(3)	3
WOMENS CHILDRENS CLIN SUPT SER Total	**114.27**	**122.09**	**6.32**	**(14.14)**	**10,968**	**12,295**	**(1,327)**
CORPORATE SERVICES							
Medical Staff - Seniors	4.05	1.64		2.41	491	296	195
Locum Medical Staff - Seniors		-		-		-	-
Agency Medical Staff - Seniors					191	127	64
Medical Staff - Juniors	25.78	25.20		0.58	878	873	5
Agency Medical Staff - Juniors						0	(0)
CORPORATE SERVICES Total	**29.83**	**26.84**		**2.99**	**1,560**	**1,297**	**263**
Community Division							
Medical Staff - Seniors	5.03	4.30		0.73	727	631	96
Locum Medical Staff - Seniors		0.20		(0.20)		35	(35)
Medical Staff - Juniors	2.63	2.63		-	174	159	15
Locum Medical Staff - Juniors						0	(0)
Agency Medical Staff - Juniors						(0)	0
Community Division Total	**7.66**	**7.13**		**0.53**	**901**	**825**	**76**
RESERVES AND PROVISIONS							
Medical Staff - Seniors					-	590	(590)
RESERVES AND PROVISIONS Total					**-**	**590**	**(590)**
Grand Total	**547.09**	**561.83**	**48.41**	**(63.15)**	**45,301**	**54,112**	**(8,812)**

*Actual WTE adjusted for Junior Medical Rotations.

Figure 6: Full Time Equivalent Medical Staff Recruitment per month





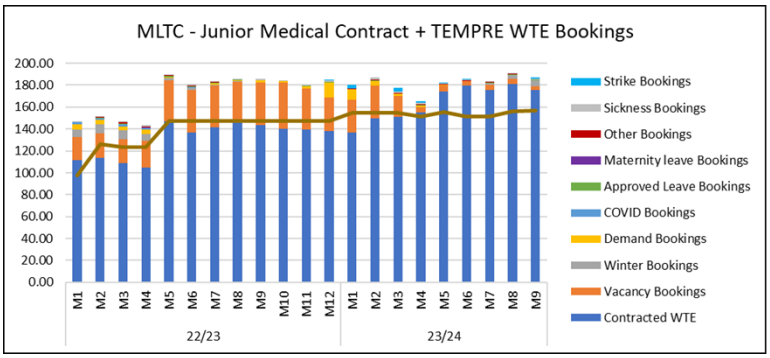
Current spend per Division is shown in Table 3 for all temporary medical spend, this table does not differentiate between short and long-term Locums. The previous trend continues with most of the temporary spend being seen in the Divisions of Medicine and Long-Term Conditions (MLTC) and Surgery due to over-establishment and vacancy bookings. The finance team are working with Divisions on a trajectory for reductions based on costing actions agreed in the Divisional sections below.

4. Divisional Positions

Medicine & Long-term Conditions Division (MLTC)

Care Group & Categories	Budget WTE	Actual WTE	TempRE MPE	Combined Vacancies	Budget YTD £000	Actual YTD £000	Variance YTD £000
Acute Medical Care Group							
Medical Staff - Seniors	12.06	6.70		5.36	1,496	821	676
Locum Medical Staff - Seniors		3.00	0.15	(3.15)		779	(779)
Medical Staff - Juniors	40.31	46.63		(6.32)	1,965	1,812	154
Locum Medical Staff - Juniors			5.50	(5.50)	171	363	(192)
Agency Medical Staff - Juniors						7	(7)
Acute Medical Care Group Total	**52.37**	**56.33**	**5.65**	**(9.61)**	**3,632**	**3,782**	**(149)**
Cardiology Care Group							
Medical Staff - Seniors	5.50	7.00		(1.50)	852	1,023	(171)
Locum Medical Staff - Seniors						74	(74)
Agency Medical Staff - Seniors						(8)	8
Medical Staff - Juniors	11.00	17.84		(6.84)	549	830	(281)
Locum Medical Staff - Juniors			0.07	(0.07)		27	(27)
Agency Medical Staff - Juniors						20	(20)
Cardiology Care Group Total	**16.50**	**24.84**	**0.07**	**(8.41)**	**1,401**	**1,966**	**(565)**
DERMATOLOGY CARE GROUP							
Medical Staff - Seniors	7.46	7.51		(0.05)	821	949	(128)
Locum Medical Staff - Seniors	0.70		0.15	0.55	76	72	3
Agency Medical Staff - Seniors					60	55	5
Medical Staff - Juniors	1.57	1.00		0.57	90	91	(0)
DERMATOLOGY CARE GROUP Total	**9.73**	**8.51**	**0.15**	**1.07**	**1,047**	**1,167**	**(120)**
DIABETES & ENDOCRINOLOGY CG							
Medical Staff - Seniors	3.14	3.78		(0.64)	421	523	(102)
Locum Medical Staff - Seniors	-			-	-	61	(61)
Medical Staff - Juniors	8.00	9.00		(1.00)	365	428	(63)
Locum Medical Staff - Juniors			0.14	(0.14)		6	(6)
Agency Medical Staff - Juniors						(1)	1
DIABETES & ENDOCRINOLOGY CG Tot	**11.14**	**12.78**	**0.14**	**(1.78)**	**786**	**1,017**	**(231)**
Elderly Care Group							
Medical Staff - Seniors	11.20	8.00		3.20	1,409	854	554
Locum Medical Staff - Seniors	-	1.80	0.27	(2.07)	14	634	(620)
Medical Staff - Juniors	41.50	34.88		6.62	2,326	2,078	248
Locum Medical Staff - Juniors	-		7.27	(7.27)	25	347	(322)
Agency Medical Staff - Juniors						153	(153)
Elderly Care Group Total	**52.70**	**44.68**	**7.54**	**0.48**	**3,774**	**4,066**	**(292)**
Emergency Care Group							
Medical Staff - Seniors	16.09	13.80		2.29	1,830	1,561	269
Locum Medical Staff - Seniors		3.00	0.63	(3.63)	6	968	(963)
Medical Staff - Juniors	28.80	37.20		(8.40)	1,892	1,784	107
Locum Medical Staff - Juniors		-	5.43	(5.43)	135	802	(667)
Agency Medical Staff - Juniors					154	180	(26)
Emergency Care Group Total	**44.89**	**54.00**	**6.06**	**(15.17)**	**4,017**	**5,295**	**(1,279)**

Care Group & Categories	Budget WTE	Actual WTE	TempRE MPE	Combined Vacancies	Budget YTD £000	Actual YTD £000	Variance YTD £000
Escalation Capacity							
Locum Medical Staff - Seniors	1.61		1.64	(0.03)	156	169	(14)
Agency Medical Staff - Seniors	1.35		1.44	(0.09)	43	183	(139)
Locum Medical Staff - Juniors	4.34		8.63	(4.29)	188	719	(531)
Agency Medical Staff - Juniors						245	(245)
Escalation Capacity Total	**7.30**		**11.71**	**(4.41)**	**387**	**1,316**	**(929)**
Gastro Care Group							
Medical Staff - Seniors	7.00	7.83		(0.83)	893	943	(50)
Locum Medical Staff - Seniors		-		-		110	(110)
Agency Medical Staff - Seniors						197	(197)
Medical Staff - Juniors	9.00	14.74		(5.74)	417	655	(238)
Locum Medical Staff - Juniors			0.18	(0.18)		40	(40)
Agency Medical Staff - Juniors						1	(1)
Gastro Care Group Total	**16.00**	**22.57**	**0.18**	**(6.75)**	**1,310**	**1,948**	**(638)**
MANAGEMENT - MEDICINE LTC							
Agency Medical Staff - Seniors						8	(8)
MANAGEMENT - MEDICINE LTC Total						**8**	**(8)**
NEPHROLOGY CARE GROUP							
Medical Staff - Seniors	2.35	2.50		(0.15)	306	391	(85)
Locum Medical Staff - Seniors						(4)	4
Medical Staff - Juniors	1.00	1.00		-	65	106	(41)
NEPHROLOGY CARE GROUP Total	**3.35**	**3.50**		**(0.15)**	**371**	**494**	**(122)**
RESPIRATORY CARE GROUP							
Medical Staff - Seniors	6.00	5.00		1.00	765	693	72
Locum Medical Staff - Seniors		1.00	0.05	(1.05)		175	(175)
Agency Medical Staff - Seniors						-	-
Medical Staff - Juniors	10.00	10.00		-	548	613	(65)
Locum Medical Staff - Juniors						(3)	3
Agency Medical Staff - Juniors						0	(0)
RESPIRATORY CARE GROUP Total	**16.00**	**16.00**	**0.05**	**(0.05)**	**1,313**	**1,478**	**(165)**
Specialty Medicine Care Group							
Medical Staff - Juniors		3.00		(3.00)		16	(16)
Locum Medical Staff - Juniors						1	(1)
Agency Medical Staff - Juniors						4	(4)
Specialty Medicine Care Group Total		**3.00**		**(3.00)**		**21**	**(21)**
Grand Total	**229.98**	**246.21**	**31.56**	**(47.79)**	**18,038**	**22,558**	**(4,520)**



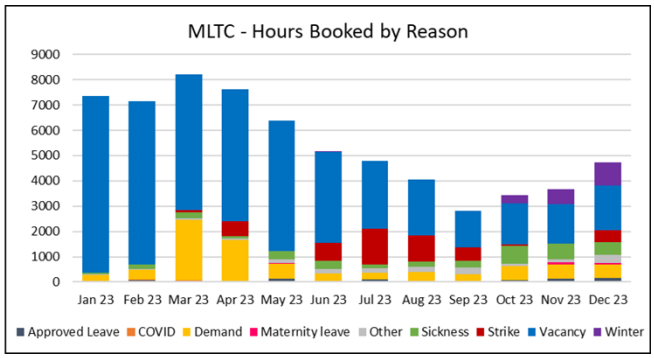
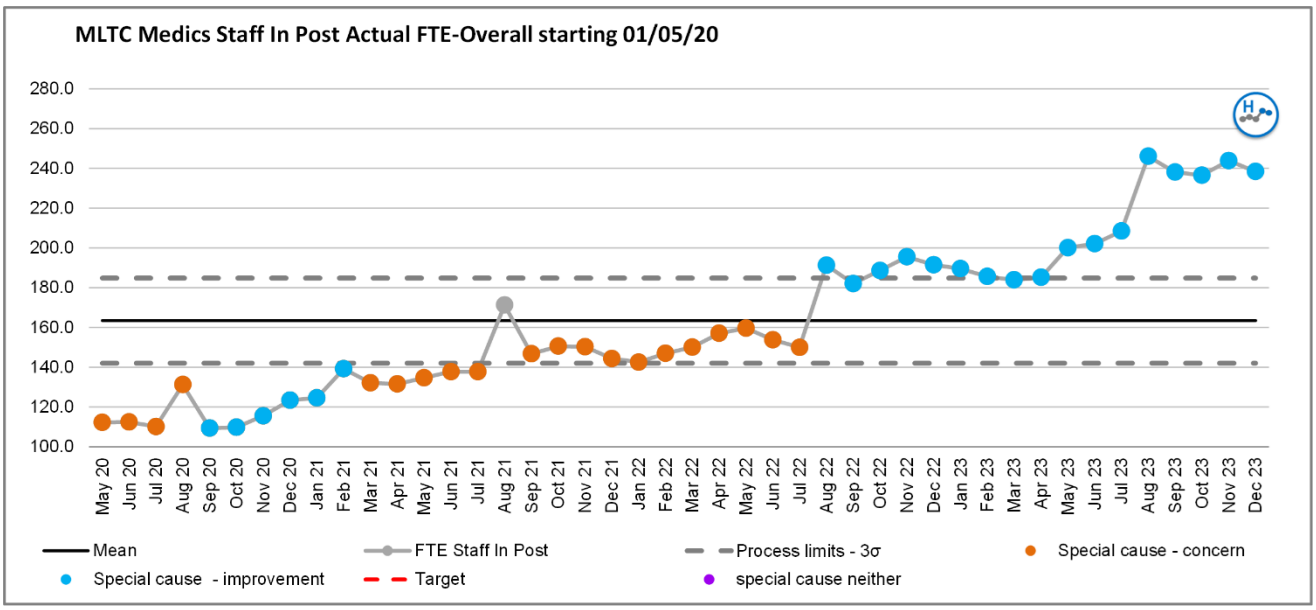


Figure 7: MLTC Medics in post (Actual FTE)



The Division remain significantly overspent at £4,520k over budget YTD. In Months 8 and 9, we have seen a significant increase in temporary expenditure due to winter pressures.

A recruitment pipeline has been set with clinical directors against vacancies within the division, with a budget re-alignment regarding HEE Trainee Posts, ESR discrepancies and job plans also being commenced. Funding for a business case for Ward 14 has been confirmed and will be allocated for 20 beds on Ward 14 (totalling £2,083k). The focal cost pressures within the Division continue to be Gastro (£638k), Cardiology (£565k) and Emergency Medicine (£1,270k). Senior Medics (£694k) and Junior Medics (£585k) in Emergency Medicine are both overspent due to industrial action and activity pressures. There have been vacancies at middle grade level which have been at a premium cost. These vacancies have now been recruited to, with the services running in excess of funded posts.

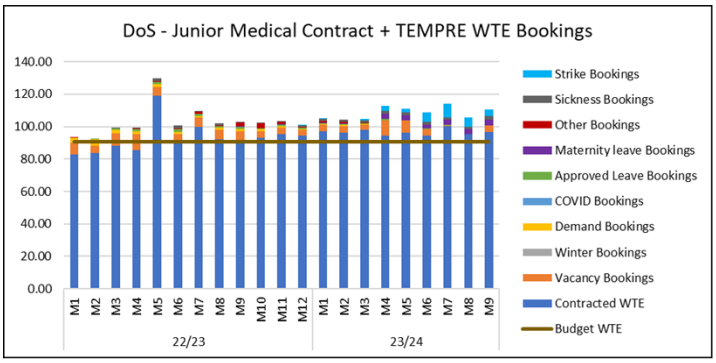
Following assurance from Health Education England (HEE) around acute medicine training, HEE has restored all training posts they withheld in the past and added further posts. Therefore, we have received ten extra Deanery trainees between F1 to IMT in August. This has been mapped out against the Clinical Fellowship intake.

Next Steps - MLTC

- Business cases for Ward 29 Consultant Weekend Ward Rounds, AEC Consultant Weekend Shifts and Middle Grade Weekend Shifts have either been approved or are going through Investment Committee.
- The EDS Junior Doctor shift has been removed and the Division are still monitoring the impact on service.
- No agency to be utilised across Specialist Nursing Team within Gastro.
- Greater scrutiny of any additional shifts is now in place (excluding Strike cover).
- Maintain sickness levels at <5% to reduce demand bookings.

Surgery

Care Group & Categories	Budget WTE	Actual WTE	TempRE MPE	Combined Vacancies	Budget YTD £000	Actual YTD £000	Variance YTD £000
Cancer Services Care Group							
Locum Medical Staff - Seniors					29		29
Cancer Services Care Group Total					**29**		**29**
Divisional Management							
Medical Staff - Seniors						-	-
Locum Medical Staff - Seniors						5	(5)
Medical Staff - Juniors						3	(3)
Divisional Management Total						**8**	**(8)**
General Surgery Care Group							
Medical Staff - Seniors	25.54	14.20		11.34	1,935	2,288	(352)
Locum Medical Staff - Seniors		3.00	1.36	(4.36)		494	(494)
Agency Medical Staff - Seniors					(10)	95	(105)
Medical Staff - Juniors	35.00	36.00		(1.00)	1,740	1,843	(104)
Locum Medical Staff - Juniors			1.41	(1.41)		153	(153)
Agency Medical Staff - Juniors						235	(235)
General Surgery Care Group Total	**60.54**	**53.20**	**2.76**	**4.58**	**3,665**	**5,108**	**(1,443)**
Head and Neck Care Group							
Medical Staff - Seniors	6.90	5.71		1.19	799	830	(30)
Locum Medical Staff - Seniors		0.60		(0.60)		36	(36)
Agency Medical Staff - Seniors			0.56	(0.56)		71	(71)
Medical Staff - Juniors	6.43	7.63		(1.20)	481	452	29
Locum Medical Staff - Juniors			0.30	(0.30)		18	(18)
Agency Medical Staff - Juniors						13	(13)
Head and Neck Care Group Total	**13.33**	**13.94**	**0.86**	**(1.47)**	**1,281**	**1,419**	**(138)**
Musculoskeletal Services Care							
Medical Staff - Seniors	12.60	11.90		0.70	1,720	1,596	124
Locum Medical Staff - Seniors						47	(47)
Medical Staff - Juniors	19.00	18.00		1.00	1,330	1,411	(81)
Locum Medical Staff - Juniors			1.50	(1.50)		94	(94)
Musculoskeletal Services Care Total	**31.60**	**29.90**	**1.50**	**0.20**	**3,050**	**3,148**	**(98)**
Theatre Crit Care and Anaes							
Medical Staff - Seniors	29.88	25.45		4.43	3,583	3,161	422
Locum Medical Staff - Seniors		2.00	3.02	(5.02)		1,099	(1,099)
Medical Staff - Juniors	30.00	35.07		(5.07)	2,226	2,298	(72)
Locum Medical Staff - Juniors			2.38	(2.38)		308	(308)
Theatre Crit Care and Anaes Total	**59.88**	**62.52**	**5.41**	**(8.05)**	**5,809**	**6,866**	**(1,057)**
Grand Total	**165.35**	**159.56**	**10.53**	**(4.74)**	**13,834**	**16,548**	**(2,715)**



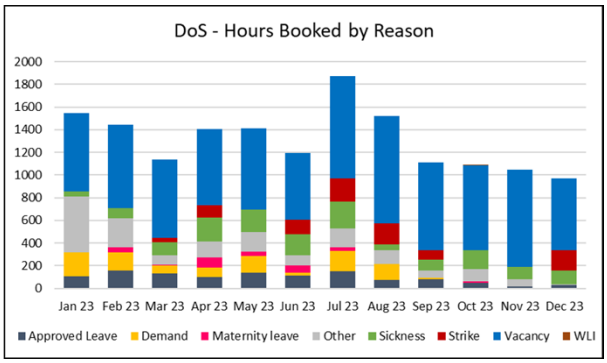
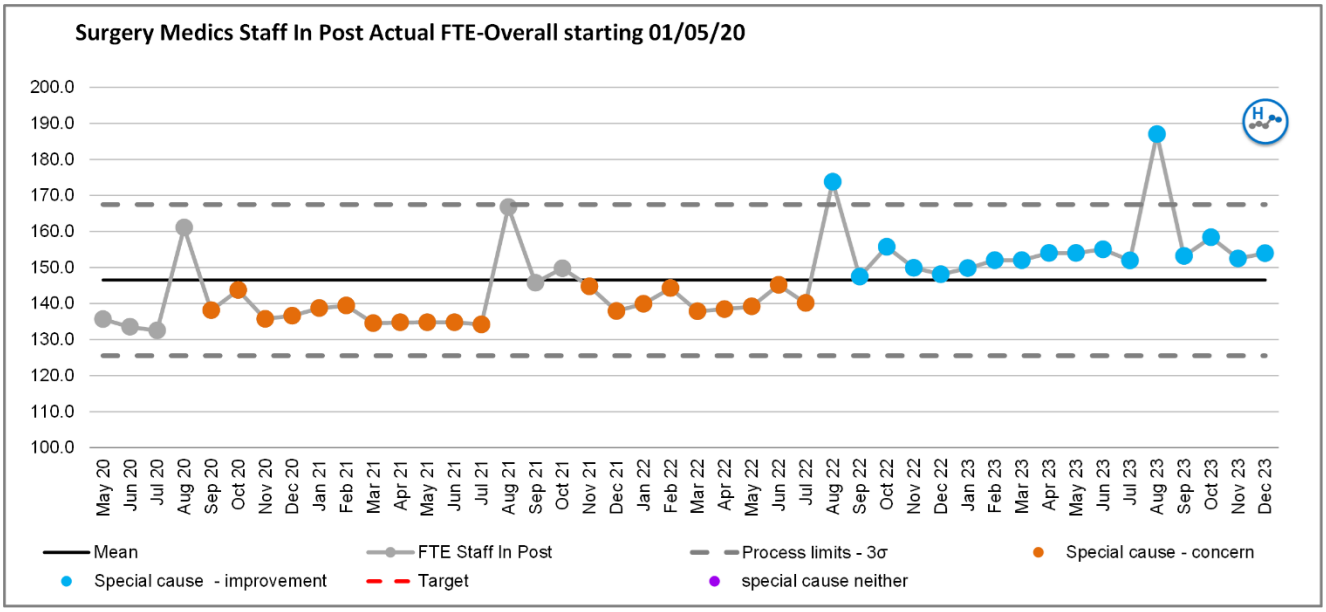


Figure 8: Surgery Medics in post (Actual FTE)



In month, DoS were (£2,700k) overspent YTD driven by:

- Junior Medical overspends of (£1,051k) driven by clinical fellow double running (Anaesthetics) – (£308k) due to cease in August and an unfunded General Surgery rota – (£491k)
- Senior Medical overspends of (£1,664k) relating to Anaesthetics Locum Bookings to support performance & strikes acting down (£601k) and General Surgery Agency to support gaps relating to restricted practice.

Anaesthetic Consultants are overspent by £579k YTD. Anaesthetics have a vacancy gap of 5 WTE vacancies. The Division are attempting recruitment via Locum agencies and have re-advertised on NHS Jobs for trainees who CCT in August 2024. Interviews for the specified role are scheduled for February 2024.

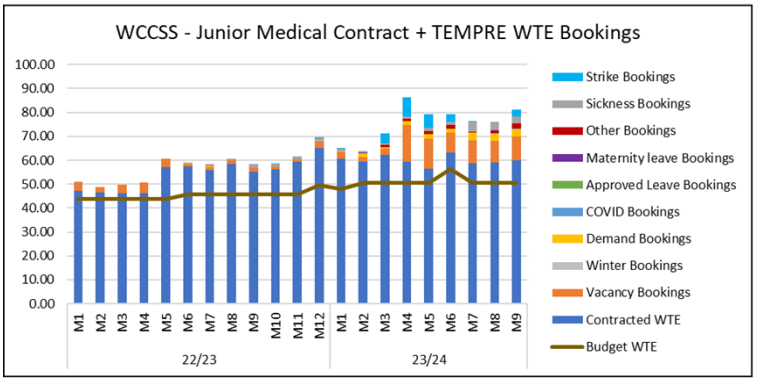
Next Steps – Surgery

- There are restricted duties within General Surgery Senior Medical Workforce team which has required additional spend.
- The Division have recruited a new Care Group Manager within Anaesthetics, a role that will support the management of Medical Workforce.
- General Surgery business case to address overspend within the Care Group is now complete considered at investment group January.
- Liaise with Finance to review financial forecasting for the next six months.
- Job planning and diary exercise for consultant staff in general surgery
- Reviewing Junior Medical rotas in all specialities and facilitating the progression of the General Surgery Business Case relating to both Elective and Non-Elective services.

Walsall Healthcare
NHS Trust

Women's Children's & Support Services

Care Group & Categories	Budget WTE	Actual WTE	TempRE MPE	Combined Vacancies	Budget YTD £000	Actual YTD £000	Variance YTD £000
Childrens and Family Services							
Medical Staff - Seniors	23.63	23.60		0.03	2,659	2,916	(256)
Locum Medical Staff - Seniors		3.00	0.52	(3.52)	212	442	(230)
Agency Medical Staff - Seniors						5	(5)
Medical Staff - Juniors	26.00	33.17		(7.17)	1,740	1,829	(90)
Locum Medical Staff - Juniors		-	3.30	(3.30)		688	(688)
Agency Medical Staff - Juniors						1	(1)
Childrens and Family Services Total	**49.63**	**59.77**	**3.82**	**(13.96)**	**4,611**	**5,881**	**(1,270)**
Clinical Support Services							
Medical Staff - Seniors	18.20	10.55		7.65	2,113	1,638	474
Locum Medical Staff - Seniors		3.00		(3.00)		308	(308)
Medical Staff - Juniors	2.60	5.00		(2.40)	136	155	(19)
Clinical Support Services Total	**20.80**	**18.55**		**2.25**	**2,249**	**2,101**	**148**
PHARMACY SERVICES							
Agency Medical Staff - Seniors						0	(0)
PHARMACY SERVICES Total						**0**	**(0)**
Womens Services							
Medical Staff - Seniors	21.84	20.91		0.93	2,675	2,633	42
Locum Medical Staff - Seniors		1.00	0.46	(1.46)		210	(210)
Agency Medical Staff - Seniors						1	(1)
Medical Staff - Juniors	22.00	21.86		0.14	1,434	1,320	115
Locum Medical Staff - Juniors			2.05	(2.05)		154	(154)
Agency Medical Staff - Juniors						(4)	4
Womens Services Total	**43.84**	**43.77**	**2.51**	**(2.44)**	**4,109**	**4,313**	**(204)**
Grand Total	**114.27**	**122.09**	**6.32**	**(14.14)**	**10,968**	**12,295**	**(1,327)**



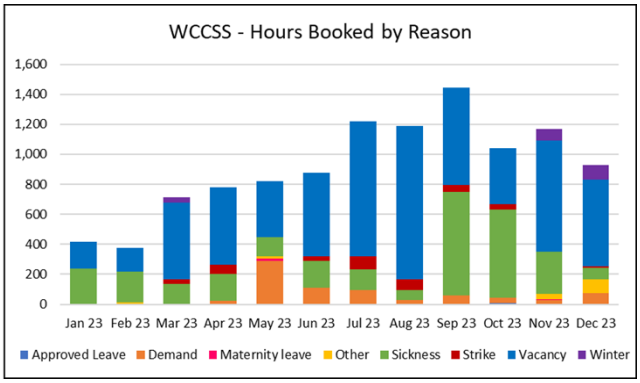
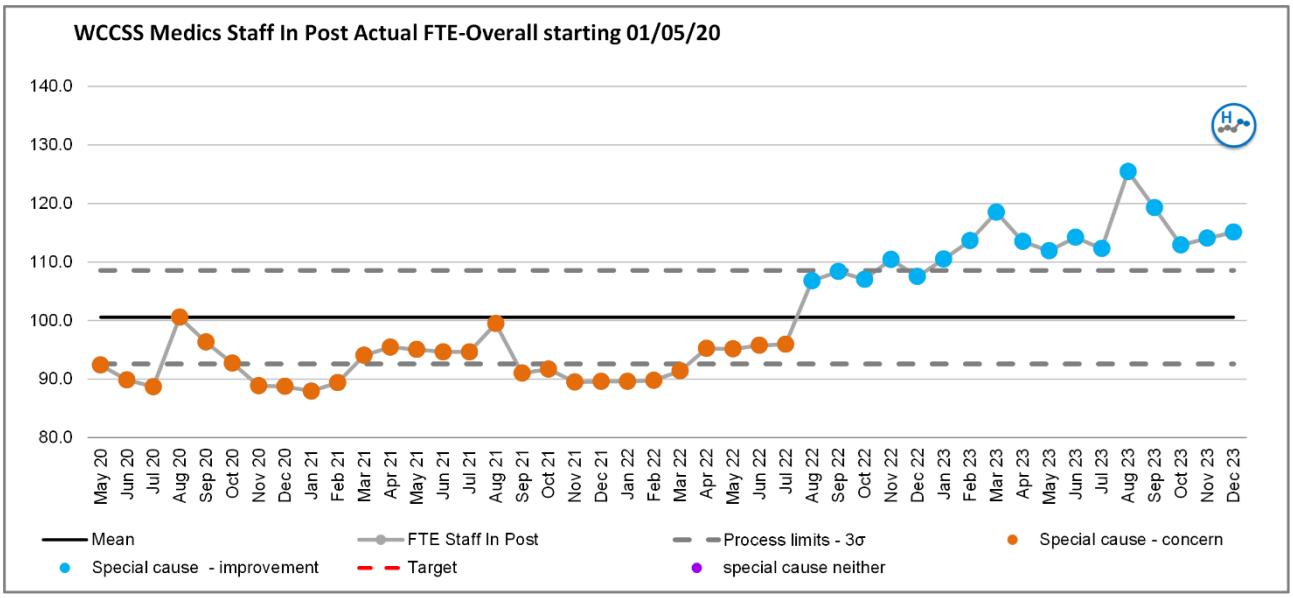


Figure 9: WCCSS Medics in post (Actual FTE)



WCCSS are £1,327k overspent YTD, driven by Locum bookings to support unfunded rotas in Paediatric Juniors (779k) and Obstetrics and Gynaecology. Current actions coming out of Medical Workforce relate to looking at the Junior Medical rotas in all specialities and a review of bookings and understand pressures.

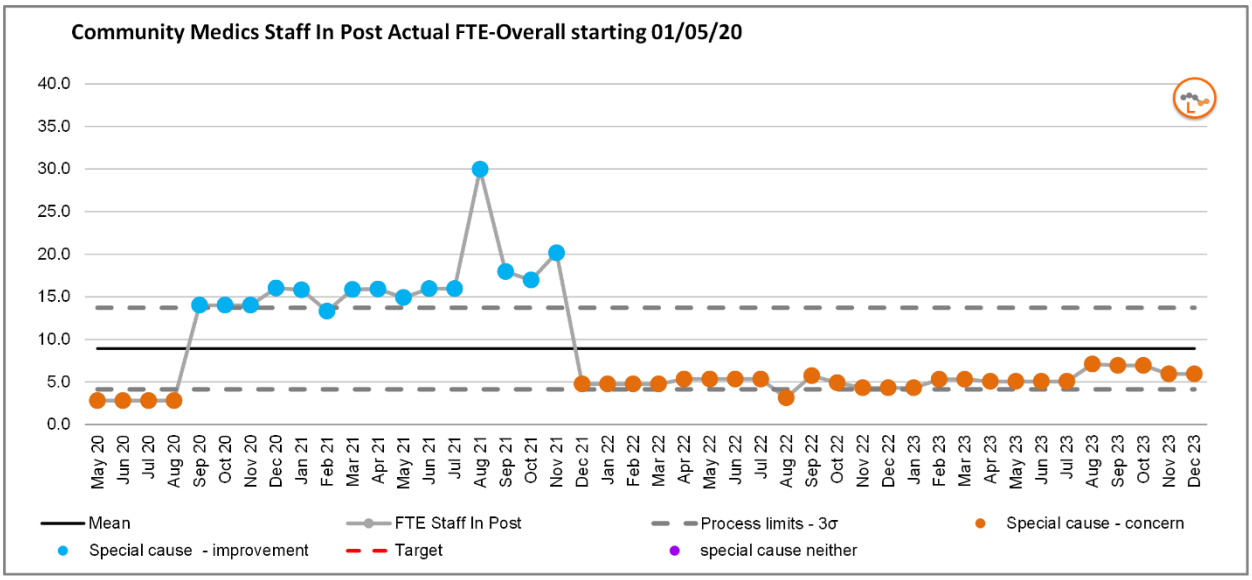
Next Steps – WCCSS

- Paediatric Medical Workforce Business Case to address the Junior and Consultant over establishments at investment committee January will need investment and escalation to ICS.
- Funding for Phases 2 and 3 of the Ockenden Business Case to address the Junior Medics gap in the Women's service.
- Agreed plan to stop recruiting additional Clinical Fellows and not replace for the next rotation.
- To investigate and understand the impact of stopping Locum usage for any unfunded rotas.
- Agreed plan to stop recruiting additional Clinical Fellows and not replace for the next rotation.
- To understand the impact of stopping Locum usage for any unfunded rotas.

Community

Community division employ one Locum consultant, a consultant Geriatrician on a 12-month contract from February 2023. A Palliative Care consultant/community Geriatrician was terminated in June 2023. The plan for the division of Community is to work the funding from these posts into two Clinical Fellows posts in Community GIM.

Figure 10: Community Medics in post (Actual FTE)



NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Mental Health Overview Report	Enc No: 8.9.6
Author:	Jodie Kirby-Owens - Head of Nursing Mental Health Email - jodie.kirby-Owens@nhs.net	
Presenter/Exec Lead:	Dr Manjeet Shehmar - Chief Medical Officer Email – manjeet.shehmar@nhs.net	

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

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Corporate risks in relation to Mental Health On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	Corporate risks in relation to Mental Health		
Resource Implications:	There are resource implications that are related to • Agency/ bank costs to support and manage patients who require mental health 1:1 (support) trust wide. • Specialist resources are used via agency and external organisations trust wide to support complex mental health patients.		
Report Data Caveats	This is a standard report using the previous 6 month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led, Safe, Effective, Caring and Responsive.
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		

Walsall Healthcare NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert

Assure

- During July - December 2023 there was 57 Mental Health Act Assessments. Following the Mental Health Act Assessments, 8 patients were detained to WHT with the remainder to Mental Health Trust Beds or discharged home.
- There have been no deaths of patients held under the Mental Health Act in the Trust.
- Mental health team is almost fully recruited with one vacancy out to advert for governance manager.

Advise

- Increased acuity for patients attending Walsall Healthcare NHS Trust (WHT) with mental health concerns. These are predominantly working age adults.
- WHT Mental Health team continue to work in collaboration with Black Country Foundation Healthcare Trust, Mental Health Liaison Service.
- 3 risks remain live on the corporate risk register, 2 in relation to internal and external risks for CYP who require Tier 4 provision and 1 in relation to adult mental health services.
- Increase in admission relating to eating disorder patients, who require specialist mental health beds.
- There have been 1710 attendances to the ED between July-December 2023 for patients with mental health issues.
- The trust is actively recruiting mental health clinical support workers to assist in the enhanced supervision of mental health patients.

Alert

- There have been 557 reported mental health related incidents.
- 1 SUI declared for care and treatment relating to a complex mental health patient.
- There is no “responsible Clinician” assigned to the organisation and this is a requirement to meet CQC mental health provider status.
- Mental health liaison team do not have a full-time consultant psychiatrist and are reliant on locum section 12 approved psychiatrists.
- Challenges continue with capacity and recruitment within the Mental Health Liaison Service resulting in delays to care & treatment.
- Increased demand for Mental Health inpatient admission/beds resulting in extended wait times in the Emergency Department and the Acute Medical Unit.

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

Walsall Healthcare NHS Trust

Mental Health Overview

Report to Trust Board Meeting to be held on 14th February 2024

1.0 Purpose Of Report

The purpose of the reports is to highlight the current mental health risks, progress and actions. Identifying internal and external factors.

2.0 Background

In 2021 Walsall Healthcare NHS Trust (WHT) registered as a provider of mental health with the CQC - allowing pateints to be detained under the Mental Health Act (MHA) to the organisation. Being a detaining authority places a responsibility onto the hospital managers (Trust Board) to ensure any MHA detention is completed in a lawful way upholding patients human rights.

As an organisation it must be evidenced that there is compliance with:

- The Mental Health Act 1983
- The Code of Pratice 2015

In the MHA the Trust Board are referred to as Hospital Managers and within the 'Code of Practice' the Hospital managers have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. They must ensure that patients detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

The trust board can accept or decline a detention to their organisation. The board are also required to support any tribunal or appeals that take place as they hold overall responsibilities of the Act within the organisation.

The MHA (1983) is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. People detained under the MHA need urgent treatment for a mental health disorder and are at risk of harm to themselves or others. The MHA enables a person to be detained or treated without their agreement. There are many sections of the MHA. Common sections of the MHA used at WHT are:

- Section 136 - Police Detention to access a mental health assessment and a patient can be held for up to 24 hours.
- Section 2 - detention for assessment for up to 28 days
- Section 3 - detention for treatment for up to 6 months (can be extended further)
- Section 5(2) – short term detention for assessment for up to 72 hours, usually resulting in further MHA assessment.
- Section 17 leave - for those patients detained to other organisations, however, may be transferred to WHT for treatment. Section 17 leave is a requirement for anyone who is detained under the mental health act and requires "leave" from the place where they are detained to.

Currently: there is no formal process or agreement in place that supports the 'Responsible Clinician' (RC) under the MHA. This is a direct requirement for any patient detained, predominantly under section 3 MHA for 'treatment'. Without a RC the organisation would not be complying with the regulations of the MHA and code of practice.

Approved Clinicians and Responsible Clinicians (AC/RC)
An approved clinician is a mental health professional approved by the secretary of state or a person or body exercising the approval function of the secretary of state. Some decisions under the Mental Health Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

Current national picture:
Newcastle upon Tyne Hospitals NHS foundation Trust were assessed by the CQC in February 2023.

CQC response:
"In response to our findings, we served the trust with a Warning Notice under Section 29A of the Health and Social Care Act 2008.

"The Warning Notice told the trust that they needed to make significant improvements in the quality and safety of healthcare provided in relation to patients with a mental health need, a learning disability or autism."

The CQC completed a very detailed report detailing all of the areas of improvements required and this report highlighted the responsibilities of the acute trust for all patients that are admitted and the required need for process and clear service delivery expectations, to support patients suffering mental health symptoms.

- There is learning from this report that the mental health team within WHT are reviewing to identify gaps and actions.

WHT Head of Nursing for Mental Health and team continue to work on improvement projects, however, are unable to provide assurance in relation to the gap related to the responsible clinician role. The responsible clinician role is imperative for the organisation to adhere to the mental health act and meet the CQC requirements for provider of mental health status.

3.0 Risks

This report contains a summary of risks that are located on the corporate risk register in relation to mental health, providing an outlining updates, escalations, and de-escalations.

2581 – Children and Young People (CYP) Mental Health delays in access to Tier - 4 bed.

External risk – 12 (downgraded from 16, October 2023)

Overall, the trust is unable to fully support and manage CYP awaiting a tier 4 bed admission and manage patient safety through the patient journey. Identified issues:

- No available registered clinician as required to adhere to the MHA 1983 or the mental health code of practice 2015.
- Suboptimal CAMHS services that are daytime only.
- Suboptimal facilities and staffing who are specialists in supporting CYP in crisis requiring treatment under the MHA 1983.

Mental health action plan in place to provide training, policy and process to support the organisations to hear the child's voice and support CYP in crisis.

Assurance in place

- Paediatric annual training for mental health act and mental health awareness is taking place monthly.
- Under 25 clinical nurse specialist RMN is now in post
- WHT mental health team are working with the paediatric team and the emergency medicine team to provide an adequate pathway for CYP in crisis.

Whilst there remain gaps within the mental health provider services there will continue to be long delays for CYP in crisis to access an appropriate assessment in a timely way.

2439 - Children and Young People Mental Health quality of care.

Internal risk - risk has been reduced to a score of 12 from 20. (October 2023)

Mental health action plan in place to provide training, policy and process to support the organisations to hear the child's voice and support CYP in crisis.

Assurance in place

- Paediatric annual training for mental health act and mental health awareness is taking place monthly.
- Under 25 clinical nurse specialist RMN is now in post.
- WHT mental health team are working with the paediatric team and the emergency medicine team to provide an adequate pathway for CYP in crisis.

Whilst there remain gaps within the mental health provider services there will continue to be long delays for CYP in crisis to access an appropriate assessment in a timely way.

3002 – Adult Mental Health Quality of Care

Risk score 16

Risk of sub optimal care and harm to adults who present in a mental health crisis, due to external services not able to deliver the required services due to the absence of an MOU. This in turn may contribute to a breach in part of the MHA, resulting in non-adherence to the MHA legislation and CQC requirements.

- There is no registered clinician allocated as per the requirements under the mental health act. Therefore, the organisation is unable to accept mental health act detention as it does not comply with MHA 1983 law and legislation.
- The organisation is currently unable to meet the CQC requirements for provider of mental health status due to no responsible clinician in place.
- There is evidence of suboptimal quality of care delivery for mental health patients due to extended waiting times to access and receive assessment and support. The evidence confirms the mental health team who are provided to deliver assessment CORE24 are not meeting the standards required and this directly impacts patient quality of care delivered.
- There has been challenges to adhere to the standards of contemporaneous record keeping due to the external services inconsistently documenting within the acute trust notes and at times not sharing relevant risk history and presentation. This contributes directly to incidents due to the acute trust staff not knowing the risks relating to the individual patient.
- Patients often wait 2-6 hours for an initial meatal health assessment, and this is against the NHSE expected times of 1 hour for assessment and 4 hours for expected discharge planning.

Assurance

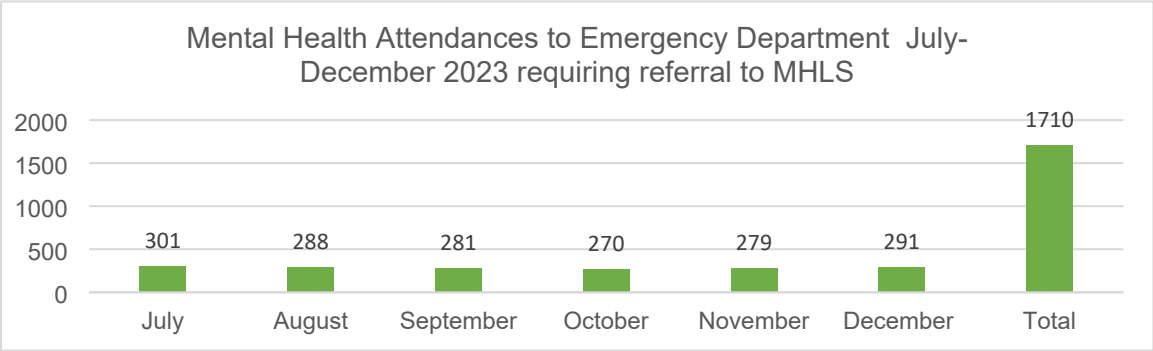
The WHT mental health team continue to work across the organisation and in collaboration to develop, deliver and embed policies and processes that support safe high quality of care for mental health patients. WHT mental health teamwork alongside the acute hospital staff to support education and escalation to manage patients safely.

However suboptimal delivery of CORE24 is outside of the scope of the WHT mental health team.

4.0 Mental Health Activity

Attendance to the emergency department for mental health, reason remains consistent, this is different from previous years where there were peaks and drops with attendances that historically were predictable. In the last year we have seen a consistently high number of mental health attendances and those attending have appeared more complex.

Chart 1 – Mental Health Attendances to ED

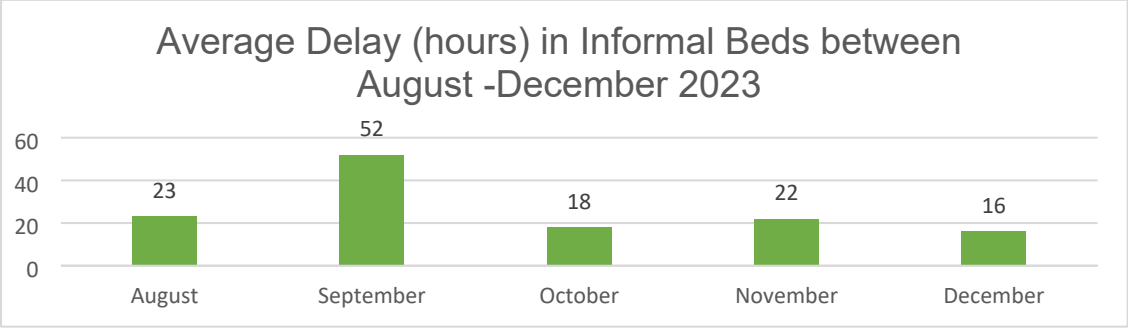


There has been through all current evidence-based practice an anticipated 'tsunami' of mental health across the country post COVID-19. There is evidence of this due to the attendance figures consistently being high and the lack of reduction in attendances that would usually be anticipated through the warmer months.

Nationally there has been significant pressures to access mental health beds and this is evident in patient wait times. There has continued to be evidence of extended waiting times for mental health beds for both in and out of area patients.

- Further analysis is to be conducted to understand the wait times in more detail.

Chart 2 – Wait times in Emergency Department for informal Psychiatric bed.



This graph identifies the wait time for a bed once the assessment is completed, this does not show an average time in ED. There is known challenges to access an appropriate assessment and there can be several hours delay accessing a full assessment by a psychiatrist whereby a decision is made around admission.

- At times patients have been known to wait 4-12 hours for a full assessment prior to the decision to admit waiting times.

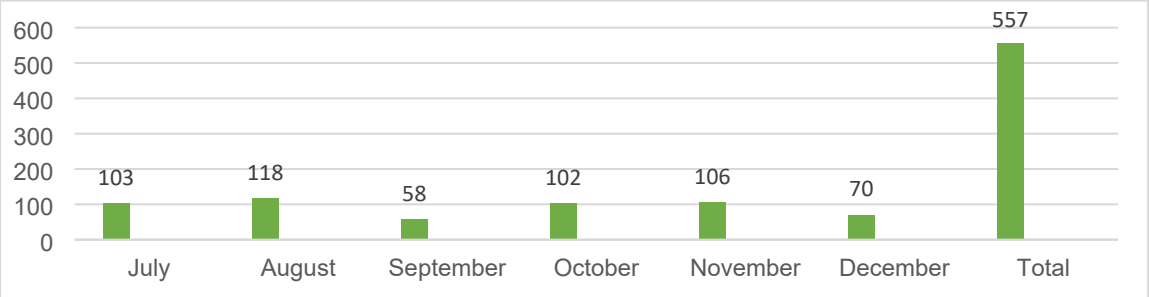
5.0 Governance

There has been 1 Serious incident declared, RCA has taken place and full summative report being completed, this was agreed at SI group due to the challenges to deliver care to a complex mental health patient who was aditted to WHT.

There were 557 mental health related incidents reported between July-December 2023 with the top cause groups of:

- Non-adherence to local policy (CORE24 standards not being met, non-adherence to policies)
- Unlawful MHA detention
- No access for Appropriate assessment for both psychiatrist and mental health nursing from the CORE24 team, due to resourcing issues.
- Patient absconded.
- Decision To Admit (DTA) breach.

Chart 3 – Incident data – 01/07/2023-31/12/2023



Other themes and challenges identified across the organisation supported by the WHT/RWT Mental health team:

- Absconding patients (all areas).
- Mental health act
- Patient delays in accessing mental health assessment by external provider.
- Breach in CORE24 service delivery standards.
- Challenges with completing section 5(2) MHA 1983 documentation and assessment.
- Delayed access to appropriate 136 suite.
- Increase in section 136 attendances to the ED.
- Supporting children under section 136 suite as CAMHS currently do not offer any support to ED.
- Challenges to access the local 136 suite for CAMHS.
- Supporting patients whilst awaiting tier 4 admission.
- Supporting CYP who are presenting in crisis due to limited access to specialist CAMHS team.
- Supporting and escalating through appropriate routes.
- Overuse of restraint/inappropriate restraint by security staff/ward staff.
- Frequent admissions/HISU (High Intensity Service User).

Action:

WHT have now developed a meeting to share incident reports with the external mental health provider on a regular basis. To improve collaborative working and supporting the quality of care for patients who are in WHT/RWT trust.

6.0 Mental Health Act

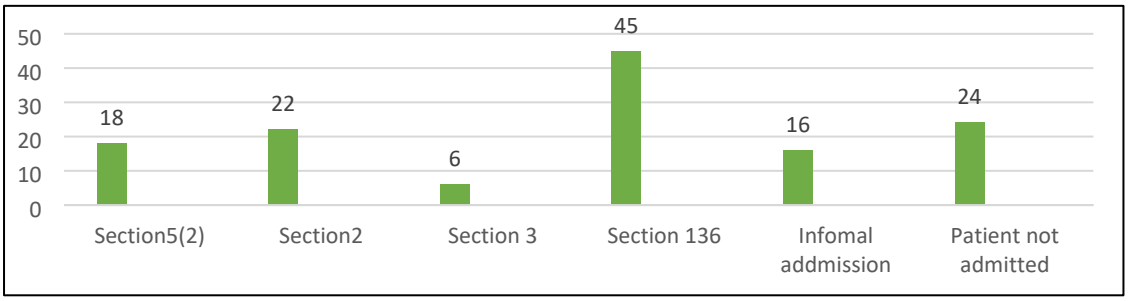
6.1 Equalities data

The equalities data for those that were detained is as follows:

- Sex: 2 male and 6 females.
- Age: The average age was 32 years (12 - 80years).
- Ethnicity: is detailed in the graph below for those detained to WHT.

6.2 Mental Health Act (MHA) Assessments

Chart 4: There have been 131 MHA assessments within WHT between January -December 2023. The chart shows the outcome of those assessments.



7.0 Project Work

7.1 Development of Clinical Support Worker (CSW) Band 3 Bank resource

The WHT mental health team have been working with the resourcing team to employ BANK CSW band 3 staff that are mental health trained and have experience of working within mental health services. This is to support the quality of care for all mental health patients within the organisation, ensuring safe high-quality care. Especially for those who require enhanced care and support.

WHT mental health team are providing an additional bespoke induction that includes de-escalation and breakaway training, incident reporting, documentation and escalation.

8.0 Action plan & Training

The Head of Nursing for Mental Health and team have developed an action plan for mental health that has 60+ actions listed. The team are setting out a new project plan and aspire to have completed all actions by the end of 2024.

9.0 Additional

Deputy Head of Nursing for Mental Health NHSE has met with the Head of Nursing for Mental Health and would like to work together over 2024 to support an increasing awareness of the work undertaken within the acute trust nationally. Nationally there is an awareness of the challenges faced for acute hospitals in relation to mental health and an increasing interest in how acute trusts are managing the risks and demands. WHT invested in a team and service to support mental health, and this is an innovative approach.

End of Report

Walsall Healthcare NHS Trust

Trust Board Meeting -to be held in Public 14th February 2024		
Title of Report:	Learning from Deaths Report (October – December 2023)	Enc No: 8.10
Author:	Mrs Lorraine Moseley Business Manager lorraine.moseley3@nhs.net	
Presenter/Exec Lead:	Dr Manjeet Shehmar Chief Medical Officer manjeet.shehmar@nhs.net	

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

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: • BAF001 Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm • Performance against SHMI is recorded on the trust risk register On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	Data is correct at the time of reporting. NHS Digital reporting is 3 months in arrears.		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details:
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

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

Summary of Key Issues using Assure, Advise and Alert

Assure

The most recent published SHMI value for the 12-month rolling period (published by NHS Digital September 2023 for the period August 2022 to July 2023) is 0.9933 which is within the expected range (this relates to the acute Trust excluding palliative care). Please note - this is the most up to date data available at the time of writing the report.

Advise

- No mortality alerts have been received for the period of this report.
- The medical examiner team reviewed 100% of the total eligible inpatient deaths for the period covered by this report.
- The ME service reviewed 138 community deaths within the period of this report.
- 8 LeDeR deaths were reported during this period, learning from LeDer deaths is included.
- The ME team continue to liaise with GPs, 62% are now signed up to the process. All remaining GP practices have been contacted and provided with Data Sharing Agreement to ensure process in place before April 2024.

Alert

- Observed deaths are higher than expected deaths: Septicemia, COPD & bronchiectasis, aspiration pneumonia and cancer of bronchus.
- The number of outstanding SJRs for the period of this report is 27, which is consistent with the previous report, however this is expected to reduce as a new process for community division SJRs has been agreed and reviewers are being trained. There is also a new lead for surgery who is currently reviewing the backlog.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement. • Prioritise the treatment of cancer patients. • Safe and responsive urgent and emergency care
Support our Colleagues	• Improve overall staff engagement. • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative. • Improve clinical service sustainability. • Implement technological solutions that improve patient experience. • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Walsall Healthcare NHS Trust

Learning from Deaths Report (October – December 2023)
Report to Trust Board Meeting to be held on 14th February 2024

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

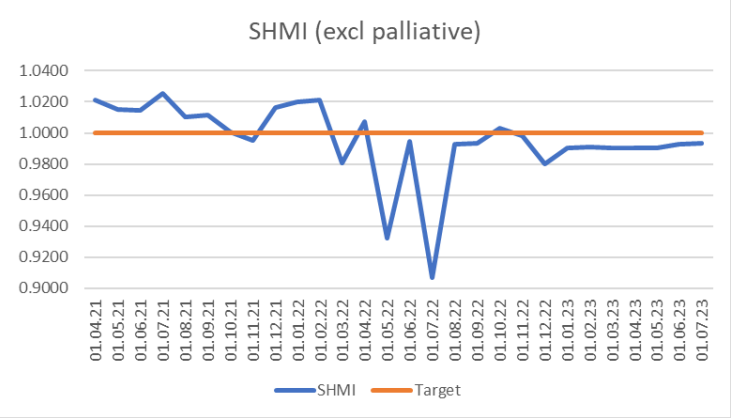
1. Update on Standardised Mortality Rates (SMRs) and inpatient data relevant to these calculations

1.1 Activity levels over this period is as follows:

	Admissions	Hosp Deaths	Total Discharges	Covid Deaths
Oct 23	8299	115	9112	8
Nov 23	8616	128	9242	12
Dec 23	7619	125	8388	4

1.2 SHMI (Inpatient deaths plus 30 days post discharge

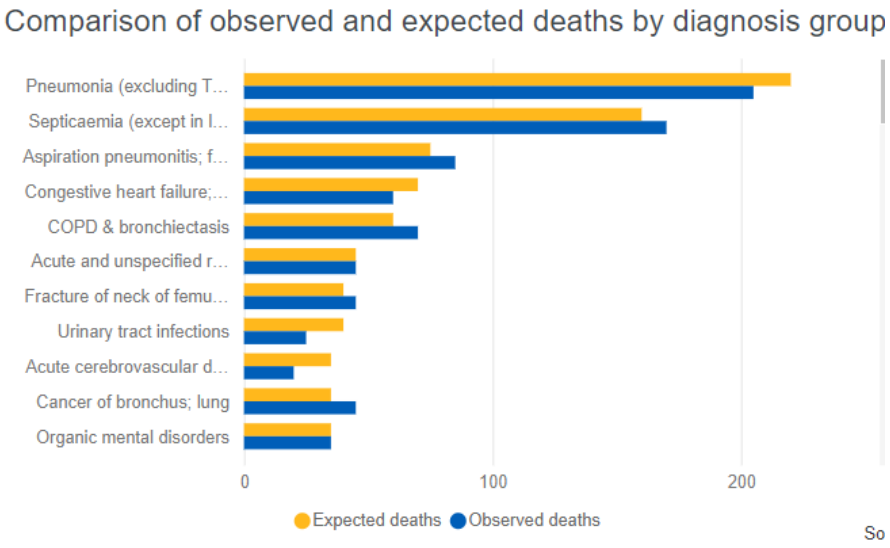
The most recent published SHMI value for the 12-month rolling period (published by NHS Digital September 2023 for the period August 2022 to July 2023) is 0.9933 which is within the expected range (this relates to the acute Trust excluding palliative care).



Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RBK02	Manor Hospital	62,935	1,520	1,530	0.9933
RBK49	Holly Bank House	90		10	
RBK83	Walsall Hospice	165	110	10	11.5884
E0Z3F	Walsall Manor Hospital Elective Surgical Hub	1,535			

SHMI in comparison with neighbouring Trusts (*NHS Digital)

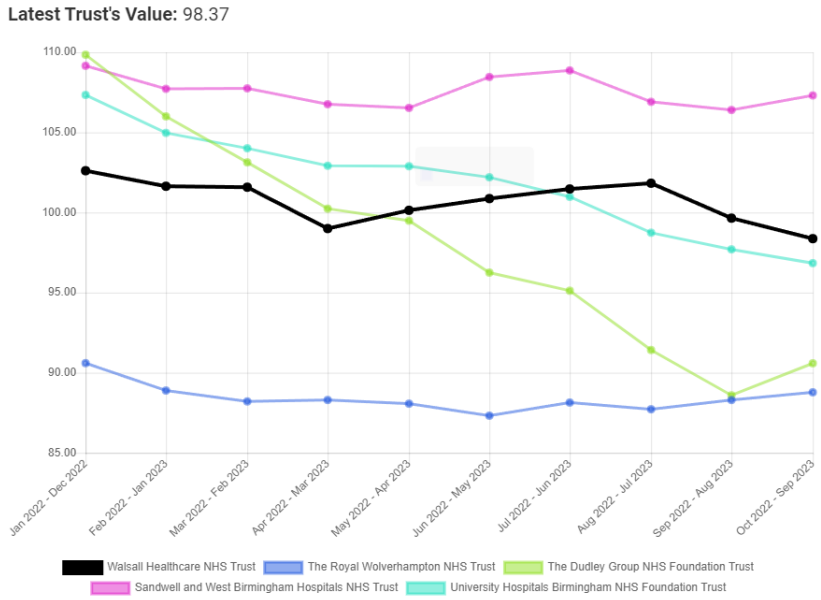
Trust	August 2022 - July 2023
Walsall Healthcare NHS Trust	0.9933
The Royal Wolverhampton NHS Trust	0.9025
The Dudley Group NHS Foundation Trust	1.0699
Sandwell And West Birmingham Hospitals NHS Trust	1.1180



It can be seen from the above that there are three areas where observed deaths are higher than expected deaths: Septicaemia, COPD & bronchiectasis, aspiration pneumonia, fractured neck of femur and cancer of bronchus. Patient level data has been provided to specialties and investigations are currently taking place to identify possible areas of concern and the outcome will be reported in future reports. The respiratory team have been asked to identify any aspiration pneumonia cases relating to patients with learning disabilities and these will be further investigated by the LeDeR team. The business cases for Mouth Care Matters is awaiting a funding source to help reduce hospital acquired pneumonia. Please note these have not changed from the previous report as the data is a 12 month rolling period and improvements are not immediately visible.

2. HMSR

The chart below is taken from available data within HED and illustrates the Trust's performance in relation to peer group. HMSR for this period is lower than the national average (98.61) and continues to show a steady reduction in HMSR.



3. Ethnicity

Ethnicity data for deaths for the period of this report (October 2023 to December 2023)

Grp By	(07) Oct	(08) Nov	(09) Dec	Total
Any other ethnic group	0	0	2	2
Any other White background	1	4	1	6
Asian - other	1	0	0	1
Black Caribbean or Black British Caribbean	1	0	1	2
Indian or British Indian	2	9	2	13
Mixed White and Black Caribbean	0	1	0	1
Not Stated	8	4	3	15
Pakistani or British Pakistani	2	2	1	5
Unknown	6	7	6	19
White British	86	90	88	264
White Irish	0	1	0	1
Total	107	118	104	329

The Trust are working on improving collation of ethnicity data at source level and with GPs. The highest ethnicity group for deaths remains within the white British group.

Alerts

There have been no alerts received during this period.

Reporting on previous alerts can be found below.

4. Alerts and focus

Perinatal Mortality Review Process (PNMR) Quarterly Report

The following cases were reported in Q2 with no concerns raised in the performance metrics of PNMR:
0 cases for concise review
0 cases reported as serious incident.
0 cases reported to Healthcare Safety Investigation Branch (HSIB)
1 for JAR meeting/review
4 reported to CDOP.

Improvement actions:

	Issue	Aim	Method	Results
1	Inappropriate place of birth for babies depending on their care needs.	Ensure capacity for Intra-uterine transfer within the region and support from Trusts within the LMNS when there is no capacity within the region.	1. Escalated to the LMNS via the 'Best Start' workstream meetings. Concerns escalated regarding cases where the baby has not been in the appropriate place at the time of birth.	1. Ongoing work within LMNS 2. Q2 report for Perinatal Mortality presented to the LMNS 'Best Start' workstream meeting on 16.11.2023 highlighting the mismanagement of SFH and increased rates of missed IUGR detection
2	Lack of referral and recognition of high CO readings in pregnancy and the possible adverse outcomes to the pregnancy	To ensure all mothers with CO readings over 3ppm are referred to smoking cessation and given very brief advice (VBA). Ensure mothers are aware of risk of smoking in pregnancy such as increased risks of stillbirth and IUGR.	1. Snapshot audit of maternal pregnancy records to be completed by PMRT Lead Midwife to check compliance to Smoking in Pregnancy Guideline (2023)	- Support requested from inpatient managers to scope care records for audit
3	Absence of checking with the women to ensure compliance with taking aspirin where it has been identified that aspirin is indicated.	Aspirin compliance linked to better outcomes in terms of reducing chance of developing pre-eclampsia and reducing risk of IUGR	1. Ongoing audit to ensure compliance with aspirin (due to be presented in January 2024)	Aspirin compliant tick-box available on Badgernet. At each point of contact the women is to be asked if she is taking her aspirin (if it is recommended)
4	Lack of appropriate escalation of vulnerable mothers when appointments were missed, or mother failed to present for care when they contacted maternity services	To ensure the safety and wellbeing of all mothers and babies and ensure compliance to the Trust Safeguarding Children Policy (2018)	1. Learning vignette to be produced with Maternity Governance team to share learning of specific case	Learning Vignette produced with Maternity Governance team
5	Symphysis fundal height (SFH) measurements missed during antenatal care with unknown IUGR babies. Mis-management of SFH measurements and increased rate of Missed IUGR detection.	Regular SFH measurements and growth US5 linked to better surveillance and monitoring of IUGR babies. IUGR is linked to higher rates of stillbirth and forms Element 2 of the Saving Babies' Lives programme (V3)	1. Saving Babies' Lives SMW has approached Perinatal Institute to explore face to face training for clinicians around GAP/Grow 2. Shared learning from LMNS 'Best Start' workstream	Q2 report for Perinatal Mortality presented to the LMNS 'Best Start' workstream meeting on 16.11.2023 highlighting the mismanagement of SFH and increased rates of missed IUGR detection

The following areas of good practice were highlighted:

1. Pre-eclampsia audit commenced with junior doctor and PMRT Lead Midwife to check adherence to local and national guidelines.
2. Lessons Learned Publication released monthly to show trends and learning from recent PMRT reviews.
3. CNST Safety Action 1 – evidence is all up to date and in appropriate evidence folders.
4. Implemented at WHT community services/self-referral for pregnant women. This will enable women to refer directly to the CMW and ensure a timely booking is completed as per NICE guidelines. Fail safes put into place for out of area women to ensure we are supporting with bookings.

- A thematic review of stillbirths and neonatal deaths for the period May to July 2023 was completed on 24th August 2023. Issues identified included; increase in pre-eclamptic mothers.. In view of the further increase in stillbirth rates following this review, an external review was recommended and supported by LMNS. The Divisional Director to identify external reviewer for perinatal cases.
- Integration of PMRT and CDOP to enable closer working with colleagues and reduce duplication of information.
- Audio and visual presentation of case examples developed and will be shared with staff.
- Support sessions for staff to discuss PMRT cases, specifically for those involved in giving care and wishing for a debrief/understanding of whole pregnancy journey.
- PMRT DoC process to be reviewed to ensure compliance and implementing letters to parents using available PMRT resources.
- Working group to look at Tool taking over Level 2 reviewed for perinatal deaths, thus avoiding duplication of information and speedier completion of reports.

4.2 Colorectal cancer

As previously reported, the CMO office has formed an improvement group led by the CMO to understand and address the actions required to improve clinical outcomes.

The following improvements have been implemented and work continues.

- Colorectal services performance metrics dashboard is available on Infohub
- Monthly assurance meeting with CMO since September 2023
- Reporting structures of Colorectal Review and Mortality Review are in place
- Culture external coach has started engaging the Colorectal Services stakeholders and an action plan was proposed
- Patient Experience workstream was formed and the survey results from Colorectal patients has been shared

Work continues on pathways with the involvement of Physiotherapy, OT and Social Care working alongside specialties.

There are two areas to highlight which are being worked through:

- Current Anaesthesia resources has gaps to support the review of post-op patients
- Current Palliative resources has gaps to support the ward round of post-op patients

Updates will continue to be reported to this Committee and the colorectal team will be presenting at the Learning from Deaths Group in February 2024.

Speciality Learning from deaths.

The following specialties presented at the monthly Learning from Deaths Group since the last report:

Diabetes/Endocrinology and Renal
10 deaths reviewed during the period October 2022 to November 2023 with no SIs identified.
Themes of good practice were recognition and good care of severe hyponatraemia, end of life care, involvement of relatives and good post take ward round documentation. Actions in progress were around support from learning difficulties team.

Cardiology
26 deaths reviewed during the period October 2022 to March 2023. SJRs completed, poor care was not identified during the SJR process.
Themes of good practice were good cardiac care with early investigations, end of life care, involvement of palliative care team and with early recognition of dying and end of life patients. Actions in progress were around documentation improvements and inter hospital transfers.

Child Death
A total of 29 child deaths were reported in 2022-2023 with 24 reviews completed. A total of 18 deaths were reported in 2023-2024 (to October 2023) with 2 reviews.
At October 2023 there were 24 reviews outstanding; 1 awaiting court date, 4 police investigations, 8 awaiting coroner outcome, 5 awaiting PMRT from outside the area, 3 awaiting PMRT at Walsall, 1 awaiting safeguarding review and 2 CDRMs arranged.
Themes of good practice included good multidisciplinary team work in ED, WMAS service provision including prehospital doctor and medical team, urgent referral for cardiac review. Education and simulation training provided for all staff.
Developmental points included SUDC box in ED not fully equipped for post mortem sampling (there is a new SUDC box now in place and forms part of daily nurse check), ED and laboratory staff unfamiliar with new chain of evidence forms and samples to be taken.

LeDeR Annual Report April 2022 – March 2023
The report focuses on the Black Country with three long term objectives which aim to improve health, deliver better care and improve quality.

A total of 80 notifications were received, 1 autistic person and 79 for people with LD.

	Black Country	Dudley	Sandwell	Walsall	Wolverhampton
Initial reviews	52	18	19	7	8
Focused reviews	28	8	7	7	6
Total (FR %)	80 (35%)	26 (31%)	26 (27%)	14 (50%)	14 (43%)

Learning points for the Black Country identified in the report included: poor compliance with Mental Capacity Act, lack of advanced care planning impacting on end-of-life care, aspiration pneumonia as the main cause of death. There has been an increase in deaths of younger people with complex needs. There is work underway to raise importance of SALT referrals and the ICB has set up groups to look at dysphagia and choking. Locally, aspiration pneumonia mortality data relating to patients with LD is being reviewed by the specialty and will be reported in the next Learning from Deaths report.

Areas of good practice highlighted in the report and specific to Walsall Healthcare Trust, regular audits on MCA compliance, training on MCA available to all staff, support from safeguarding teams. Patients identified as having LD, autism or ADHD have alert added to electronic patient records, reasonable adjustments can be recorded in Fusion.

Geriatric Medicine
8 deaths reviewed for the period May to August 2023. SJR outcomes of 3a and 2 identified and clinical incidents raised, further investigations to be carried out and outcome to be reported in the next report.
The following areas of concern were raised; no consultant ward round prior to transfer to ward; no clear indication documented for morphine prescription and entry on drug chart illegible; poor communication with family in relation to end of life; poor documentation.
The team have implemented two quality improvement projects; appropriate antibiotic use in CAP; and fluid management which has already presented a reformatted proforma for IV fluid management.

Gastroenterology
2 deaths were reviewed for the period June to August 2023 with no SIs or complaints during the period. Areas of good practice identified were: appropriate escalation of deteriorating patients; and clear documentation. Areas for improvement were the highlighting of patients with Respect form on board round, documentation of anticoagulation on endoscopy report and raising awareness of MET team call.

#NOF
5 deaths were reviewed for the period April to August 2023. The following was identified as learning points: patients on DOAC to be bridged with Clexane in preoperative period, poor documentation leading to poor handovers, high incidence of AKI which needs further audit and early MDT intervention reduces poor outcomes in frail elderly patients.
The team is planning to visit Russells Hall Hip Fracture Unit to review pathways. An MDT study day is planned for March 2024.

Alert review:
Chronic obstructive pulmonary disease and bronchiectasis
An update on the review of records will be presented at the January 2024 Learning from Deaths meeting.

5. Mortality Reviews - Structured Judgement Reviews (SJRs)

5.1 The number of outstanding SJRs for the period of this report is 27, which is consistent with the previous report. This figure is expected to reduce as a new process for community division SJRs has been agreed and reviewers are being trained. A new mortality lead in surgery has been appointed who is working through the backlog and this will be reflected in the next report. The continuing industrial action has impacted on the available time to complete SJRs.

5.2 A total of 8 LeDeR reviews were identified in the period covered by this report (three in October and five in December). The outcome of these reviews is awaited.

5.3 The issue around missing notes/loose filing remains an issue.

SJR outcomes – Q3 (total deaths reviewed categorised by outcomes)*

Score 1 Definitely avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	1	1.6%

Score 2 Strong evidence of avoidability		
This Month	0	25.0%
This Quarter (QTD)	1	5.3%
This Year (YTD)	4	6.6%

Score 3a Probably avoidable (more than 50:50)		
This Month	1	25.0%
This Quarter (QTD)	3	10.5%
This Year (YTD)	7	11.5%

Score 3b Probably not avoidable (less than 50/50)		
This Month	1	0.00%
This Quarter (QTD)	1	31.6%
This Year (YTD)	13	21.3%

Score 4 Probably not avoidable		
This Month	4	25.0%
This Quarter (QTD)	14	36.8%
This Year (YTD)	33	54.1%

Score 5 Slight evidence or definitely not avoidable		
This Month	0	0.0%
This Quarter (QTD)	1	10.5%
This Year (YTD)	3	4.9%

*This data refers to the number of SJRs completed
The total number of deaths in the Trust for this quarter = 368, YTD 977. SJR 1-3a rate YTD 1.2%
Number of completed SJRs with scores of 1-3a Q3 rate 1.1%

6. Medical Examiner

The medical examiners reviewed 100% of deaths in this reporting period with 368 hospital deaths 138 community deaths reviewed during the period of this report. The community ME programme continues to be promoted to all Walsall GPs with 62% of Walsall GPs now part of the programme. All remaining GP practices have been contacted and provided with Data Sharing Agreement to ensure process in place before April 2024.

Coroner referrals are now reported to the Learning from Deaths Group monthly to provide oversight.

7. Matters for escalation to Quality Committee

No matters for escalation were identified during the period of this report.

Walsall Healthcare NHS Trust

Trust Board Meeting – to be held in Public 14 February 2024 ENC 8.11.1	
Title of Report:	**Board Assurance Framework and Corporate Risk Register**
Author:	Kevin Bostock, Group Director of Assurance Keith Wilshere, Group Company Secretary
Presenter/Exec Lead:	Kevin Bostock, Group Director of Assurance Keith Wilshere, Group Company Secretary

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

Recommendations:

- ☐ For the Board Committees/Board to note the updates to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).
- ☐ For the Board Committee to highlight to the Board areas of significant Assurance, Advisory or Alert issue.
- ☐ For the Board Committees/Board to consider and/or commission further action relating to BAF and/or CRR Risks.

Implications of the Paper:			
Risk Register Risk	Risk Description: The risks identified in the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) are risks that are deemed to be appropriate for the BAF and are regularly reviewed and revised.		
Changes to BAF Risk(s) & CRR Risk(s) agreed	Associated risks are identified in the BAF/CRR. Change resulting from a review of the BAF/CRR are listed in the BAF/CRR and the revised risks.		
Resource Implications:	None from the BAF or CRR.		
Report Data Caveats	This report contains the latest Director reviews; however data and positions may change in real-time.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led Standards
	NHSE	Yes☒No☐	Details: Well-led Standards
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	NHS Constitution	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
Equality and Diversity Impact	The BAF Risk NSR 106 specifically addresses risks related to the pursuit of greater equality, diversity, and inclusion at the Trust.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: 23 November 23
	Board Committee	Yes☒No☐	Date: November 2023
	Board of Directors	Yes☒No☐	Date: November 2023
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert - BAF

Assure

- The risks identified in the BAF are regularly reviewed and revised.
- **NSR103** Attracting, recruiting, and retaining staff – NHS England Long-term workforce plan provides a 15 year forward look to increase workforce numbers. The Trust has submitted a one year forward view in line with the financial plan via the ICB.

NHS
Walsall Healthcare
NHS Trust

Summary of Key Issues using Assure, Advise and Alert
Advise The BAF Risks have been revised in the light of, and the inclusion of the new shared Strategic Aims and Objectives. • **NSR101** - Data and systems Security (Cyber-attack) – No recommended change in the risk level. • **NSR102** - Culture and behaviour change (incorporating Population Health) – no recommended change in risk level. • **NSR103** - Attracting, recruiting, and retaining staff– no recommended change • **NSR104** - Patient Safety and Quality of Care - no recommended change in risk level however note that a reduction in the likelihood (3 or 2) is considered soon. • **NSR105 -** Resource availability (funding) – No recommended change in the risk level. • **NSR106** - Equality, Diversity, and Inclusion (incorporating Staff, Patients and Population Health) – No recommended change in the risk level.
Alert • **NSR105 remains of concern**

Summary of Key Issues using Assure, Advise and Alert - CRR
Assure: • The report ensures that the Audit Committee receives summary information on the Trust's Corporate Risk Register (CRR) • The CRR is reviewed monthly at an Executive Confirm and Challenge meeting.

Advise:
• Of the 24 agreed risks that sit on the CRR∆:
  ○ 10 risks have a current **High** rated risk score'
  ○ the number of Corporate Risks remaining the same (11 of 27).
  ○ No risks have been de-escalated from the CRR in this reporting period

Alert:
• Of the 24 agreed risks that sit on the CRR∆:
  ○ At time of generating this report 11 current CRR levels risks were awaiting a review by the Risk Owner.
  ○ No Risks have reduced in score in this reporting period
• 8 Risks are scored 9-12 score in moderate grading
• New processes are being developed to simplify the user interface with the system of recording and updating risks in readiness for Datix Cloud roll out in early summer 2024.
• Our Internal Auditors will be commencing Internal Audit into Risk Management in WHT in February 2024

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been takenon their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Walsall Healthcare NHS Trust

Risk Management Report – February 2023 (covering up until the 29 January 2023)

1.1. CRR Details

There are currently 24 agreed risks that sit on the CRR.

- 10 Risk score between 15-20 (High) and these have not changed in score when reviewed in December 2023.
- 9 Risks score between 9-12 and remain static in number and grading.
- 11 Reviews remain outstanding at time of writing this report and these are flagged to Risk owners

Details of the Corporate Risks is shown in *Appendix 1* for information.

Table below highlights the 10 risks on the CRR that are graded as HIGH and shows movement up to 8 January 2024.

Risk ID	Risk Title	April-May 23	June-July 23	Aug-Sept 23	Oct-Nov 23	Dec 23-Jan 24	Change Direction
25	Failure to achieve 18 Week RTT constitutional standards	20 High	20 High	20 High	20 High	20 High	
208	Failure to achieve 4-hour emergency access standard resulting in compromised patient safety and patient experience.	16 High	12 Moderate	12 Moderate	16 High	16 High	↔
665	Cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) to the Trust and other NHS partner organisation within the West Midlands Conurbation.	15 High	15 High	15 High	15 High	15 High	↔
2081	Delivery Operational Financial Plan	12 Moderate	20 High	20 High	20 High	20 High	↔
2082	Future Financial Sustainability	20 High	20 High	20 High	20 High	20 High	↔
2163	Limited access to Respiratory Support Unit resulting in increased likelihood of morbidity and mortality.	15 High	15 High	15 High	15 High	15 High	↔
2325	Trust-wide: Incomplete patient Health Records.	16 High	15 High	15 High	15 High	15 High	↔
3002	Adult Mental Health quality of care.	16 High	16 High	16 High	16 High	16 High	↔
3043	Suboptimal paediatric nursing ratios.	20 High	16 High	16 High	16 High	16 High	↔
3036	Significant reduction in activity for elective care, due to absence of resolution in industrial pay disputes					16 High	

Walsall Healthcare NHS Trust

Board Assurance Framework
Report to the Trust Board Meeting January 2024

EXECUTIVE SUMMARY

The BAF is currently comprised of 6 risks, 4 of which are red rated risks:

- NSR101 Data and systems Security (Cyber-attack)
- NSR102 Culture and behaviour change (incorporating Population Health)
- NSR103 Attracting, recruiting, and retaining staff
- NSR104 Consistent compliance with safety and quality of care standards
- NSR105 Resource availability (funding)
- NSR106 Equality, Diversity, and Inclusion (incorporating Staff, Patients and Population Health)

			RISK SCORES: LIKELIHOOD x CONSEQUENCE = TOTAL																	Aims			
REF	STRATEGIC RISK	ASSURANCE	INITIAL	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	First to current	SINCE LAST UPDATE	Current 2023	Target	1	2	3	4
NSR 101	Data and systems Security (Cyber-attack)	SIRO	15	15	15	15	15	15	15	15	15	15	15	15	15			→	→	15	8				✓
NSR 102	Culture and behaviour change (incorporating Population Health)	GCPO	12	12	12	12	12	12	12	12	12	12	12	12	12			→	→	12	4	✓		✓	
NSR 103	Attracting, recruiting, and retaining staff	GCPO	9	9	12	12	12	12	12	12	12	12	12	12	12			↑	→	12	9		✓		
NSR 104	Consistent compliance with safety and quality of care standards	GDoA CMO, DoN	12	16	16	16	16	16	16	16	16	16	16	16	16			↑	→	16	6	✓			
NSR 105	Resource availability (funding)	GCFO	15	15	15	15	15	15	20	20	20	20	20	20	20			↑	→	20	6	✓			
NSR 106	Equality, Diversity, and Inclusion (incorporating Staff, Patients and Population Health)	GCPO	16	16	16	16	16	16	16	16	16	16	16	16	16			→	→	16	9		✓	✓	

BACKGROUND INFORMATION

The timeline for review of the BAF is on a two-month cycle (urgent updates can be made at any time):

Reviews

- The BAF, CRR Heat Map Summary are presented at the Board for reference and information.
  - NSR101 Data and systems Security (Cyber-attack) – reviewed by Finance and Productivity Committee
  - NSR102 Culture and behaviour change (incorporating Population Health) – reviewed by People Committee
  - NSR103 Attracting, recruiting, and retaining staff - reviewed by People Committee
  - NSR104 Consistent compliance with safety and quality of care standards- reviewed by Quality Committee
  - NSR105 Resource availability (funding) – reviewed by Finance and Productivity Committee
  - NSR106 Equality, Diversity, and Inclusion (incorporating Staff, Patients and Population Health) – reviewed by People Committee

Potential revisions to BAF Risks
None proposed at this review.

Relationship between Corporate Risk Register (CRR) Risks and BAF Risks – Ratings
A previous Internal Audit recommended that "*the BAF reporting should make explicit the relationship between operational and strategic risks. It should explain to the reader why for example there a collection of amber level risks at an operational level may culminate in an overall red strategic risk*."
In each BAF Risk case, any related CRR risks are identified.

RECOMMENDATIONS
The Board is asked to receive and note the Board Assurance Framework and Corporate Risk Register Summary Report.

Walsall Healthcare NHS Trust

Paper for submission to the Trust Board – to be held in Public Wednesday 14 February 2024		
Title of Report:	Chief Operating Officer's report	Enc No: 8.12
Author:	Ned Hobbs – Chief Operating Officer Ned.Hobbs1@nhs.net 01922 603351	
Presenter/Exec Lead:	Ned Hobbs, Chief Operating Officer and Deputy Chief Executive	

Action Required of the Board/Committee/Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☒No☐	Yes☐No☒
Recommendations: **To note the contents of the report for assurance.**			

Implications of the Paper:	
Risk Register Risk	Yes ☒ No ☐ Risk Description: Corporate Risk 208 – Failure to achieve 4-hour emergency access standard Corporate Risk 25 – Failure to achieve 18 week constitutional standards On Risk Register: Yes☒No☐
Changes to BAF Risk(s) & TRR Risk(s) agreed	None
Resource Implications:	Revenue: Elective Recovery Fund income for additional outpatient first attendances, outpatient procedures, elective daycase and elective inpatient admissions. Capital: Lead Lined Procedure Room, West Wing Theatre upgrade and UECC phase 2 reconfiguration of old ED and old UTC space all within Trust Capital Plan. Workforce: The Trust is mindful of increasing resilience in core Urgent and Emergency Care services to be able to safely manage increased Winter pressures. Funding Source: The Trust's Winter Plan was approved at Trust Board in October 2023.
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision. Cancer performance metrics are always reported 1 month in arrears. National benchmarking metrics are always reported 1 month in arrears (with the exception of Urgent & Emergency Care benchmarking)

Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led
	NHSE	Yes☒No☐	Details: Access standards
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☒No☐	Details: Access standards
	Other	Yes☐No☐	Details:
CQC Domains	**Safe:**	**Responsive:**	**Well-led:**
Equality and Diversity Impact	There is clear evidence that greater deprivation is associated with a higher likelihood of utilising Emergency Department services, meaning longer Emergency Access Standard waiting times will disproportionately affect the more deprived parts of the community we serve. Whilst not as strongly correlated as emergency care, there is also evidence that socioeconomic factors impact the likelihood of requiring secondary care elective services and the stage of disease presentation at the point of referral. Consequently, the Restoration and Recovery of elective services, and the reduction of waiting times for elective services must be seen through the lens of preventing further exacerbation of existing health inequalities too. The published literature evidence base for differential access to secondary care services by protected characteristic groups of the community is less well developed. However, there is clear evidence that young children and older adults are higher users of services, there is some evidence that patients who need interpreters (as a proxy for nationality and therefore a likely correlation with race) are higher users of healthcare services. And in defined patient cohorts there is evidence of inequality in use of healthcare services; for example, end of life cancer patients were more likely to attend ED multiple times if they were men, younger, Asian or Black. In summary, further research is needed to make stronger statements, but there is published evidence of inequity in consumption of secondary care services against the protected characteristics of age, gender and race.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☒No☐	Date: Fortnightly Restoration & Recovery meeting

NHS
Walsall Healthcare
NHS Trust

Summary of Key Issues using Assure, Advise and Alert

Assure:-

This paper provides a summary update to the Board on performance against the NHS Constitutional Standards and other relevant matters to the Chief Operating Officer portfolio.

Emergency Care and Winter Plan

The Board should be assured that:

- The Trust continues to deliver some of the best Ambulance Handover times (<30 minutes) in the West Midlands, with 83.04% of patients handed over within 30 minutes of arrival by ambulance in December 2023. The Trust was the second best performing organisation in the West Midlands in December 2023, and has now been in the Top 3 performing organisations in the region for the last 38 consecutive months. Board should note that December's ambulance handover performance was special cause deterioration, however, a reflection of the scale of pressure on Urgent & Emergency Care services across the country.
- In December 2023, 72.3% of patients were managed within 4 hours of arrival, against the revised national expectation of at least 76%. WHT's national ranking for the four-hour emergency access standard (EAS) remained upper quartile at 28th best Trust out of 123 reporting Acute Trusts in December 2023. 4 hour performance remains common cause statistical variation.
- The Board should note that UEC demand has been tracking closer to the pessimistic scenario in the Winter Plan. In particular, December 2023 was the 2nd highest month of Type 1 ED attendances on record and the second highest month of net importing of Intelligently Conveyed ambulances to Walsall Manor hospital on record, with 212 ambulances conveyed to Walsall Manor, and 24 conveyed away, representing a net import of 188 ambulances. This is a reflection of the extent of pressure at neighbouring organisations and poses a risk to the Trust's ability to maintain timely access to emergency care locally, and also poses a significant financial risk too.

Cancer Care

- In November 2023, 78% of patients with confirmed Cancer were treated within 62-days, as part of the new 62-day combined performance indicator. This places the Trust in the upper quartile of performance nationally, at 18th best performing Trust out of 119 reporting general acute Trusts. Timely Cancer treatment is vital to treat the disease early which is associated with improved survival rates.
- The number of patients on an incomplete cancer pathway waiting in excess of 62-days continues to remain below forecast.

Elective Care

- The Trust delivered the national standard to have no patients waiting in excess of 78 weeks as of the end of December 2023 (excluding patient choice), for the 10th consecutive month.
- The Trust's total RTT incomplete waiting list is now showing steady incremental reductions, despite persistent industrial action. The Trust's total RTT incomplete waiting list has decreased from a peak of 35,882 in April 2023 to 31,255 in December 2023. This represents a 12.9% reduction over the course of the last 8 months.
- The Trust has delivered a statistically significant increase in outpatient clinic booking utilisation with 12 consecutive months above the baseline mean.

Advise:-

Emergency Care

- All Trusts have received a letter (25th January 2024) from the National Director of iUEC and Deputy Chief Operating Officer (NHS England) and the Regional Director (NHS England – Midlands), reiterating the performance requirement to deliver (all type) 4-hour Emergency Access Standard performance of 76% or greater in March 2024. The Trust's performance YTD is over 74% and so 76% in March 2024 is not unachievable, however the disproportionate growth in UEC demand, and in particular UEC demand from neighbouring boroughs, represents the single largest risk to achieving 76%+ in March 2024.

Elective Care

- The Trust's 18-week RTT performance for December 2023 has 56.7% of patients waiting under 18 weeks, and a national ranking position of 61st (out of 121 reporting Trusts) for November 2023 performance – the Trust's highest national ranking for 2 years. In addition, the Trust's 52-week waiting time performance is 65th out of 121 reporting Trusts.
- The Trust has a plan to deliver zero patients waiting in excess of 65 weeks (excluding patient choice) by 31st March 2024. The plan contains some risk; most notably for Oral Surgery, but as of January 2024 remains on track.

Cancer Care

- Overall access to suspected cancer and Breast symptomatic 2 week wait clinic appointments is showing common cause variation. However, both Breast and Skin tumour sites remain under pressure. Whilst no longer a formal constitutional standard, access to initial suspected cancer clinic appointments is an important intermediary step to deliver the 28-day Faster Diagnosis standard. The Trust met the constitutional Faster Diagnosis standard to ensure more than 75% of patients received a diagnosis within 28-days of referral in November 2023 and performance was upper decile nationally. Timely care for patients with cancer is vital given the clear evidence that clinical outcomes (including survival rates) correlate with the stage of the cancer disease on diagnosis, and thus detecting and treating cancer early directly improves patient outcomes.

Alert:-

Diagnostic access

- The Trust's 6 Week Wait (DM01) Diagnostics performance is now 69th best (November 2023 reporting), out of 120 reporting general acute Trusts, with 27.03% of Trust patients now waiting over 6 weeks in December 2023. The business case to sustainably expand Endoscopy capacity was approved by the Trust's Performance & Finance Committee in June 2023 following categorisation in the highest priority category through the Executive Team prioritisation. Endoscopy remains the most challenged Diagnostic modality at the Trust, with Non-Obstetric Ultrasound as the other significant pressure modality, as is the case across the Black Country. Recovery plans are in place for both. Recovery of access to diagnostics is important to ensure that serious disease that needs urgent treatment is detected and acted upon promptly, and to ensure GP and other community clinicians have access to timely diagnostic information to support the management of patients in community settings.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	
Improve the Healthcare of our Communities	
Effective Collaboration	• Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Trust Board Metrics Report – Support our Colleagues	Enc No: 9.1
Author:	Author - Amanda Cater, Head of Performance Responsible Directors: Alan Duffell, Group Chief People Officer.	
Presenter/Exec Lead:	Alan Duffell, Group Chief People Officer and Clair Bond, Interim Director of Operational HR	

Action Required of the Board/Committee/Group **(Please remove action as appropriate)**			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐

Recommendations:

Board members are asked to note the contents of the report and note that metrics included in the report maybe reported in further detail within other subcommittee papers.
Areas for focus are included within subcommittee highlight reports.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☐ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) : Any risks associated with individual metrics reported within the report are detailed within the appropriate sub-committee papers.		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State: **None** Risk Description Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	(if none, state 'none') Revenue: **None** Capital: **None** Workforce: implications associated with the capture and reporting of performance data. Funding Source: **None**		
Report Data Caveats	This is a standard report using the previous months or most recent data. It may be subject to cleansing and revision. The report relies on timely and accurate data recording in corporate systems and, for data provided outside of corporate systems, timely provision of the data to the Performance Team for incorporation into the report		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Effective, Caring, Responsive, Well-led
	NHSE	Yes☒No☐	Details: Publication PRN00196 Elective care prioritise 2023/24
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☒No☐	Details: NHS contractual requirements
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Walsall Healthcare
NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert

Introduction

'Board Level Metrics' are a rationalised set of priority metrics for the Board to focus on. The metrics align against our four strategic objectives (Care, Colleagues, Collaboration and Communities) and our Vision. Whilst this is a rationalised set of metrics to generate higher quality discussions and assurance, we also monitor a considerable number of metrics within subcommittee papers. Highlight reports from each committee are included for Board focus. This report includes data in Statistical Process Control (SPC) charts using the NHS 'Make Data Count' style of reporting. Further detail on how to interpret SPC charts icons is explained in the final page of this report. This is the second time this new report has been produced; the content will evolve over time. This report replaces the previous IQPR – Integrated Quality and Performance Report.

Please refer to subcommittee highlight reports for areas of Assure, Advise and Alert

Trust Board Metrics - Key Objectives

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L		Cancer - No. of patients waiting 63+ Days for treatment (CARE) MSFD - Average number of Medically Fit for Discharge Patients in WMH (COMMUNITIES)	18 Weeks RTT - Number of 78 Week Breaches (excluding patient choice) (CARE)	
		Urgent Crisis Response (UCR) - 2 Hour Response Rate (CARE) Vacancy Rates - Overall (COLLEAGUES) Virtual Ward - Total Referrals (COLLABORATION)	18 Weeks RTT - Number of 65 Week Breaches (CARE)	
H / L		ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival (CARE)		

Dashboard metrics for the below Objectives do not contain enough data points to populate the above matrix - Please see exception page for further detail

- Carbon Footprint - 5% reduction in the carbon footprint (COMMUNITIES)
- R&D - Number of Recruits - Commercial (COLLABORATION)
- R&D - Number of Recruits - Non Commercial (COLLABORATION)

Dashboard metrics for the below Objectives are currently in development

- 10% increase on previous year in the percentage of staff responding positively in the annual staff survey when asked if they are able to suggest and make improvements in their area (CARE)
- Delivery of the agreed financial plan (CARE)
- Deliver an improvement on 2022/23 in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing by March 2024 (COLLEAGUES)
- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged (COLLEAGUES)
- Deliver an improvement on 2022/23 in Workforce Equality Standard performance by March 2024 (COLLEAGUES)
- Identify, implement and report on a agreed set of outcome measures for each of the projects within the provider colloborative programme (COLLABORATION)
- Develop and implement a Health Inequalities Strategy with measurable outcomes in 2023/24 (COMMUNITIES)

NHS
Walsall Healthcare
NHS Trust

Trust Board Metrics - COLLEAGUES Dashboard

KPI	Latest month	Measure	Trajectory	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Agency Usage	Nov 23	1.74%					6.04%	4.09%	7.99%
Bank Usage	Nov 23	11.83%					11.53%	8.00%	15.07%
Mandatory Training Compliance	Dec 23	89.46%	90%	90%			88.61%	86.53%	90.70%
PDR Compliance	Dec 23	83.74%	90%	90%			80.03%	76.12%	83.94%
Retention Rates (12 Months)	Dec 23	91.38%	88%	88%			89.98%	89.09%	90.86%
Sickness Absence	Dec 23	5.95%	5%	5%			5.73%	4.64%	6.81%
Staff Turnover	Dec 23	10.52%	10%	10%			11.05%	10.16%	11.95%
Vacancy Rates - Overall	Nov 23	7.18%	7%	7%			4.88%	0.35%	9.41%

Footnotes

* The Variation SPC icon is based off the target column. The trajectory column has been added for information only

** Targets are sourced from Trust Board approved targets / constitutional standard targets / local expectations

Care Colleagues
Collaboration Communities

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.

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting - to be held in Public
14 February 2024.

Title of Report	Highlight Report from the People Committee Chair	Enc No: 9.2
Author:	Clair Bond – Interim Director of HR Operations and OD Walsall Healthcare NHS Trust	
Presenter:	Junior Hemans – Non Executive Director and Chair of the People Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	29 January 2024.	

Action Required of Committee/Group			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☒	Yes☐No☒	Yes☐No☒	Yes☒No☐

Recommendations:

For the Board to note the summary of key discussions from the People Committee, in particular the Committee's approval of the Joint People Strategy and Joint Behaviour Framework to move forward for Trust Board approval.

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	The Committee noted an increase of risk score for 3036 in relation to industrial action (increasing from moderate 12 to high 16). CRR and BAF risks updates as at 31 December were reviewed and accepted by the Committee.		
Compliance and/or Lead Requirements	CQC	Yes	Details: Well Led Domains
	NHSE	Yes	Details: Health and Wellbeing Framework
	Health & Safety	Yes	Details: Statute and Governance Frameworks
	Legal	Yes	Details: Equality and Employment Statute and Governance Frameworks
	NHS Constitution	Yes	Details: NHS Constitution and Values
	Other	Yes	Details:

Summary of Key Issues:

1. The Committee received and approved the Joint People Strategy and the Joint Behavior Framework to proceed to Trust Board.

2. The Safter Staffing report advised the Committee that registered nurse / midwife vacancies had increased from 4% to 6%. The Committee noted 'off framework' agency continued to support pediatric and neonatal services and the emergency department. All requests are approved at director level.

3. The Committee received a report detailing performance against the 23/24 workforce plan and noted that the Trust remains above the submitted workforce plan, however overall substantive workforce is below budgeted establishment and temporary staffing primarily through bank and to a lesser extent agency exceeds budgeted establishment costs. The Committee will seek further assurance regarding progress of divisional plans to reduce workforce costs as discussed within the monthly meetings led by the Deputy Chief Executive and Director of Finance.

4. The Committee were assured that two of the six core workforce metrics are within target (vacancy rate of 7.7 % and the 12 month retention rate of 91.4%). The Committee were reassured that mandatory and statutory training compliance has continued to increase to 89.5% and that following the deep dive review of appraisal compliance rates undertaken in November 2023 there has been a significant improvement from 76% to 83.7%.

5. Sickness in month (December 2023) was above target at 6% and is driven by short term sickness absence although sickness levels are lower than December 2022. The Committee remain assured that staff are able to access both the flu vaccine (accessed by 34.5% of staff as at 15 January 2024) and the Covid-19 booster vaccine (accessed by 17.6%) at the Trust and noted the Trust is not an outlier in vaccination uptake noting in particular flu vaccination levels are higher than January 2023 at 29.4%.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Effective Collaboration	• Progress joint working across Wolverhampton and Walsall

Report Journey/ follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	People Committee 29.01.24
	Board of Directors	Yes☐No☒	Date
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

Walsall Healthcare NHS Trust

EXCEPTION REPORT FROM PEOPLE COMMITTEE CHAIR

ALERT

1. The Committee remain concerned that the Trust will not meet the 23/24 workforce plan and that total workforce (including bank and agency utilisation) remains above budgeted establishment despite a reduction in the growth of substantive workforce and agency spend. The Committee are considering an approach to seek further assurance at divisional level that appropriate controls are in place to reduce temporary staffing and align workforce establishment to budgeted establishment.

2. The Committee are aware that an outline workforce plan for 24/25 is due to be submitted in early February 2024 and that this will be triangulated with finance, with activities plans being scrutinised by the Executive team prior to submission.

3. The Committee were concerned with levels of engagement of Freedom to Speak Up training 'Speak Up' which is available via an e-learning module for all staff to complete. The Committee have requested active monitoring of rates of completion for the training and that consideration is given to positioning the training as essential / core to role via a future Trust Management Committee (TMC) discussion. The Committee also set an expectation that increasing engagement in the training would form a core action of divisional staff survey action plans (due to be in place by May 2024).

ADVISE

1. The vacancy rate, at 7.7%, has increased for the second consecutive month and remains within target. (increased from 6.1% in October 2023)
2. The 12-month turnover rate, at 10.5%, is **above** the target. (increased from 10.4%)
3. The 12-month retention rate, at 91.4%, has **achieved** the target. (increased from 91.1%)
4. November sickness absence rate, at 6.0%, is **above** the target. (increased from 5.6% in October)
5. The mandatory training compliance rate, has increased 89.5% (from 88%) and remains just **below** the target. The Committee noted that compliance has increased for the fourth consecutive month and is assured from the deep dive exercise completed in October that overall compliance of 90% will be achieved in Q4.
6. The appraisal compliance rate has increased to 83.7% (from 76%) however **below** the 90% target.
7. The Committee noted that the Corporate Risk 3036 relating to the impact of industrial action on patient care has been increased from a Moderate 12 (Severity 4 x Likelihood 3) to High 16 (Severity 4 x Likelihood 4) following further periods of industrial action taken by junior doctors in December 23 and January 24. The Committee received a aa verbal update that the Consultants had voted against the pay deal by a slim majority and retain an active mandate to take industrial action.
8. The Committee formally approved the Joint People Strategy and Joint Behaviour Framework to proceed to Trust Board for final ratification.
9. The Committee received an update report relating to the NHSE 'developing workforce safeguards' which supports Trusts to address challenges to attract and retain clinical staff aligned to the National Quality Board (NQB) guidance. The Committee were advised that the Trust is complaint with 10 of the 14 standards and that progress

towards compliance with the remaining four standards would be covered in the monthly CNO Safe Staffing Report.

ASSURE

1. The Committee were assured that the civility and respect programme developed in collaboration with internal stakeholders has commenced and noted that the staff would been encouraged to attend the training which will be highlighted as essential to role. The Committee will receive updates on a quarterly basis to understand evaluation from delegates and impact.
2. The Guardian of Safe Working Hours (GoSW) provided a quarter three update and assurance that (i) the review of work schedules in the Division of Surgery is underway and will be reported in the next quarter and (ii) no immediate safety concerns had been reported in the period. The GoSW highlighted that a work schedule review in Medicine will be undertaken in Quarter two (July-September 2024) and work was being undertaken to improve the experience of FY1 doctors who accounted for 90% of the exceptions reported in the period.

MATTERS FOR THE BOARD's ATTENTION

- The Committee were pleased to approve the progression of the Joint Behaviour Framework through to Trust Board for final ratification prior to a formal launch in March 2024. The Committee were particularly assured of the engagement that has taken place in the development of the framework which will work to complement the individual values of both Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust.

- The Committee received and approved the Joint People Strategy through to Trust Board for final ratification. The Committee were assured that the People Strategy has been codeveloped between Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust to enable the achievement of the Trusts overall joint strategy and in particular the strategic objective linked to "Supporting our Colleagues"

ACTIVITY SUMMARY

The following papers were received and discussed at the People Committee: -

1. Workforce Metrics Report.
2. Board Assurance Framework and Corporate Risk Register
3. Safe Staffing Report.
4. Developing Workforce Safeguards
5. Update Report on performance against workforce plan
6. Update report on Bank and Agency utilisation
7. Civility and Respect Programme Update
8. Freedom to Speak Up Report (Q3 September to December 2023)
9. Joint Behaviour Framework
10. Joint People Strategy
11. Guardian of Safe Working Update report (Q3 September to December 2023)

Matters presented for information or noting • Joint Staff Consultative Committee Meeting minutes – December 2023 • Local Negotiating Committee minutes – November 2023 • Action notes from Equality, Diversity and Inclusion Group – October 2023
Chair's comments on the effectiveness of the meeting:

ENC 9.2.1

Report to the Trust Board- to be held in Public 14 February 2024	
Title of Report:	Caring for All- Our standards of behaviour
Author:	Amy Sykes, Head of Organisational Development and Workforce Transformation (RWT) Email: amy.sykes1@nhs.net Gail Parry, Deputy Head of Organisational Development (RWT) Email: gail.parry@nhs.net Karen Bendall, Staff Engagement and Organisational Development Lead (WHT) Email: k.bendall1@nhs.net
Presenter/Exec Lead:	Alan Duffell, Chief People Officer: a.duffell1@nhs.net

Action Required of the Group			
Decision	**Approval**	**Discussion**	**Other**
Yes☐ No☒	Yes☒ No☐	Yes☐No☒	Yes☐ No☒
Recommendations: The Trust Board are asked to note the development of a joint behavioural framework for staff at The Royal Wolverhampton Trust (RWT) and Walsall Healthcare Trust (WHT).			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ The development and implementation of the Joint Behaviour Framework is an action captured under the following **Risk ID 2489** - Trust-wide: Staff bullying, discrimination and harassment. Risk score of 12 Moderate (Severity 4 x Likelihood 3).		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	This is a standard report using Quarterly Pulse Survey Data		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Effective, Caring, Responsive and Well-led
	NHSE	Yes☐No☒	Details:
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	The framework makes reference to 'we are inclusive' as a top priority for encouraging the behaviour we want to see from all our staff.		
Report Journey/Destination or matters that may have been referred to other Board/Committees	Working/Exec Group	Yes☒No☐	Date: People and OD Group: 14th September 2023. WHT Executive Team: 28th November 2023. People Committee: 29th January 2024
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • The Board can be assured that the behaviour framework has been co-designed with the engagement of a variety of staff groups from across Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust. • The Framework has been reviewed and accepted by both Executive Teams and both People Committee's. • A detailed implementation plan for launching and embedding the behavioural framework will be shared once the framework design and content is approved.
Advise • Following the launch of the first joint strategy, 'Our Strategy' 2022-2027' it was agreed through a Committee in Common, that both organisations would retain their existing Trust values and progress working on a set of joint behaviours. • The Behavioural Framework, that all staff can adhere to will form part of the cultural aspects of the people plans, policies and procedures, which supports both Trusts to develop and maintain a cohesive and positive culture and expected behaviours to work towards. • The framework can be utilised by managers when promoting the behaviour they want to see and when challenging unwanted and unacceptable behaviour. • A copy of the behaviour framework on a page is provided within this report and copies of additional documents / guidance to support implementation are provided within the reading room.

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

Caring for All- Our Standards of Behaviour

1.0 Introduction

In October 2022, The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) launched the first joint strategy, 'Our Strategy' 2022-2027, which reflects collaborative working between the two organisations. It was agreed through a Committee in Common, that both organisations would retain their existing Trust values (**Appendix 1**), and progress working on a set of joint behaviours.

The purpose of this report is to provide assurance to the Trust Board that the behavioural framework has been developed jointly by RWT and WHT, involving feedback from colleagues across both Trusts. The Trust Board is asked to approve the design and content of the framework known as Caring for All- Our standards of Behaviour. This will support the planned launch of the framework in March 2024 and allow for the framework to be embedded as a core feature of cultural aspects of the people plans, policies and procedures, promoting the expected standards of behaviour for staff to work towards.

2.0 Development

Following an initial scoping exercise, undertaken by the Associate Director of People at RWT, a phased approach to developing the framework was agreed, with the Organisational Development (OD) leads for each Trust being involved. The OD Leads met in January 2023 to discuss the design and delivery options for this work and to agree on the following timelines.

High Level Milestones	When
Cross-site listening events for staff to share what they would want to see in a behavioural framework.	March 2023/April
Thematic analysis of findings and draft behavioural framework	May 2023
Develop draft behavioural framework	July- August 2023
Further consultation period on framework design	Sept- October 2023
Papers to People and OD Group, People Committee and Trust Management Committee for approval, discussion at Exec Meetings and Inaugural Group Joint Partnership Forum	November- February 2023
Launch behavioural framework	March 2024
Embed Joint Behavioural Framework	March- December 2024

3.0 Initial Consultation

To ensure the framework was developed in a consultative way, a series of in person and online engagement events were held in March and April 2023. The workshops were co-facilitated and although they yielded low attendance, staff provided valuable contributions and input, sharing their lived experiences of working at both organisations.

Staff agreed on the importance of having a robust behavioural framework in place, that all staff can adhere to, and importantly, that managers can utilise when promoting the behaviour they want to see and when challenging unwanted and unacceptable behaviour.

Following discussion with workshop attendees, a general consensus of words and phrases emerged and main themes are highlighted below and have informed the content of the framework.

Professional	Engagement	Inclusive	Approachable
Responsive	Adaptable	Caring	Respectful
Visible	Engaged	Supportive	Compassionate

4. Design

4.1. Initial Draft

The framework outlines the behaviours we want to see from all our staff in their interactions with each other, and in the way they behave with patients, their relatives and friends. These behaviours map on to both organisations' values. This framework is also aligned to the NHS People Promise and the NHS Leadership Way. The framework will supersede the existing Professional Values and Standards for RWT and the Values and Behaviour Standards at WHT, which both outline expected staff behaviours, however, both Trusts will retain their agreed values.

The OD leads for RWT and WHT worked collaboratively to produce a plan on a page and complementary supporting guidance to support staff to implement the framework. The Chief People Officer, who gave the brief for the work, provided input and clarity on the requirements going forward, and four key headings were agreed: Listening; Kind; Inclusive and Professional. These behaviours provide the foundation of the framework and more detailed content will fall under these headings and will be included in a supporting guidance document. The supporting guidance includes an introduction to the work, a message from our Chair, Sir David Nicholson, detail of the behaviours we want to see from our staff, the behavioural framework in practice and how to raise concerns if staff see behaviour that is contrary to the expected standards.

4.2. Further Consultation

Further consultation with colleagues in the Communications Team led to timelines being agreed for the overall design of the framework. A first draft of the framework was produced, and it was agreed with the Chief People Officer that further consultation with key stakeholders was required to gain feedback on the content and structure of the documents. Further consultation with RWT and WHT colleagues took place in September and October 2023. Stakeholders were invited to feedback via a brief online survey and feedback was sought in a variety of meetings. Overall, the feedback was positive and has helped with making further improvements to the content and design.

4.3. Final Design

The final design for the behavioural framework includes:

- Caring for All- Our standards of behaviour plan (**Appendix 2**): this document shows our 'plan on a page'. This will be used as a poster design and distributed across the Trust to support promotion of the framework
- Caring for All- Our standards of behaviour guidance (**Appendix 3**): this document provides an introduction to the framework, the key behaviours we expect to see from our staff and additional information about what these behaviours will look like. Information on how this will be put into practice and how staff can escalate concerns is included.
- Caring for All- Our standards of behaviour pledges (**Appendix 4**): this document can be used by individuals, managers and leaders to reflect on how they currently behave in the workplace and to reflect on what they might do differently against the four behaviour headings of Listening; Kind; Inclusive and Professional.

5.0 Implementation

The following areas will be focused on during implementation to ensure the framework is sufficiently embedded.

- **Recruitment**: Behavioural based interviewing will support the Trust to find excellent candidates who are a suitable cultural-fit as well as job-fit.
- **Corporate awards**: Staff demonstrating outstanding behaviour and those who are an advocate for the values and culture of the organisation are recognised.
- **Performance management**: Staff are managed, supervised and appraised for their work performance, not only in terms of task delivery, but related to their behaviours and approach taken to work.
- **Learning and development**: Personal development will include conversations about behaviour. Corporate learning materials and training will be available to support staff to deliver the required behaviours.
- **Policy**: Our policies e.g. dispute resolution and the disciplinary policy, will reference and align to the behavioural framework. Processes and guidance will be designed to support the workforce and our managers with embedding the framework.
- **Well-being initiatives**: We recognise that an individual's well-being can be affected by negative behaviour and we will ensure support is available and easy to access.

Please see **Appendix 5** for more detail on the engagement and communications plan to support the framework being embedded across both Trusts.

6. Recommendation

The Trust Board is asked to approve the joint behavioural framework for staff at The Royal Wolverhampton Trust (RWT) and Walsall Healthcare Trust (WHT).

Appendix 1: Our Joint Vision, Goals and Values

Our Joint Vision & Goals

To deliver exceptional care together to improve the health and wellbeing of our communities

Joint Strategy - The 4 Cs:

Excel in **CARE**, Support your **COLLEAGUES**, Effective **COLLABORATION**, Improve the health of our **COMMUNITIES**

WHT Values

Respect, Compassion, Professionalism, Teamwork

RWT Values

Safe & effective, Kind & caring, Exceeding expectation

Appendix 5: Proposed engagement and communications activities

What	Why/content	Channel	Dependencies
Internal bulletin content	• Launch of Behavioural Framework and call to action. • 'Making everyone feel they belong' plan on a page. • Monthly pledges- appeals and showcasing of pledges	Dose and Brief	Approval of details and content from key contacts.
Staff intranet	• Dedicated pages– including access to printed materials. • Monthly pledges to be housed on the intranet.	Trustnet.	Colin Cranfield, Web Content Officer.
Social media - Internal staff Facebook	• Joint Behavioural Framework is coming. • Launch of Joint Behavioural Framework. • Video from chosen senior colleague to share the launch of the framework. • Feature of a monthly pledge.	Trust Brief.	Content from OD Team.
Screensaver	• Launch of Joint Behavioural Framework. • Call for pledges. • 'Making everyone feel they belong' plan on a page.	Electronic screensavers.	Medical Illustration.
Senior manager email	• Guide on embedding the framework within their team and within colleagues 1:1 meeting – making a difference within their area. • Identify potential issues within their area and how can they address/solve this using the framework.	Email.	NHS Mail.
David's Despatch	Launch of Joint Behavioural Framework – including 'making everyone feel they belong' and how this is important to him.	All user email from David.	Depending on content submissions
Video	Film variety of staff speaking about the importance of the framework and why everyone should be involved, making RWT and Walsall great places to work.	Staff FB group, link to be shared on internal comms.	Depending on availability.
Roadshows/ward walks	OD Team to do ward walks to discuss framework with mainly clinical colleagues. Comms team to capture and promote.	Internal comms.	Availability of OD Team.
Printed materials	Print posters, pull-ups, and other suggested materials to support the launch of the behavioural framework.		Confirmation on budget amount.

Caring for All

Our Standards of Behaviour

We will be a
Listening, **Kind**,
Inclusive and **Professional**
organisation.

Listening

Actively listen to others, showing an interest in their perspective and how they think and feel.

Be present and engaged when others are talking to you.

Listen to people's feedback with an open mind and without judgement.

Kind

Role model civility and respect.

Be understanding of others, showing compassion and empathy.

Look after my own and others' health and wellbeing.

Inclusive

Promote equality, value diversity and help everyone to feel they belong.

Treat people with dignity and respect and value everyone's contribution.

Respectfully challenge inappropriate behaviour.

Professional

Lead by example, communicating clearly and honestly and by maintaining a professional attitude and behaviours.

Always look for opportunities to learn, develop and improve.

Escalate concerns appropriately and be honest if something goes wrong.

These are the behaviours we value and expect our staff to display when interacting with colleagues, patients, and relatives.

Visit the Trust intranet for more information on our Joint Behavioural Framework.

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

Care Colleagues
Collaboration Communities

01077 v10.1 02/01/24

ENC 9.3.2

Joint People Enabling Strategy

The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

1.0 Introduction

Welcome to our new Joint People Enabling Strategy which belongs to all our colleagues across The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust ('the Group').

Our enabling strategy Plan has been created based on feedback and engagement with colleagues and leaders and supports our Joint Trust Strategy *to deliver exceptional care together to improve the health and wellbeing of our communities*.

The focus of our enabling strategy will be to "Support our ***Colleagues***" and achieve our strategic aim to **be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations.** Our success against this aim will be recognised, through the delivery of our strategic objectives:

- Being in the top quartile for vacancy levels across the organisations, recruiting and retaining staff.
- Delivering year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing.
- Improving overall staff engagement, addressing identified areas for improvement where groups are less well engaged.
- Delivering year on year improvement in Workforce Equality Standard performance.

Delivery of these objectives will enable us to meet our ambition for our group to be a great place to work. We will achieve our aim and objectives through the delivery of our Joint People Ambitions to create *a great place to work and thrive* through:

- *Leading by putting our people first*
- *Ensuring equality, diversity and inclusion in all that we do*
- *Being a safe and healthy place to work*
- *Recruiting and retaining the workforce of today and of the future*

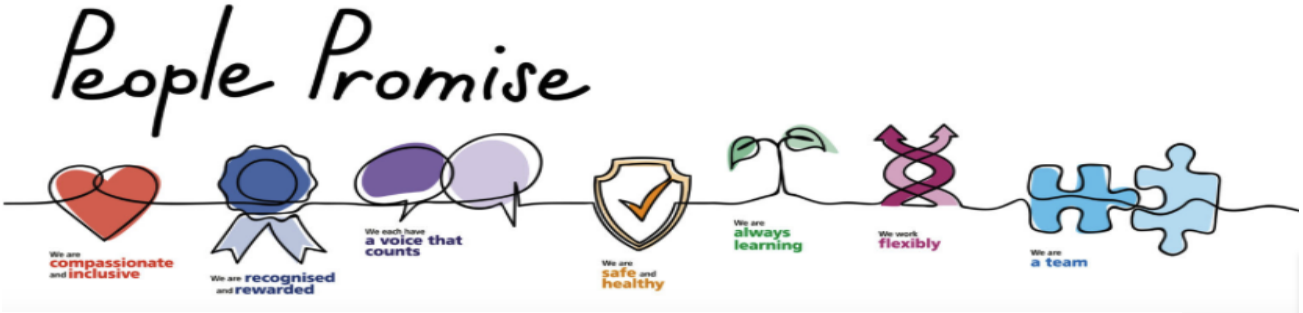
We know through the delivery of Our Joint People Enabling Strategy we will be expecting a lot of our people and especially our leaders. We cannot create a *great place to work and thrive* without the contribution of each and every person. Through the delivery of this enabling strategy we will bring about the sense of belonging and to reflect on how we behave towards one another using the Joint Behaviour Framework, consider the culture we want to create and the level of focus we give to our people as well as our patients.

Our enabling strategy has also been designed to embrace the ethos of the NHS People Promise and to address the relevant actions outlined in the Future of HR and OD in the NHS report and the We are the NHS: People Plan 2020/21 - action for us all.

NHS **People Plan** pillars

to deliver **more** people, working **differently**, in a **compassionate** and **inclusive** culture

Our **People Promise**



The **future** of **NHS human resources** and **organisational development** 2030 vision

2.0 National Context

The **NHS Long Term Plan** was published in 2019 it recognised concerns about funding, staffing, increasing inequalities and pressures from a growing and ageing population. Recognising we must tackle the pressures our staff face head-on, while making our extra funding go as far as possible whilst accelerating the redesign of patient care to future-proof the NHS for the decade ahead.

The **NHS People Plan** was published in 2021 outlining a clear direction in delivering better support to our NHS staff to ensure the NHS is a modern, supportive, and inclusive employer. The focus is on 4 themes: Looking after our people, belonging in the NHS, growing for the future and new ways of working. Embedded within the NHS People Plan are the seven elements of the NHS People Promise which details what we must do to provide a supportive work environment for our staff.

The **NHS Future of HR and OD** (November 2021) reviewed how people function should provide the support needed to enable the delivery of the People Plan and People Promise setting clear expectations of how we should deliver people services to our staff. It includes expectations that we continue to be forward thinking, professional and embed the values and behaviours within the People Plan in how we develop and deliver our people services.

The **Messenger Review** (June 2022) provides a renewed commitment to leadership development within health and social care with a focus on seven key deliverables. These are included throughout our journeys and are focused on leadership behaviours, action on equality diversity and inclusion, consistency in management, high quality appraisals, career development and supporting potential.

The **Long Term Workforce Plan** (June, 2023) sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff over a 15-year period, and working in new ways to improve staff experience and patient care. The plan sets out the strategic direction over the long term as well as short- to medium-term actions to be undertaken locally, regionally and nationally. Those actions fall into three priority areas: Train, Retain and Reform.

The **NHS Equality, Diversity and Inclusion (EDI) improvement plan** (June 2023) sets out targeted actions to address the prejudice and discrimination, direct and indirect, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

3.0 Local Context

3.1 Joint Strategy

Our five-year strategy for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) reflects the closer working relationship between the two Trusts under the leadership of a joint Chair and Chief Executive. Uniting us is our shared vision *"to deliver exceptional care together to improve the health and wellbeing of our communities."*

3.2 Black Country Integrated Care System

The Black Country has 1.26 million residents, is made up of four distinct places: Dudley, Sandwell, Walsall, and Wolverhampton and is a hugely diverse system; as such there is no "one size fits all" approach to working with local people or partners. The Black Country Integrated Care System (ICS) is made up of several partners including the Integrated Care Board (ICB), the Local Authorities across the four places, health and social care provider organisations from all sectors and other stakeholders (e.g. Healthwatch). The ICB People Strategy aims to make the Black Country the best place to work. Working under two key themes – 'Workforce Optimisation' and 'Inclusive Culture' – workforce leaders from across the system are driving improvements to deliver the principles of 'one workforce'; enabling a culture of belonging where all colleagues in the Black Country can thrive and continue to deliver high quality patient care.

3.3 Black Country Provider Collaborative

Black Country Provider Collaborative (BCPC) enables collaborative working between the four acute hospital Trusts across the Black County to achieve the vision of 'One healthcare system, across multiple sites, working in partnership to provide better, faster and safer care to the population of the Black Country and beyond.' The BCPC also collaborates with non-NHS Partners such as schools, universities, and local authorities to meet the requirements of the NHS workforce plan and the national goals within the People Plan and Promises. Collaborative working between providers/within the Integrated Care System and place-based partnerships means the movement of our staff across organisations should be easier and less organisation focused. Over time, we may develop ways to deliver this together.

3.4 One Wolverhampton and Walsall Together

We recognise that our group sits in two 'places', the Wolverhampton Place, and the Walsall Place. Place based working is through One Wolverhampton in Wolverhampton and Walsall Together in Walsall and each of the collaborations has its own identity and priorities, borne out of the wider needs of the local populations. We fully recognise that this strategy will deliver best where is learns from successes across the places we serve with delivery for the local population such that our organisations support local priorities.

4.0 Our Joint People Ambitions

Our Joint People Enabling Strategy is underpinned by our Joint People Ambitions, centred on our Group being a **great place to work and thrive**. We see this as critical to delivering our strategic aim of supporting our colleagues through ensuring low levels of vacancies, an effective approach to health and wellbeing, ensuring high levels of engagement and, critically, ensuring our organisations are truly diverse where all our people can belong.

4.1 Leading by putting our people first

The delivery of this enabling strategy requires leaders and managers to create the conditions locally for those they lead to be their best and to succeed. We will:

- Develop a clear vision of our expectations of leaders and managers, setting out what great leadership looks like.
- Implement a robust leadership and management development activities and programmes
- Embed compassionate leadership (West, 2021) in all that we do, including people practices such as recruitment and development
- Embed the joint behavioural framework across our organisations, in colleague behaviours and in all of our people practices including recruitment, promotion and appraisal.
- Ensure our people are trained in civility and respect to provide the best possible working environment for our people.
- Embed restorative, just and learning practices in partnership with our staff side colleagues, working with key stakeholders such as our employee voice groups and cultural ambassadors.

- Ensure effective job design, which provides rewarding work, enabling our people to maximise their potential and productivity.

4.2 Ensure equality, diversity and inclusion in all that we do

Our organisations benefit from the diversity of our people, drawn from our local communities and beyond. This ambition sets out our commitment to embed equality, diversity and inclusion in not only our policies and procedures but also in the expected behaviours and way we do things. We will:

- Grow a workforce that is truly representative of the communities we serve.
- Ensure policies and procedures are developed and implemented in a people centric way to truly deliver a 'people before process' culture which ensures consistency and fairness across our group.
- Boldly set out what it means to be an ally and recognise those who stand-up and call out unwanted and uncivil behaviours.
- Maintain our accreditation with the RACE Equality Code and continue to deliver improvement embedding anti-racism and a zero tolerance to discrimination of any kind.
- Work closely with our employee voice groups ensuring real impact on the ground and contribution to collective decision making.

4.3 Safe and healthy place to work

Being a healthy and safe place to work enables colleagues to be their whole selves at work and to provide the very best experience for staff, service users, patients and their carers. In the delivery of this ambition we will:

- Ensure all leaders have the knowledge and tools to demonstrate responsibility towards the health and wellbeing of colleagues through their actions and decisions.
- Establish and deliver a joint health and wellbeing delivery plan across our organisations.
- Ensure our people are able to safely raise concerns.
- Embed the 'Sexual Safety Charter' across our organisations.
- Strengthen safeguards for staff against abuse, aggression and violence
- Support our people to maximise their attendance at work

4.4 Recruit and retaining the workforce of today and for the future

Through robust workforce planning from service to organisational and system level our colleagues will be supported to build careers and access development and opportunities to learn new skills to increase retention and support system working across the Black Country. We will:

- Develop our role as anchor employer within our communities, to deliver health equality through employment opportunities and engage young people to consider working for the NHS
- Seek to identify and address the drivers for turnover to minimise vacancies and reliance on temporary staff
- Enable development and implementation of new roles and new ways of working and training to harness flexibility of roles

- Provide clear career frameworks and support progression of people through structured appraisal and talent planning processes.
- Further enhance our approach to flexible working supporting to enable our people to have greater choice in when, where and how they work in a way that supports the delivery of services.
- Provide a clear reward and recognition approach which values the contribution of all staff and supports new ideas and innovation.
- Embrace digital ways of working to release time to care and to provide a truly 'customer grade' employee experience, supporting our staff as required.

5.0 How we will get there

Our joint enabling strategy is grounded in our continued work at group level. We also recognise our role in the integrated care system, the provider collaborative and at place. This complex matrix means that as we further develop this strategy, we will review each of the work areas as to their appropriateness for collaboration, maximising impact and minimising duplication.

We will work collaboratively across our organisations and with colleagues from across our services including staff networks, union colleagues, team members whose roles are focused on staff experience and the leadership community to co-design programmes of work and priorities to delivery against our joint people ambitions.

6.0 Governance and success measures

The strategy will be governed through the People Committees in each Trust and delivery against our joint people ambitions will be measured by a variety of people metrics. The actions plans that are developed to achieve our joint people ambitions will set clear timescales for delivery of outputs and we will ensure this is reported through an appropriate governance structure.

Together with this, we have a significant number of outcome measures such as:

- Key staff survey metrics in relation to learning, compassion, wellbeing and inclusion
- Operational People metrics, such as turnover, retention and attendance
- Equality metrics including the workforce race equality scheme, workforce disability equality scheme, gender pay gap and RACE Equality Code.

Updates on the strategy delivery will be provided to the People Committees on at least an annual basis. A summary of the strategy is shown at appendix 1 with an overview of activity over the four years shown at appendix 2.

Risk and Mitigations

Risk	**Mitigations**
Ongoing operational pressures (including industrial action) impacting on progress with defined priorities	Oversight of progress via the delivery groups and timely escalation to People Committees. Consideration of profiling/ scheduling of activity and delivery of the enabling strategy.

Workforce challenges impacting on progress with defined priorities	Ongoing staff recruitment and retention activities. Oversight of progress via the delivery groups and timely escalation to People Committees Consideration of profiling/ scheduling of activity and delivery of the enabling strategy.
Financial constraints impacting on progress with defined priorities	Prioritisation of key investments that are likely to have the most positive and sustainable impact on improving quality and safety Oversight of progress via the delivery groups and timely escalation to People Committees Consideration of profiling/ scheduling of activity and delivery of the enabling strategy.

Equality Impact Assessment

This Joint People Enabling Strategy has been equality impact assessed and no adverse and conflicting impact on the workforce, any service we provide, and the communities we serve has been identified.

Review of the Strategy

This is a 4-year strategy, which will be overseen by People Committees at both Trusts. Progress updates will be provided on an annual basis.

Appendix 1: Our Joint People Enabling Strategy Summary Overview: Creating a great place to work and thrive

Our Joint People Priorities and Ambitions… we will great a great place for all our staff to work and thrive by: -			
Lead by putting our people first	*Ensure equality, diversity and inclusion in all that we do*	*Safe and healthy place to work*	*Recruit and retain the workforce of today and for the future*
Outcomes			
- Clear vision of great leadership in place. - Robust leadership activities and programmes in delivered. - Compassionate leadership embedded in all people and organisational practices. - Joint behavioural framework embedded across our group. - Our people are trained in civility and respect - Embed restorative, just and learning practices across our group. - Effective job design, providing rewarding productive work.	- Workforce that is truly representative of the communities we serve. - 'People before process' culture which ensures consistency and fairness across our group. - Embed ally ship and recognise those who stand-up and call out unwanted and uncivil behaviours. - Maintain our accreditation with the RACE Equality Code - Embed anti-racism and a zero tolerance to discrimination. - Enhance the role of our employee voice groups in collective decision making.	- Leaders have the knowledge and tools to support the health and wellbeing of colleagues through their actions and decisions. - Joint health and wellbeing delivery plan in place across our organisations. - People are able to safely raise concerns. - 'Sexual Safety Charter' embedded across our organisations. - Safeguards in place for staff against abuse, aggression and violence - People supported to maximise their attendance at work.	- Clear role as anchor employer within our communities, delivering employment opportunities and engage young people to consider working for the NHS. - Identify and address the drivers for turnover, minimised vacancies and reliance on temporary staff. - New ways of working and training developed to harness flexibility of roles - Clear career frameworks in place with support for progression of our people. - Best in class approach to flexible working. - Clear reward and recognition valuing contribution and innovation. Effective use of apprenticeships to develop our current and future workforce. - Embrace digital to provide a customer grade employee experience with support for our people.
Specific Measures of success for each ambition			
People processes fully reviewed and in date. *Development programmes, people policies and practices in place and reviewed as effective.* *Top quartile performance in the national staff survey for we are compassionate and inclusive.* *90% of colleagues have and appraisal and agreed development plan, with, over the life of the strategy top quartile performance in the staff survey for quality of appraisals*	*Continued RACE Equality Code accreditation* *Organisation representative of the community we serve.* *No unwarranted variation in key equality measures e.g. WRES & WDES.* *Appropriate accreditations in place e.g. veteran aware, disability confident.*	*Single Occupational Health Service in place across our group.* *Joint delivery plan in place, monitored tracked and working.* *Top quartile performance in the 'We are safe and healthy' score for the NHS Staff Survey* *Sexual safety charter – joint actions delivered.* *Sickness absence reduced to <4% over the life of this strategy.*	*Career support in place* *Development programmes in place with top quartile performance in the 'We are always learning' score for the people promise* *TBD% utilisation of apprenticeship levy.* *Workforce and talent plans in place.* *Staff survey scores for access to development and progression opportunities in the top quartile for all groups.* *Top quartile performance for 'Reward and Recognition'* *Top quartile performance in the staff survey for flexibility.* *Agreed career frameworks in place for key staff groups.* *Vacancy levels below 6%* *Over 60% of our workforce from the local community*

Appendix 2: ***Our Joint People Enabling Strategy Summary Annual Plan:***

	2024/25	*2025/26*	*2026/27*	*2027/28*
Lead by putting our people first	- Clear vision of great leadership in place. - Robust leadership activities and programmes in delivered. - Joint behavioural framework	- Compassionate leadership embedded in all people and organisational practices. - Effective job design, providing rewarding productive work.	- Our people are trained in civility and respect	Embed restorative, just and learning practices across our group.
Ensure equality, diversity and inclusion in all that we do	- Maintain our accreditation with the RACE Equality Code - Embed anti-racism and a zero tolerance to discrimination. - Enhance the role of our employee voice groups in collective decision making.	- Embed ally ship and recognise those who stand-up and call out unwanted and uncivil behaviours.	- 'People before process' culture which ensures consistency and fairness across our group.	- Workforce that is truly representative of the communities we serve.
Safe and healthy place to work	- Joint health and wellbeing delivery plan in place across our organisations. - Safeguards in place for staff against abuse, aggression and violence - 'Sexual Safety Charter' embedded across our organisations.	- Leaders have the knowledge and tools to support the health and wellbeing of colleagues through their actions and decisions. - People supported to maximise their attendance at work.	- People are able to safely raise concerns.	
Recruit and retain the workforce of today and for the future	- Identify and address the drivers for turnover, minimised vacancies and reliance on temporary staff. - Clear career frameworks in place with support for progression of our people.	- Clear role as anchor employer within our communities, delivering employment opportunities and engage young people to consider working for the NHS. - New ways of working and training developed to harness flexibility of roles.	- Best in class approach to flexible working. - Clear reward and recognition valuing contribution and innovation. - Effective use of apprenticeships to develop our current and future workforce.	- Embrace digital to provide a customer grade employee experience with support for our people.

References

Civility Saves Lives (undated) Civility Saves Lives (website) [online] available here: https://www.civilitysaveslives.com (accessed 10 September 2023)

Department of Health and Social Care (2022) Health and social care review: leadership for a collaborative and inclusive future [online] available at: https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future (accessed 14 December 2023)

House of Lords (2017) The Long-term Sustainability of the NHS and Adult Social Care [online] available here: https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/15102.htm (accessed 10 September 2023)

National Guardian (undated) FTSU Index (website) [online] available here: https://nationalguardian.org.uk/learning-resources/speaking-up-data/ftsu-index/

NHS England (2019) The NHS Long Term Plan [online] available here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf (accessed 31 July 2023)

NHS England (2020a) We are the NHS: Our People Plan [online] available here: https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (accessed 31 July 2023)

NHS England (2020b) Our People Promise [online] available here: https://www.england.nhs.uk/our-nhs-people-promise (accessed 31 July 2023)

NHS England (2021) The Future of NHS human resources and organisational development [online] available here: https://www.england.nhs.uk/wp-content/uploads/2021/11/B0659_The-future-of-NHS-human-resources-and-organisational-development-report_22112021.pdf (accessed 31 July 2023)

NHS England (2021) Violence prevention and reduction standard [online] available here: https://www.england.nhs.uk/publication/violence-prevention-and-reduction-standard/ (accessed 14 December 2023)

NHS England (2023a) NHS equality, diversity and inclusion (EDI) improvement plan [online] available here: https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/ (accessed 31 October 2023)

NHS England (2023b) NHS Long Term Workforce Plan [online] available here: https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf (accessed 31 July 2023)

Social Partnership Forum (2023) Violence Reduction [online] available here: https://www.socialpartnershipforum.org/articles/violence-reduction (accessed 14 December 2023)

The Royal Wolverhampton NHS Trust (2022) Our Strategy 2022 – 2027 [online] available here: https://www.royalwolverhampton.nhs.uk/about-us/our-joint-trust-strategy.html (accessed 16 January 2024)

West, M (2021) Compassionate Leadership, London, The Swirling Leaf Press

Walsall Healthcare NHS Trust

Trust Board Meeting – to be held in Public 14 February 2024.		
Title of Report:	Group Chief People Officer Update	Enc No: 9.3
Author:	Sebastian Smith – Cox (Group Head of Workforce Intelligence & Planning) s.smith-cox@nhs.net & Clair Bond (Interim Director of Operational HR and Operational Development) clair.bond2@nhs.net	
Presenter/Exec Lead:	Alan Duffell, Group Chief People Officer	

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

Recommendations:
The Board are asked to:
(i) **Note** the content of this report within the context of Trust performance management objectives, and strategic objectives related to people and organisational development.
(ii) **Approve** the Joint People Strategy which has been through the relevant committees at both Walsall Healthcare NHS Trust and The Wolverhampton NHS Trust including Executive Committee and People Committee. The Joint People Strategy is provided within the reading room for reference.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) – Workforce Metrics are reviewed in line with risk 2072 on a monthly basis "Trust-wide Shortage of workforce capacity and capability" 9 Moderate (Severity 3 x Likelihood 3)		
Changes to BAF Risk(s) & TRR Risk(s) agreed	The risk to the organisation is concerning: • Use of Resources. • Employment legislation. • Equality, Diversity & Inclusion. • Organisational Reputation. Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	Resource implications concerning staff health and wellbeing and attendance at work. Impact on financial resources concerning bank and agency cover.		
Report Data Caveats	Please see Appendix A		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details:
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☒No☐	The Committee should have regard to the

			Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. All workforce policies and procedures are required to be compliant with all relevant employment legislation and the Equality Act 2010. NHS Employers guidance and terms and conditions.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

The report provides an update on key workforce matters and provides assurance regarding key workforce metrics;

- Vacancy rates
- Turnover and Retention rates
- Sickness Absence rates
- Mandatory Training Compliance rates
- Appraisal Compliance rates

Advise

- The Joint People Strategy has been developed following a period of engagement with internal stakeholders and approval via Walsall Healthcare NHS Trust and The Wolverhampton NHS Trust including Executive Committee and People Committee. The Joint People Strategy is provided within the reading room for reference and seeks Board Approval. The document will form part of a future Board Development Session to provide Board members with the opportunity to explore the strategy in further detail.
- The vacancy rate, at 7.7%, has **achieved** the target. (increased from 6.1% in October 2023)
- The 12-month turnover rate, at 10.5%, is **above** the target. (increased from 10.4%)
- The 12-month retention rate, at 91.4%, has **achieved** the target. (increased from 91.1%)
- November sickness absence rate, at 6.0%, is **above** the target. (increased from 5.6% in October)
- The mandatory training compliance rate, has increased 89.5% (from 88%) and remains just **below** the

target.
- The appraisal compliance rate has increased to 83.7% (from 76%) however **below** the 90% target.

Alert
- Despite remaining leading causes of sickness absence, there have also been notable reductions in colleagues reporting cold, cough, influenza, or chest & respiratory problems. Compared to 2022/23, days lost to these absences have fallen by 33% and 46%, respectively, during 2023/24. Whilst caution is warranted during the remaining winter months, this health and well-being improvement is an optimistic indictment of the Trust's infection control and colleague vaccination programmes.

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

Executive Summary

This report provides the Board with information and assurance on key workforce metrics and an update on key workforce matters:

- Two of the six workforce indicators, vacancy rates and 12-month retention, meet the agreed targets/ thresholds. Mandatory training compliance, 12-month turnover and appraisal compliance are rated amber, whilst sickness absence is rated red.

- The 7.7% vacancy rate reflects a month-on-month 14.82 FTE increase in the budgeted establishment, reconciled against an 11.6 FTE decrease in the actual workforce per the month-end finance ledger. Most of the budgeted establishment growth aligns with the Registered Nursing and Midwifery (RN&M) and Additional Clinical Services staff group, whereby funding for the N&M workforce increased by 15.56 FTE, while clinical support to N&M budgeted FTE rose by 5.87 FTE.

- The Trust has been successful in winning an NHSE bid to fund a 12 month retention post. Walsall is one of five Trusts in the Black Country to secure the funding and is currently identifying local and system focus for the work.

- Whilst challenges remain regarding long-term assurance of target achievement, Mandatory Training compliance has continued an overall improvement trajectory, rising 2.4% since September 2023 to the current compliance rate 89.5% (December 2023) against an overall target of 90%.

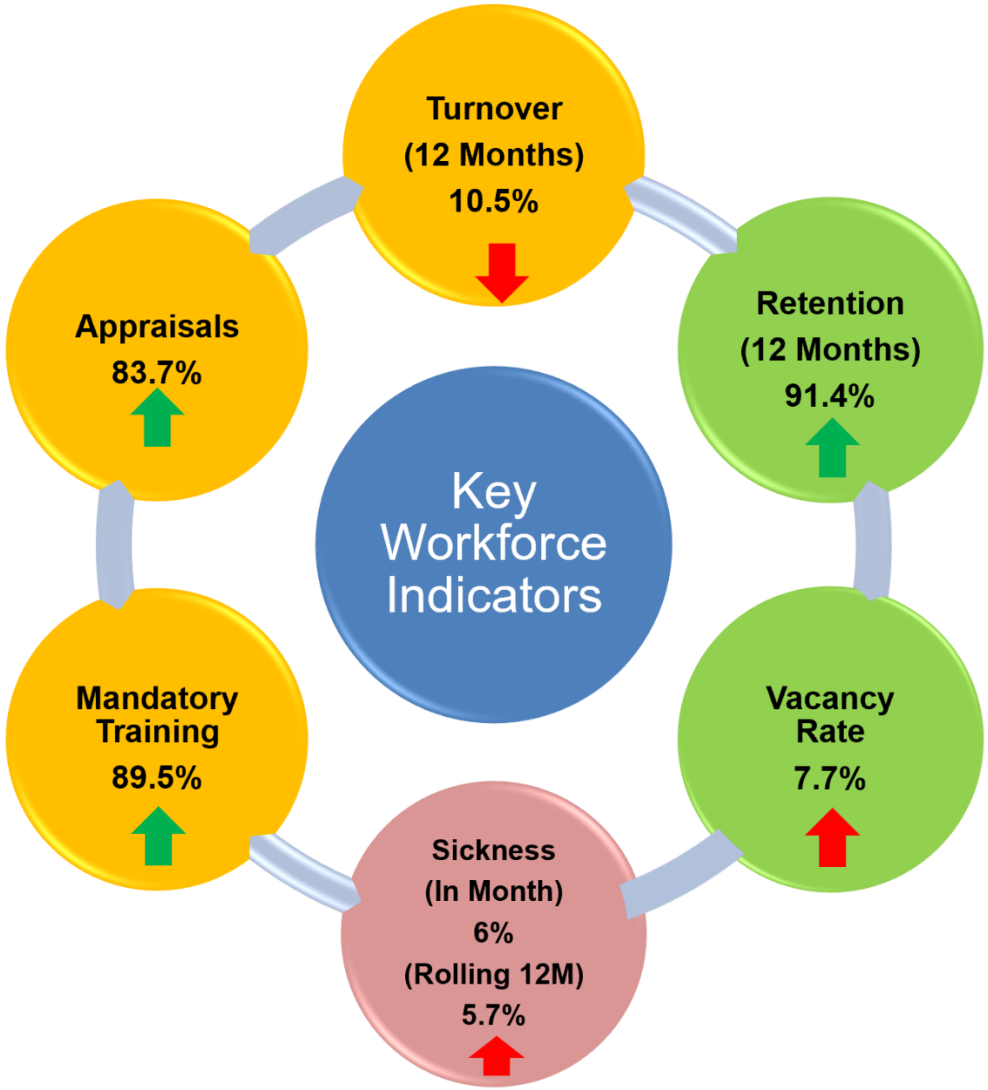
- Appraisal compliance remains 6% below the 90% target however following the deep dive review in November 2023, compliance levels have improved by 5% between M8 & M9. All five divisions with the largest numbers of staff have reported an improvement in appraisal compliance and a new enhanced reporting template has been developed for implementation in Q4 (see p16, Appendix 1 of Part 2 – reading room)

- In-month sickness absence, which was 6% during December 2023, rose above the 24-month average and no longer shows an improved trajectory within the two-year trend context, however overall sickness absence levels remain lower than December 2022. The Trusts offer of influenza and COVID-19 booster vaccination ceased on the 31 January 2024. As at mid-January, 34.5% of colleagues had taken an influenza vaccine which is an improvement on the position in January 2023 (29.4%%) and 17.6% have accessed a COVID-19 Booster which is less than the 24.1%% in January 2023.

- The BMA have confirmed that the outcome of the Consultant referendum in relation to the pay offer has been to decline the offer through a slim majority of 51%. Consultants retain an active mandate to take industrial action whilst the Junior Doctors are currently balloting to extend their mandate beyond February. The outcome of this ballot is expected mid March and is likely to reconfirm commitment to further industrial action. The NHS Pay Review Body is expected to make pay recommendations for non-medical staff in March / April 2024.

Walsall Healthcare NHS
NHS Trust

Key Workforce Metrics



Two of the six workforce indicators, vacancy rates and 12-month retention, meet the agreed targets/ thresholds. Of the three amber, two have improved towards target compliance (Mandatory training and appraisal compliance) whilst sickness absence is rated red.

Workforce performance trends are measured over a 24-month rolling period, with statistical process control methodology applied to provide assurance regarding consistent target achievement and performance stability.

There is limited assurance that the sickness absence rate, currently 6.0%, will consistently meet the 5% target, but performance is getting better. Sickness Absence levels in December 2023 are lower than December 2022.

The mandatory training compliance rate of 89.5% provides limited assurance that the 90% target will be consistently met, although performance has improved from 87.83% in November.

There is no assurance that appraisal compliance, currently 83.7%, will consistently achieve the 90% target. The performance trend continued to worsen between July and October 2023 however December 2023 represents the 2nd consecutive in month improvement of almost 5% (from 78.84% in November).

Whilst there is a lack of assurance regarding the consistent achievement of a 10% 12-month turnover target, the current 10.5% rate reflects improved performance.

Assurance can be provided that the 12-month retention rate, currently 91.4%, will consistently meet the 90% target following continued performance improvement.

The 7.7% vacancy rate offers limited assurance, in the context of a 24-month trend, that the 7% target will be consistently met, but performance is stable at current target achieving levels.

Walsall Healthcare NHS Trust

Trust Board Meeting – to be held in Public 14 February 2024		
Title of Report:	Group Chief People Officer Update	Enc No: 9.3.1
Author:	Sebastian Smith – Cox (Group Head of Workforce Intelligence & Planning) s.smith-cox@nhs.net & Clair Bond (Interim Director of Operational HR and Operational Development) clair.bond2@nhs.net	
Presenter/Exec Lead:	Alan Duffell, Group Chief People Officer	

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

Recommendations:

The Board are asked to note the content of this report within the context of Trust performance management objectives, and strategic objectives related to people and organisational development.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	The risk to the organisation is concerning: • Use of Resources. • Employment legislation. • Equality, Diversity & Inclusion. • Organisational Reputation. Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	Resource implications concerning staff health and wellbeing and attendance at work. Impact on financial resources concerning bank and agency cover.		
Report Data Caveats	Please see Appendix A		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details:
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☒No☐	The Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and

			professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. All workforce policies and procedures are required to be compliant with all relevant employment legislation and the Equality Act 2010. NHS Employers guidance and terms and conditions.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

The report provides assurance regarding key workforce metrics;

- Vacancy rates
- Turnover and Retention rates
- Sickness Absence rates
- Mandatory Training Compliance rates
- Appraisal Compliance rates

The Committee can be assured that whilst two of the metrics have achieved target (vacancy rate 7.7% and 12 month retention rate 91.4%, two metrics below target have improved towards compliance for the second consecutive month; mandatory training 89.5% from 88% and appraisal compliance 83.7% from 76%)

Advise

- The 7.7% vacancy rate reflects a month-on-month 14.82 FTE increase in the budgeted establishment, reconciled against an 11.6 FTE decrease in the actual workforce per the month-end finance ledger. Most of the budgeted establishment growth aligns with the Registered Nursing and Midwifery (RN&M) and Additional Clinical Services staff group, whereby funding for the N&M workforce increased by 15.56 FTE, while clinical support to N&M budgeted FTE rose by 5.87 FTE.

- Continued improvement regarding 12-month Retention and Turnover provides strategic assurance, as except for scientific staff groups, all areas of the workforce are evidencing long-term stability.

- Whilst challenges remain regarding long-term assurance of target achievement, particularly for subjects that rely on face to face training delivery, Mandatory Training compliance has continued the improvement

trajectory, rising 2.4% since September 2023 to achieve 89.5% in December 2023.

- Appraisal compliance remains 6% below the 90% target. However, following the deep dive review in November 2023, compliance levels have improved by 5% between M8 & M9. An enhanced level of reporting has been developed to support divisions to focus on improvement and ensure the quality of the process. This will be introduced in February 2024 and is available to review in appendix 1 of part 2 in the reading room.

- In-month sickness absence, which was 6% during December 2023, rose above the 24-month average and no longer shows an improved trajectory within the two-year trend context. The Trusts offer of influenza and COVID-19 booster vaccination ceased on the 31 January 2024. As at mid-January, 34.5% of colleagues had taken an influenza vaccine which is an improvement on the position in January 2023 (29.4%%) and 17.6% have accessed a COVID-19 Booster which is less than the 24.1%% in January 2023.

Alert

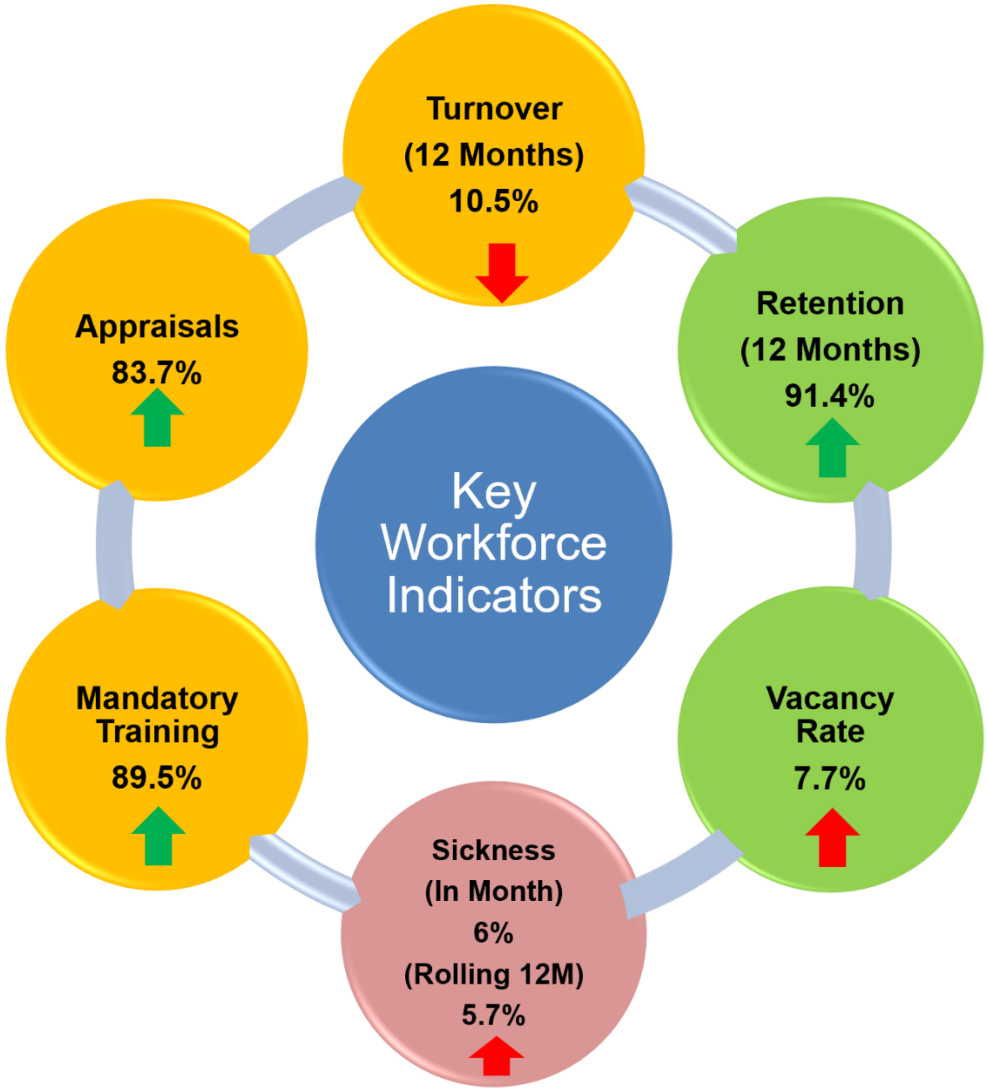
- Despite remaining leading causes of sickness absence, there have also been notable reductions in colleagues reporting cold, cough, influenza, or chest & respiratory problems. Compared to 2022/23, days lost to these absences have fallen by 33% and 46%, respectively, during 2023/24. Whilst caution is warranted during the remaining winter months, this health and well-being improvement is an optimistic indictment of the Trust's infection control and colleague vaccination programmes.

- The BMA have confirmed that the outcome of the Consultant referendum in relation to the pay offer has been to decline the offer through a slim majority of 51%. Consultants retain an active mandate to take industrial action whilst the Junior Doctors are currently balloting to extend their mandate beyond February. The outcome of this ballot is expected mid March and is likely to reconfirm commitment to further industrial action. The NHS Pay Review Body is expected to make pay recommendations for non-medical staff in March / April 2024.

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

Walsall Healthcare NHS Trust

Key Workforce Metrics



Two of the six workforce indicators, vacancy rates and 12-month retention, meet the agreed targets/ thresholds. Of the three amber, two have improved towards target compliance (Mandatory training and appraisal compliance) whilst sickness absence is rated red.

Workforce performance trends are measured over a 24-month rolling period, with statistical process control methodology applied to provide assurance regarding consistent target achievement and performance stability.

There is limited assurance that the sickness absence rate, currently 6.0%, will consistently meet the 5% target, but performance is getting better. Sickness Absence levels in December 2023 are lower than December 2022.

The mandatory training compliance rate of 89.5% provides limited assurance that the 90% target will be consistently met, although performance has improved from 87.83% in November.

There is no assurance that appraisal compliance, currently 83.7%, will consistently achieve the 90% target. The performance trend continued to worsen between July and October 2023 however December 2023 represents the 2nd consecutive in month improvement of almost 5% (from 78.84% in November).

Whilst there is a lack of assurance regarding the consistent achievement of a 10% 12-month turnover target, the current 10.5% rate reflects improved performance.

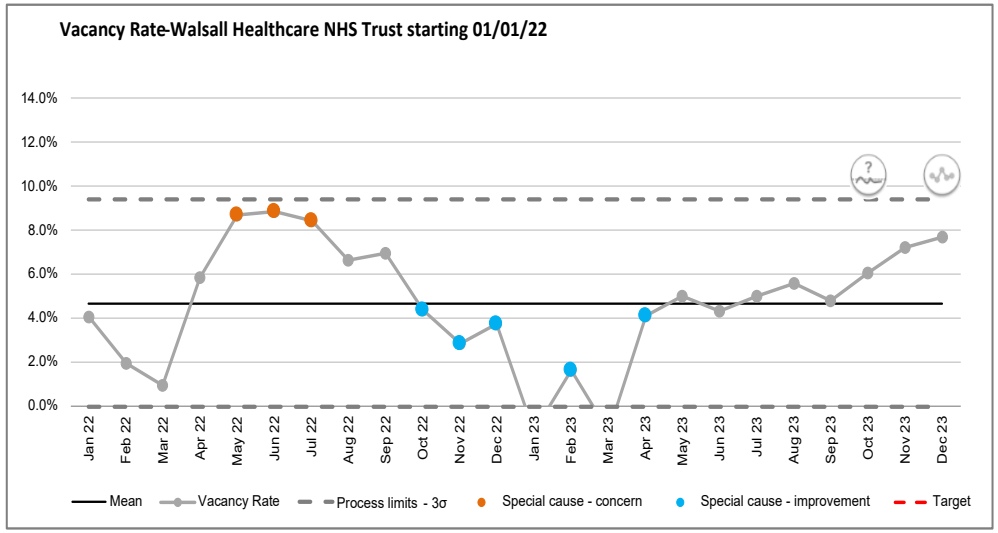
Assurance can be provided that the 12-month retention rate, currently 91.4%, will consistently meet the 90% target following continued performance improvement.

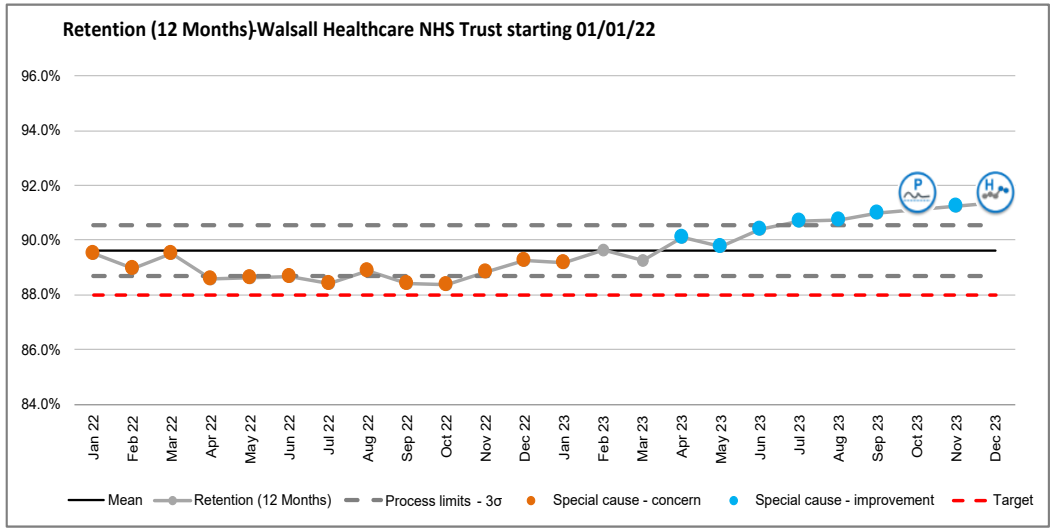
The 7.7% vacancy rate offers limited assurance, in the context of a 24-month trend, that the 7% target will be consistently met, but performance is stable at current target achieving levels.

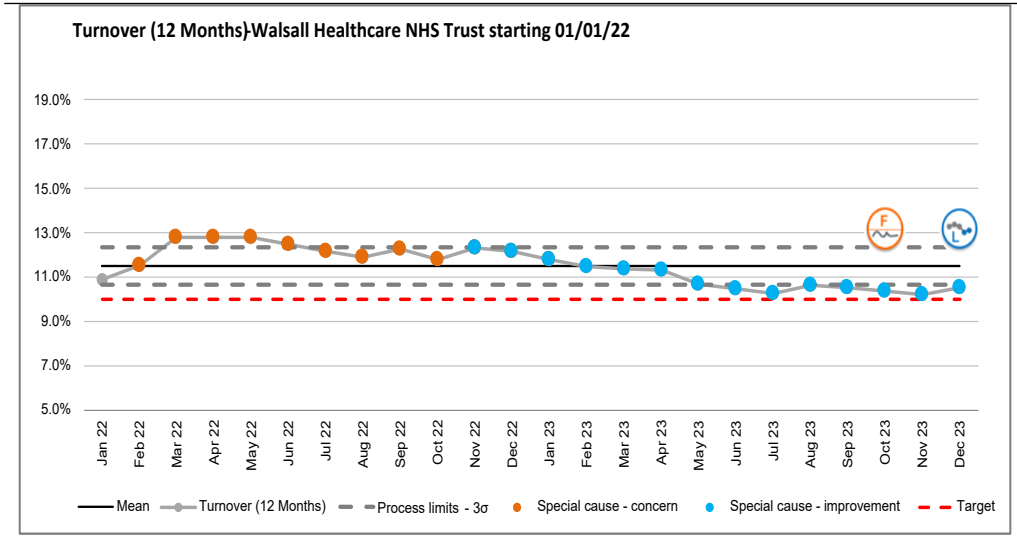
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







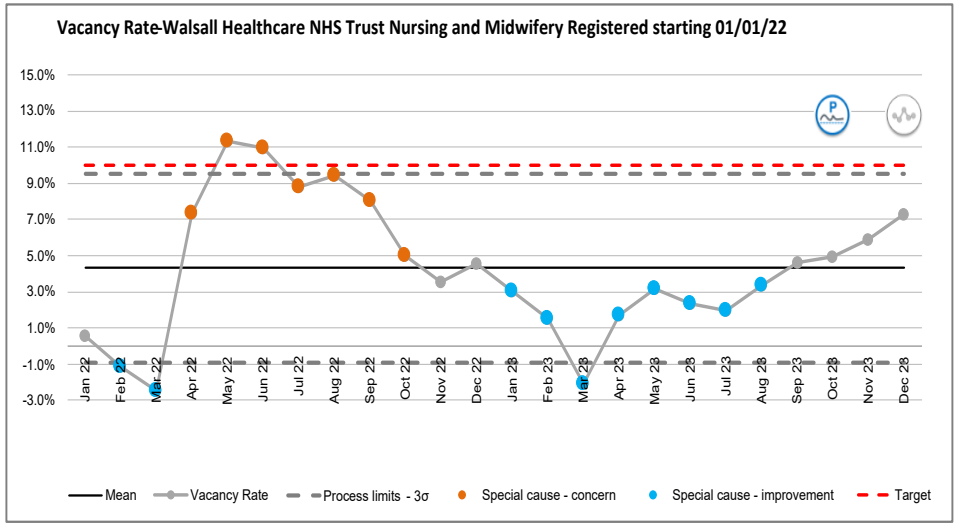
Key Issues & Challenges

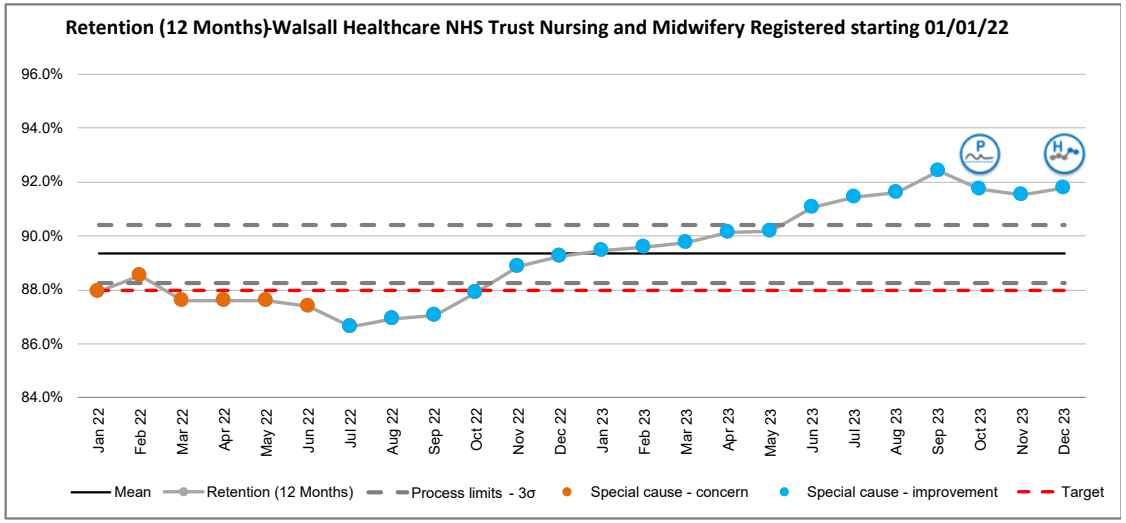
- The 7.7% vacancy rate reflects a month-on-month 14.82 FTE increase in the budgeted establishment, reconciled against an 11.6 FTE decrease in the actual workforce per the month-end finance ledger.
- Most of the budgeted establishment growth aligns with the Registered Nursing and Midwifery (RN&M) and Additional Clinical Services staff group, whereby funding for the N&M workforce increased by 15.56 FTE, while clinical support to N&M budgeted FTE rose by 5.87 FTE.
- Continued improvement regarding 12-month Retention and Turnover provides strategic assurance, as except for scientific staff groups, all areas of the workforce are evidencing long-term stability.
- Strengthening career pathways remains challenging, with external promotion the leading reason for voluntary resignation during 23/24.

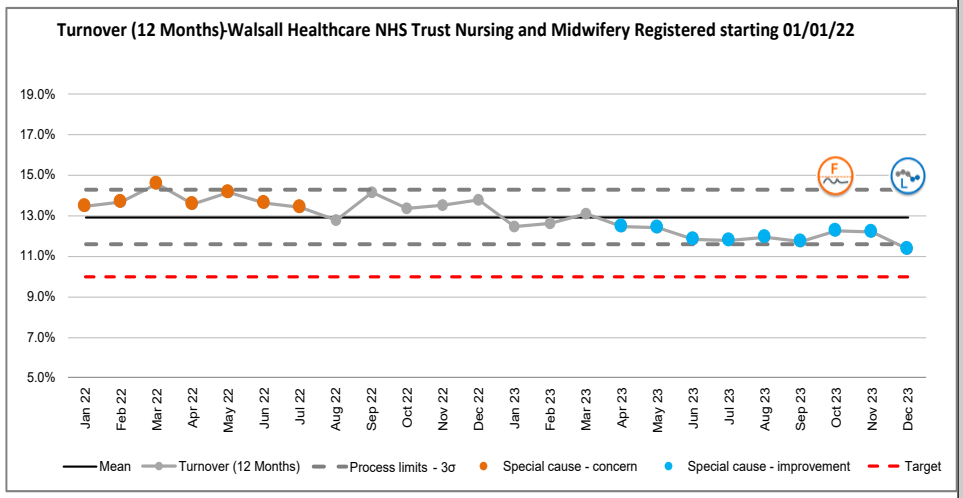
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







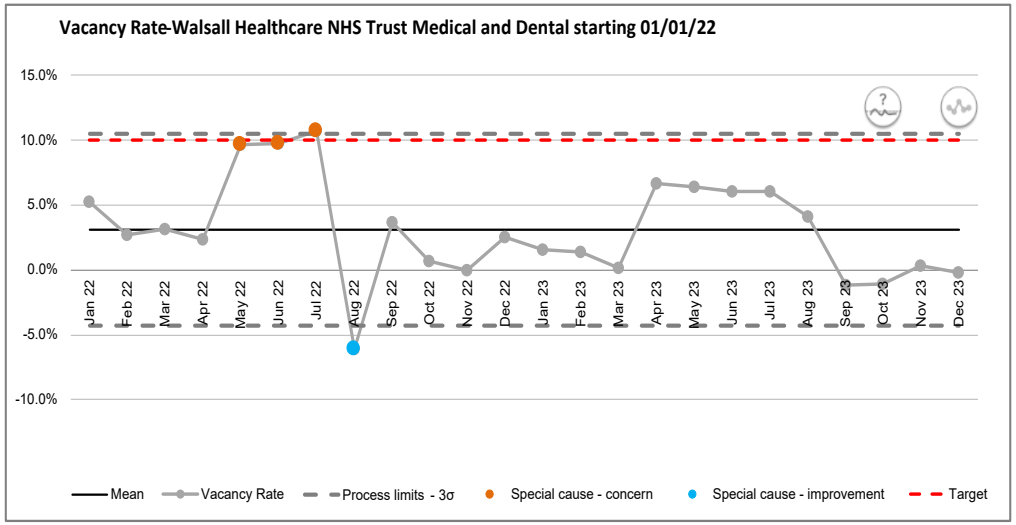
Key Issues & Challenges

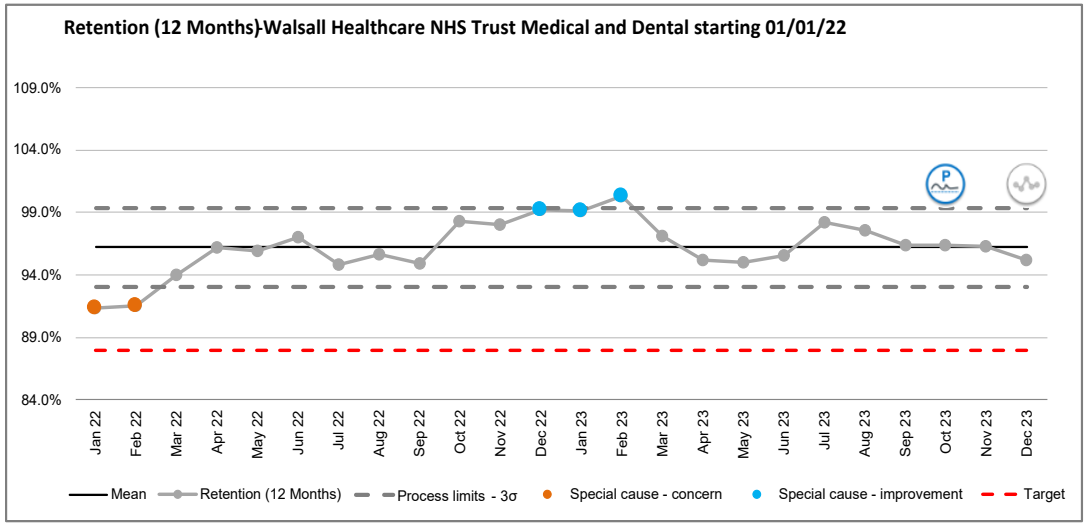
- The RN&M vacancy rate (7.31%) reflects a month-on-month 15.56 FTE increase in the budgeted establishment, reconciled against an 8.97 FTE decrease in the actual workforce; as per the month-end finance ledger.
- Improved 12-month Turnover reflects an 8% reduction in RN&M colleagues leaving the Trust due to work-life balance versus the 2022/23 monthly average.
- The continued improvement trajectory for the 12-month Retention indicator has supported a 105.62 FTE growth in the RN&M workforce since December 2022.

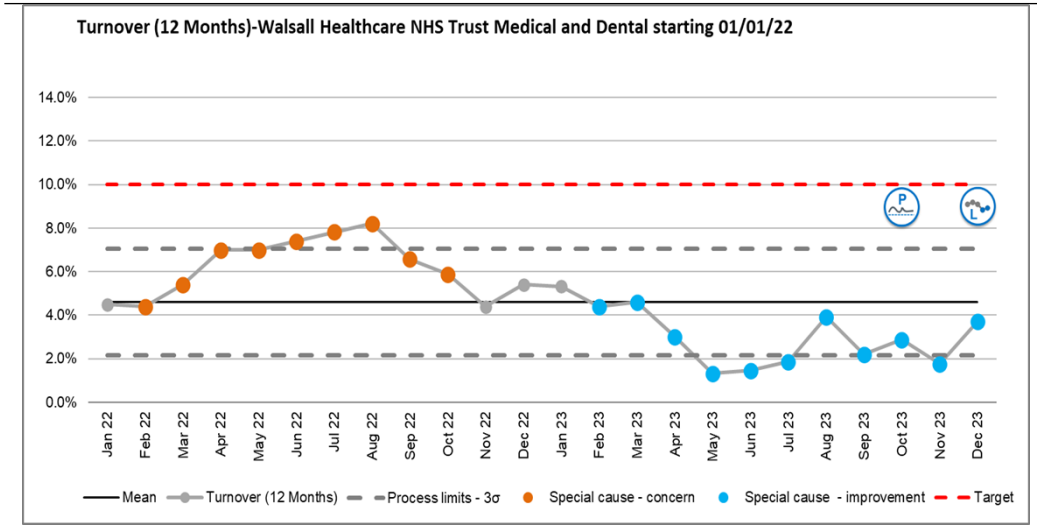
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







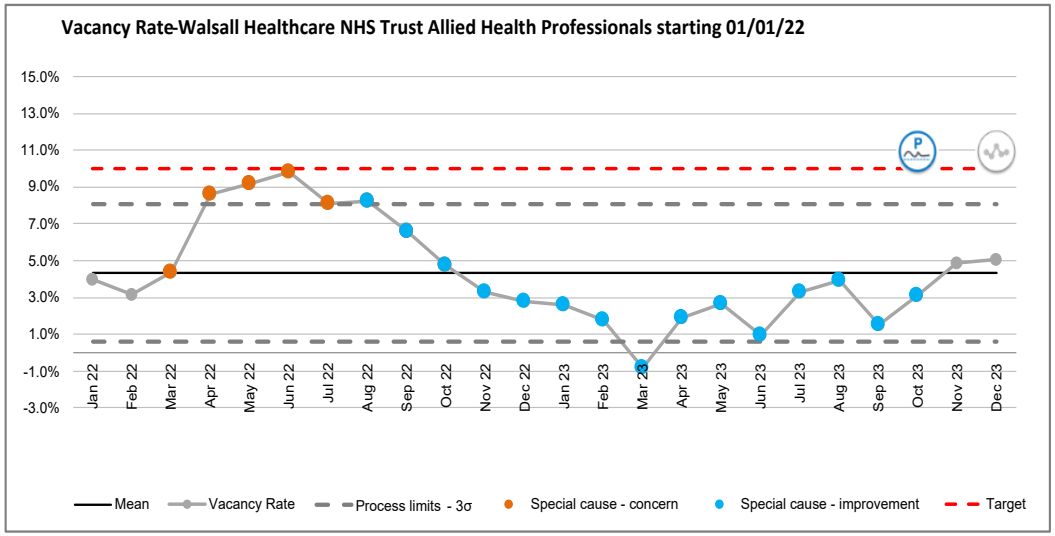
Key Issues & Challenges

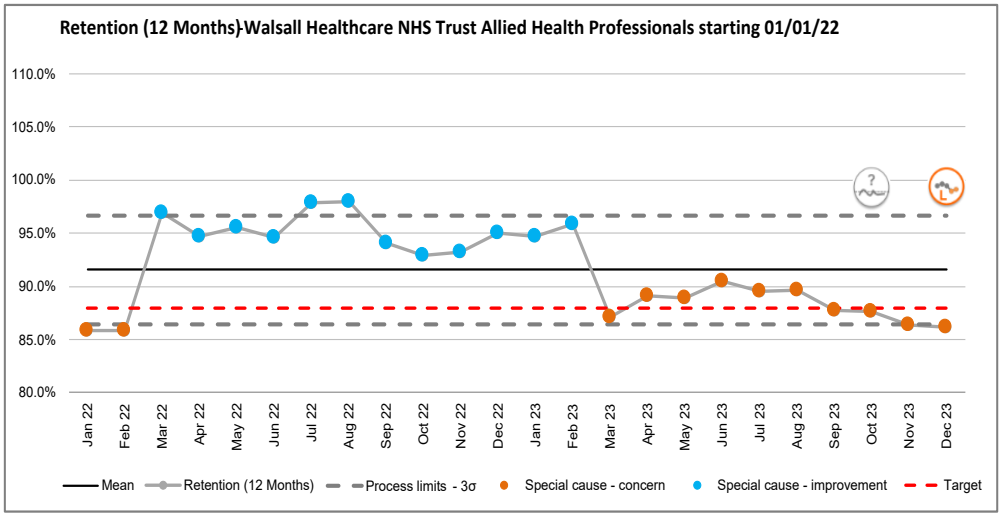
- There is continued Medical and Dental (M&D) over-establishment (1.1%) reflecting a 21.8 FTE increase in the budgeted establishment since April 2023, reconciled against a 57.1 FTE increase in the actual workforce, as per the month-end finance ledger.
- The 12-month Turnover metric remains positive, with a trend of medics leaving the organisation for external promotion mitigated by a growing young demographic aged 35 and under strategically placed to support succession planning.
- 12-month Retention remains high, with the 2023/24 trend forecasting that 26% more M&D colleagues will have joined the organisation this year versus the year-end trajectory for M&D colleagues leaving.

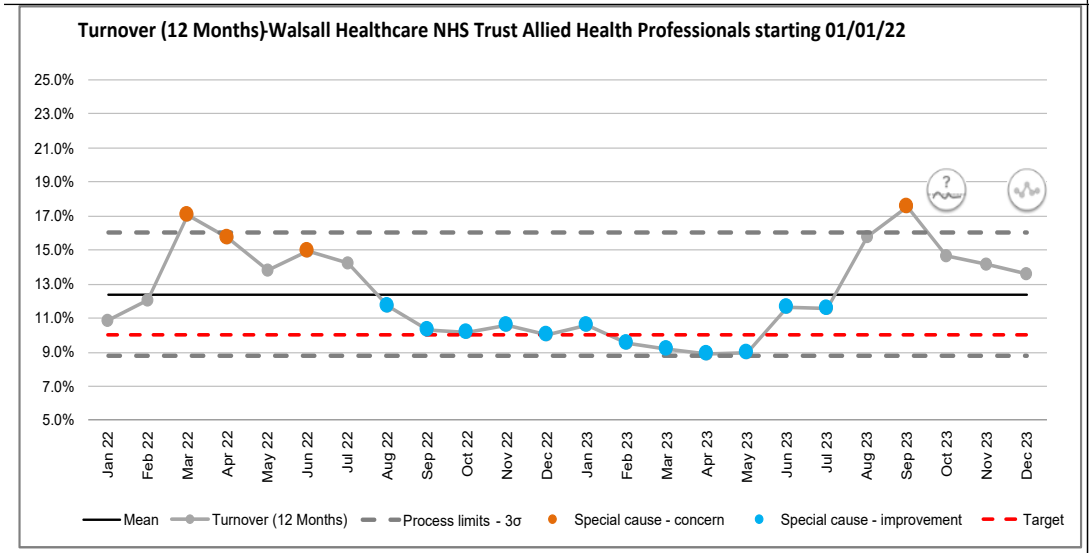
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Attract, Recruit Retain







Key Issues & Challenges

- The increased Allied Health Professionals (AHP) vacancy rate (5%) reflects a month-on-month 1.2 FTE decrease in the budgeted establishment, reconciled against a 1.8 FTE decrease in the actual workforce; as per the month-end finance ledger.
- 12-month Turnover is back within the two-year range following four months of positive trajectory, with AHP colleagues leaving the Trust during December 2023, declaring external promotion or a lack of internal opportunities as their exit reason.
- The 12-month retention indicator remains slightly below target; however, performance has stabilised near the lows of a two-year range.

Walsall Healthcare NHS Trust

Mandatory Training and Appraisals

Medicine & Long-Term Conditions - Mandatory Training Compliance			
	Nov-23	Dec-23	Movement +/-
*Division Overall	89%	90%	0.21%
Acute Care Group	86%	87%	0.78%
Cardiology	88%	87%	-1.37%
Elderly Care Group	92%	92%	-0.13%
Emergency Care Group	90%	91%	1.02%
Gastroenterology	92%	91%	-0.97%
Long-Term Conditions	87%	87%	0.47%
Medicine & Long-Term Conditions Management	88%	89%	0.22%

Surgery - Mandatory Training Compliance			
	Nov-23	Dec-23	Movement +/-
*Division Overall	86%	88%	1.50%
Cancer Services	90%	90%	0.40%
General Surgery	85%	86%	1.25%
Head & Neck Care Group	80%	83%	2.65%
Outpatient & Support Services	83%	83%	0.39%
Surgery Management	89%	90%	1.16%
Theatres, Critical Care & Anaesthetics	88%	90%	1.91%
Trauma Orthopaedics and MSK Services	84%	86%	1.43%

Women's, Children's & Clinical Support Services - Mandatory Training Compliance			
	Nov-23	Dec-23	Movement +/-
*Division Overall	87%	91%	3.20%
Children's, Families and Neonates Care Group	89%	91%	1.51%
Clinical Support Services	87%	89%	1.29%
Women's & Children's Management & Support	80%	91%	10.74%
Women's Services	88%	93%	5.44%

Estates and Facilities - Mandatory Training Compliance			
	Nov-23	Dec-23	Movement +/-
*Division Overall	80%	85%	5.03%
Facilities	80%	85%	5.19%
Estates Management	88%	91%	3.08%
Facilities	80%	85%	5.19%

Community - Mandatory Training Compliance			
	Nov-23	Dec-23	Movement +/-
*Division Overall	90%	91%	1.09%
Place Based Teams	84%	86%	1.70%
Adult Services Management	94%	93%	-0.94%
Intermediate & Urgent Care	90%	91%	0.68%
Palliative Care & End Of Life Care	95%	95%	0.20%

Staff Group	Appraisal Compliance Numerator	Appraisal Compliance Denominator	Appraisal Compliance Outturn
*All	2750	3284	83.74%
Add Prof Scientific and Technic	74	92	80.43%
Additional Clinical Services	599	667	89.81%
Administrative and Clerical	610	822	74.21%
Allied Health Professionals	213	248	85.89%
Estates and Ancillary	289	344	84.01%
Healthcare Scientists	32	45	71.11%
Medical and Dental	180	196	91.84%
Nursing and Midwifery Registered	753	870	86.55%
AfC Only	5320	6372	83.49%

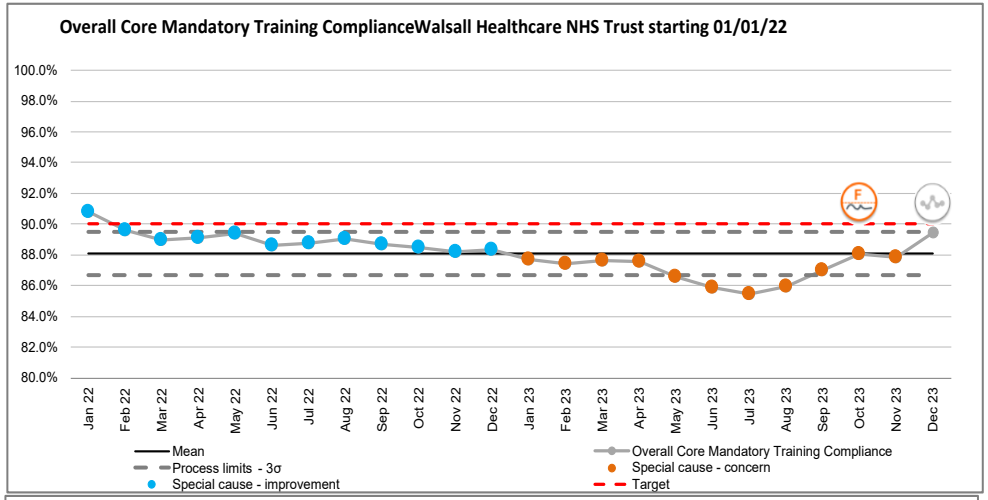
Key Issues & Challenges

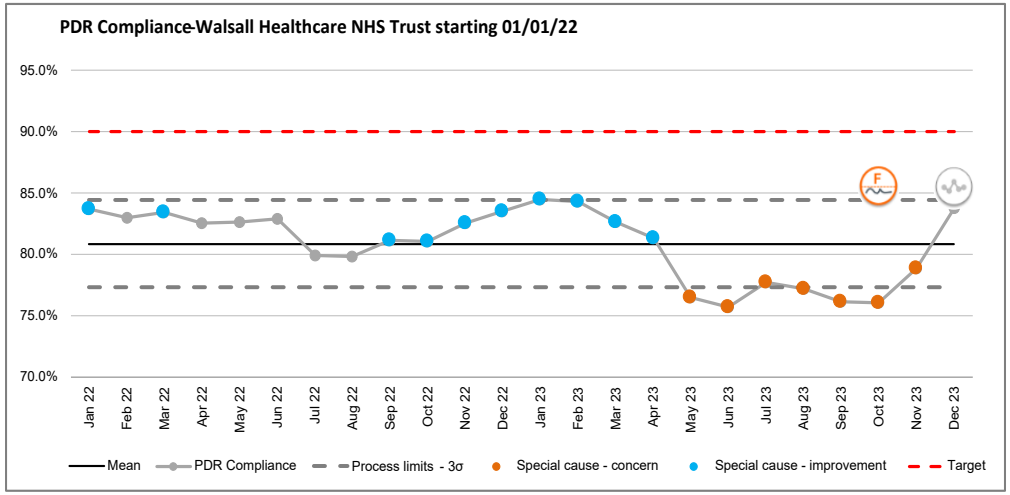
- Whilst challenges remain regarding long-term assurance of target achievement, Mandatory Training compliance has continued the short-term improvement trajectory, rising 2.4% since September 2023.
- December 2023 performance reflects increased compliance for all Mandatory Training competencies. Infection Prevention, Safeguarding Adults Level 3, Information Governance and Patient Handling competencies have all improved by over 2.5% monthly.
- There is still low confidence that appraisal compliance for staff employed on Agenda for Change terms and conditions will be achieved by the end of March 2024.
- Whilst compliance amongst M&D colleagues remains above the 90% target, attainment rates amongst other staff groups have fallen.

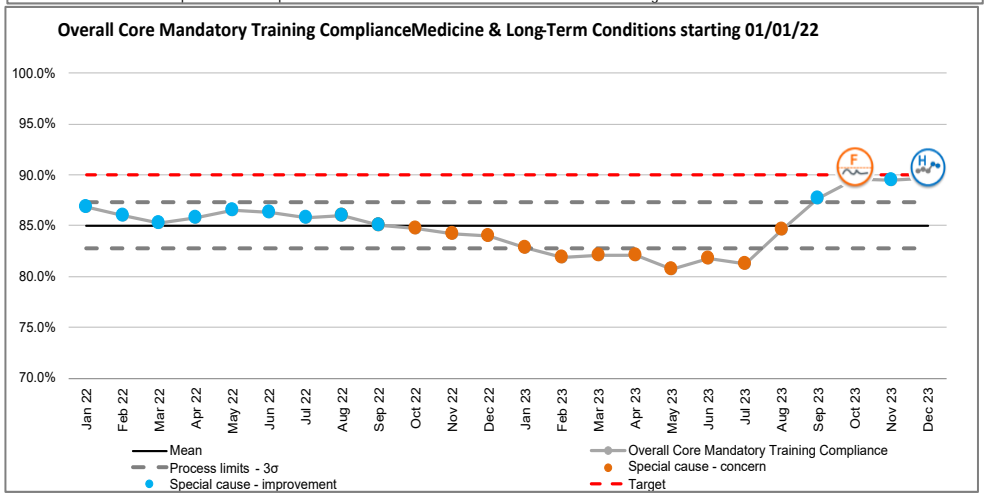
What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

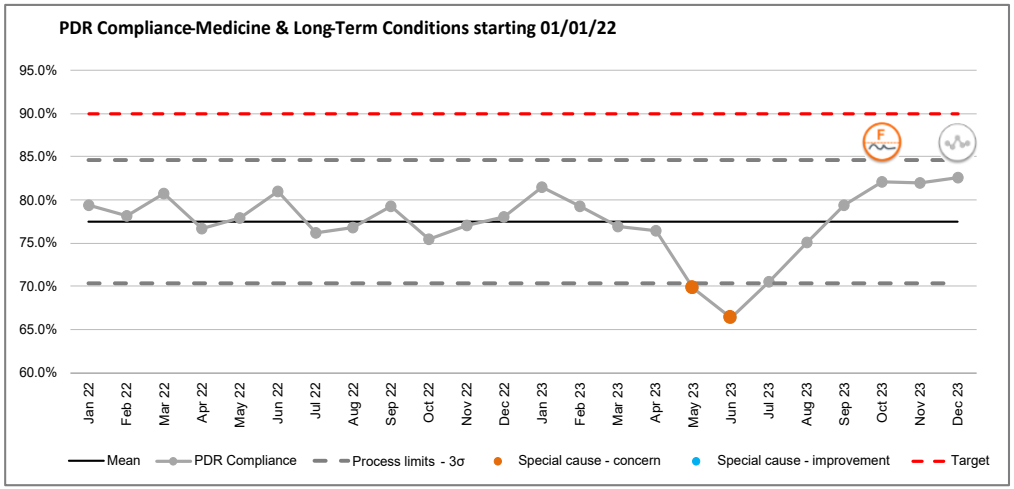
Walsall Healthcare NHS Trust

Mandatory Training and Appraisals





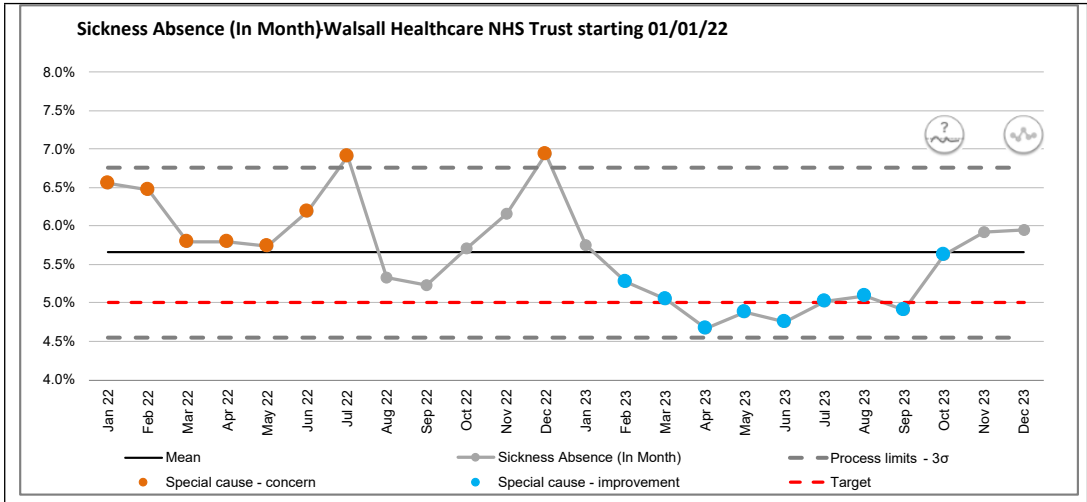


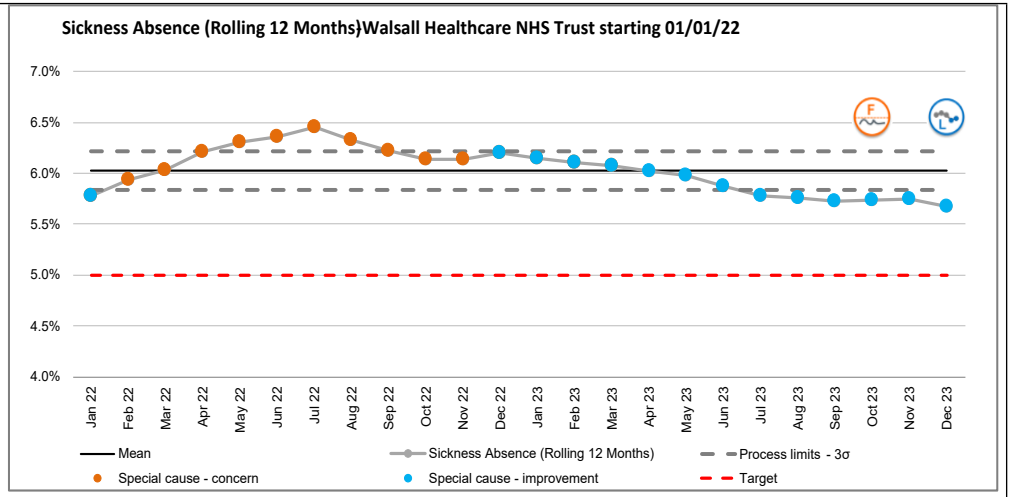


What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Health & Wellbeing





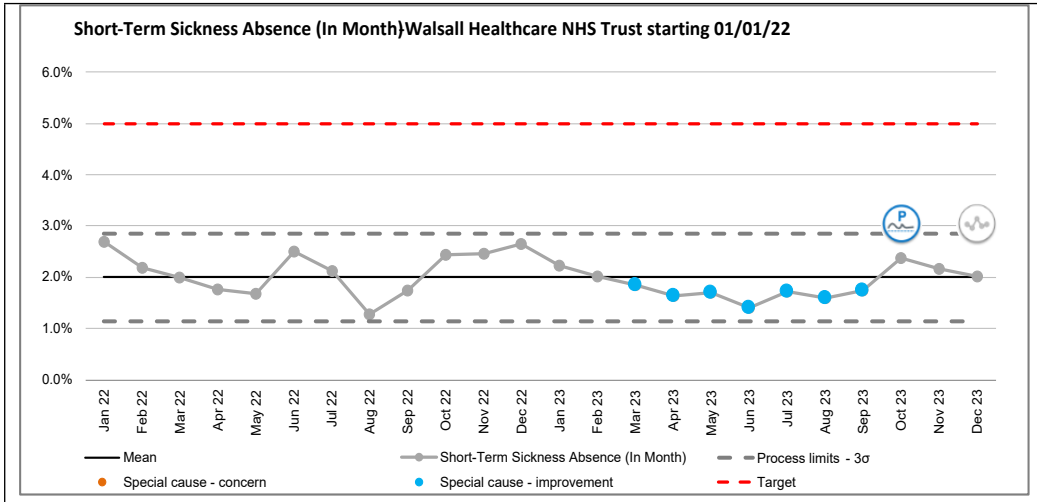
Key Issues & Challenges

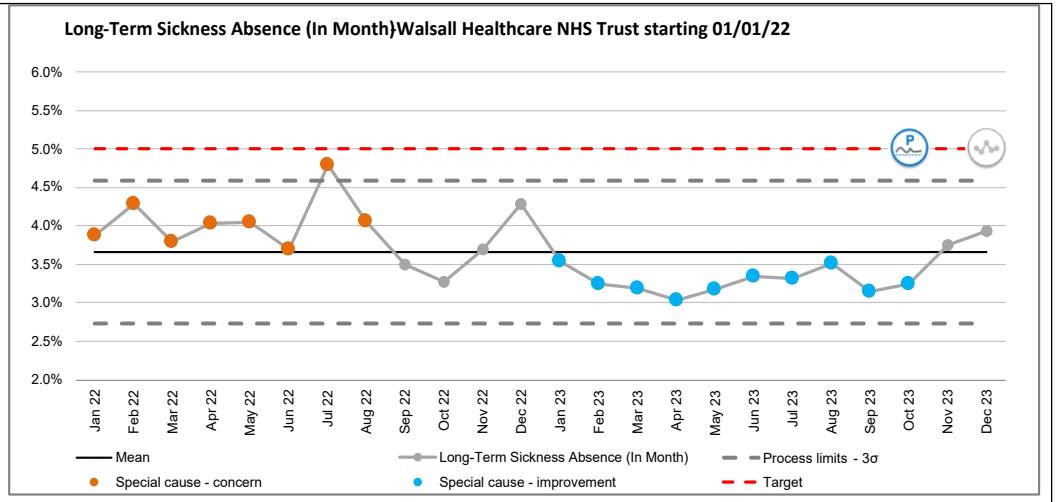
- In-month sickness absence, which was 6% during December 2023, rose above the 24-month average and no longer shows an improved trajectory within the two-year trend context.
- This is reflected in the above chart analysis, which no longer illustrates a continued special cause improvement, but In-month sickness absence remains within the upper proposed limits.
- Rolling 12-month analysis, whereby absence during the 12 months to December 2023 was 5.68%, remains below the two-year range, providing continued assurance of a strategic improvement regarding colleague attendance.
- The Estates & Facilities and Surgery divisions experienced high levels of sickness, with December 2023 in-month sickness rates of 7.69% and 6.49%, respectively. Within both divisions, high absence levels are influenced by a spike in winter illnesses.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Walsall Healthcare NHS Trust

Health & Wellbeing





Key Issues & Challenges

- Winter illnesses, such as colds, coughs, and influenza, are driving short-term absence, accounting for 20% of sickness episodes during December 2023. However, it should be noted that current levels fall below historical winter trends.
- The most prominent driver for sickness absence remains stress/anxiety (long-term), but a reduction of 3% in days lost to this absence reason (during 2023/24 year-to-date) suggests broad improvements regarding colleague mental health.
- Despite remaining leading causes of sickness absence, there have also been notable reductions in colleagues reporting cold, cough, influenza, or chest & respiratory problems. Compared to 2022/23, days lost to these absences have fallen by 33% and 46%, respectively, during 2023/24. Whilst caution is warranted during the remaining winter months, this health and well-being improvement is an optimistic indictment of the Trust's infection control and colleague vaccination programmes.

NHS
Walsall Healthcare
NHS Trust

Workforce Metrics

Workforce Profile	As at 31/03/2023	2023/24												YTD Change
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Substantive Staff FTE	4435.71	4434.69	4461.89	4481.04	4488.98	4535.01	4580.51	4588.40	4607.32	4607.80	-	-	-	172.09
Substantive Staff FTE (Ex. Rotational Drs)	4341.71	4342.69	4369.89	4389.04	4396.98	4423.58	4471.08	4479.97	4498.89	4501.23	-	-	-	159.52
Substantive Staff Headcount	5112	5119	5141	5167	5170	5217	5269	5277	5292	5290	-	-	-	178
Bank Staff Only Headcount	1181	1198	1230	1219	1050	1074	1083	1072	1105	1132	-	-	-	-49
% Staff from a BME Background	37.30%	37.60%	39.03%	39.23%	39.42%	39.57%	39.92%	39.85%	39.95%	40.08%	-	-	-	2.78%

Workforce Profile BY Staff Group (FTE)	As at 31/03/2023	2023/24												YTD Change
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Add Prof Scientific and Technic	103.29	101.00	101.10	101.77	102.77	102.63	101.90	102.26	105.49	102.49	-	-	-	-0.81
Additional Clinical Services	845.07	835.77	839.50	837.37	838.35	833.73	839.09	831.07	829.46	815.04	-	-	-	-30.02
Administrative and Clerical	921.93	920.29	916.72	914.25	920.35	923.17	924.15	926.87	929.57	930.74	-	-	-	8.81
Allied Health Professionals	294.29	291.18	293.43	293.28	295.15	299.65	305.02	305.44	304.01	303.17	-	-	-	8.88
Estates and Ancillary	256.83	255.87	253.30	253.18	251.93	255.75	256.75	255.57	256.50	256.31	-	-	-	-0.52
Healthcare Scientists	44.02	45.61	44.61	44.61	44.61	44.51	44.51	45.51	44.51	44.51	-	-	-	0.49
Medical and Dental	498.05	494.53	511.78	512.93	514.12	532.18	538.59	543.65	549.63	548.23	-	-	-	50.18
Nursing and Midwifery Registered	1454.23	1470.44	1482.46	1504.66	1502.71	1524.38	1550.50	1558.04	1570.16	1589.32	-	-	-	135.08
Students	18.00	20.00	19.00	19.00	19.00	19.00	20.00	20.00	18.00	18.00	-	-	-	0.00

Starters by Staff Group (FTE)	2022/23	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Starters	765.10	53.57	37.46	44.86	21.05	159.27	71.94	54.79	39.19	31.49	-	-	-	513.62
Add Prof Scientific and Technic	13.17	2.40	2.30	0.20	0.00	2.07	0.91	0.00	2.60	0.00	-	-	-	10.47
Additional Clinical Services	176.28	15.48	4.61	15.17	7.84	6.53	18.31	6.53	9.13	6.00	-	-	-	89.61
Administrative and Clerical	124.51	14.36	7.41	9.80	5.60	8.99	7.80	10.88	4.00	6.40	-	-	-	75.24
Allied Health Professionals	47.80	1.00	3.92	4.00	3.00	5.80	10.03	4.60	1.00	3.76	-	-	-	37.11
Estates and Ancillary	29.57	0.00	0.45	0.00	0.00	4.00	0.00	1.00	1.00	1.41	-	-	-	7.87
Healthcare Scientists	5.20	1.60	0.00	0.00	0.00	0.00	0.00	1.00	1.00	0.00	-	-	-	3.60
Medical and Dental	219.34	6.00	10.00	8.00	4.00	113.95	18.54	13.60	11.00	6.00	-	-	-	191.09
Nursing and Midwifery Registered	134.22	12.73	8.76	7.69	0.61	17.93	14.36	17.17	9.45	7.92	-	-	-	96.64
Students	15.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00	-	-	-	2.00

Employee Relation Activity – Number of Open & Closed Cases	2022/23 Monthly Avg.	2023/24												YTD Monthly
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Open Formal Grievance Cases	15	13	11	9	6	6	5	5	4	4				7
Open Bullying & Harassment Cases	5	4	4	4	1	2	2	2	2	2				3
Open Capability Cases	3	2	2	5	4	2	2	3	3	2				3
Open Disciplinary Cases	18	24	28	27	29	28	25	22	26	28				26
Cases Closed	10	3	10	7	3	10	4	7	7	4				6

Walsall Healthcare NHS Trust

Workforce Metrics

Leavers by Staff Group (FTE)	2022/23	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Leavers	623.91	47.90	38.97	38.87	45.15	131.41	49.42	59.91	33.45	51.45	-	-	-	**496.54**
Add Prof Scientific and Technic	13.24	0.00	2.00	0.00	0.00	0.80	1.64	0.64	0.37	3.00	-	-	-	8.45
Additional Clinical Services	112.73	11.06	6.43	5.01	5.95	13.92	12.79	11.35	8.15	11.24	-	-	-	85.89
Administrative and Clerical	119.94	11.65	7.88	13.48	8.35	8.59	10.04	9.72	5.00	13.00	-	-	-	87.71
Allied Health Professionals	36.30	1.00	0.60	3.80	2.12	7.80	4.60	2.40	5.31	4.60	-	-	-	32.23
Estates and Ancillary	20.20	0.47	3.48	0.00	0.89	0.40	0.00	1.27	0.67	1.33	-	-	-	8.51
Healthcare Scientists	6.57	0.00	1.00	0.00	0.00	0.00	0.00	1.10	0.00	1.00	-	-	-	3.10
Medical and Dental	152.30	10.00	4.00	5.80	10.10	87.46	9.17	11.88	3.00	8.49	-	-	-	149.90
Nursing and Midwifery Registered	161.63	13.72	13.59	10.77	17.75	12.44	11.18	19.56	9.96	8.79	-	-	-	117.75
Students	1.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	1.00	0.00	-	-	-	3.00

Retention	2022/23	2023/24												2023/24 Average
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Retention Rate (12 Months)	**89.27%**	**90.11%**	**89.76%**	**90.41%**	**90.71%**	**90.72%**	**91.00%**	**91.11%**	**91.26%**	**91.38%**	-	-	-	**90.72%**
Retention Rate (24 Months)	**79.39%**	**79.39%**	**79.18%**	**79.64%**	**79.81%**	**80.26%**	**80.16%**	**80.79%**	**81.15%**	**81.81%**	-	-	-	**80.24%**
Retention Rate (5 Years)	58.62%	58.09%	57.75%	57.94%	58.56%	58.45%	58.34%	58.36%	58.46%	59.03%	-	-	-	58.33%

Retention Rate (12 Months)	2022/23	2023/24												2023/24 Average
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Add Prof Scientific and Technic	**69.23%**	**86.25%**	**80.06%**	**85.44%**	**51.43%**	**56.86%**	**55.61%**	**54.49%**	**54.98%**	**55.77%**	-	-	-	**64.55%**
Additional Clinical Services	**86.84%**	**87.02%**	**86.69%**	**87.08%**	**76.88%**	**77.48%**	**78.11%**	**78.55%**	**79.76%**	**79.79%**	-	-	-	**81.26%**
Administrative and Clerical	**92.36%**	**92.23%**	**91.47%**	**91.03%**	**82.20%**	**82.61%**	**82.62%**	**82.30%**	**82.52%**	**83.92%**	-	-	-	**85.66%**
Allied Health Professionals	**87.13%**	**89.16%**	**88.93%**	**90.47%**	**85.40%**	**84.10%**	**79.57%**	**79.53%**	**80.04%**	**82.70%**	-	-	-	**84.43%**
Estates and Ancillary	**89.79%**	**90.60%**	**91.29%**	**92.35%**	**80.40%**	**81.60%**	**81.17%**	**82.12%**	**82.23%**	**81.21%**	-	-	-	**84.78%**
Healthcare Scientists	**86.28%**	**87.26%**	**89.32%**	**91.48%**	**85.72%**	**85.58%**	**85.58%**	**83.61%**	**81.61%**	**79.79%**	-	-	-	**85.55%**
Medical and Dental	**97.13%**	**95.19%**	**95.02%**	**95.56%**	**91.96%**	**92.67%**	**92.35%**	**95.57%**	**94.81%**	**94.36%**	-	-	-	**94.17%**
Nursing and Midwifery Registered	**89.78%**	**90.15%**	**90.19%**	**91.07%**	**79.28%**	**79.52%**	**79.96%**	**81.41%**	**81.62%**	**82.33%**	-	-	-	**83.95%**

Walsall Healthcare NHS Trust

Workforce Metrics

Turnover % (Normalised) - Rolling 12 Months	2022/23	2023/24												2023/24 Average
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Overall Turnover	11.38%	11.33%	10.65%	10.44%	10.24%	10.63%	10.51%	10.38%	10.23%	10.52%	-	-	-	10.55%
Add Prof Scientific and Technic	12.45%	12.45%	14.99%	14.53%	13.31%	12.83%	13.81%	12.61%	12.24%	14.89%	-	-	-	13.52%
Additional Clinical Services	14.35%	15.09%	13.58%	13.04%	13.52%	13.86%	13.43%	13.52%	13.20%	13.65%	-	-	-	13.66%
Administrative and Clerical	9.14%	9.61%	8.38%	8.80%	8.18%	7.97%	7.43%	7.14%	7.28%	7.82%	-	-	-	8.07%
Allied Health Professionals	9.17%	8.91%	8.97%	11.65%	11.54%	15.78%	17.58%	14.66%	14.17%	13.60%	-	-	-	12.98%
Estates and Ancillary	8.04%	6.87%	7.67%	6.33%	5.20%	2.86%	3.98%	4.77%	4.89%	4.93%	-	-	-	5.28%
Healthcare Scientists	9.96%	9.45%	8.63%	3.55%	2.43%	2.53%	2.60%	4.05%	3.65%	7.16%	-	-	-	4.90%
Medical and Dental	4.59%	3.01%	1.33%	1.46%	1.86%	3.92%	2.19%	2.87%	1.76%	3.70%	-	-	-	2.46%
Nursing and Midwifery Registered	13.08%	12.45%	12.40%	11.84%	11.76%	11.93%	11.70%	12.23%	12.22%	11.37%	-	-	-	11.99%

Sickness Absence	2022/23	2023/24											2023/24 Average
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
% Sickness Absence In Month	5.05%	4.67%	4.89%	4.76%	5.03%	5.09%	4.91%	5.62%	5.92%	5.95%	-	-	-	5.20%
% Sickness Absence (Rolling 12 Months)	6.07%	6.02%	5.98%	5.87%	5.78%	5.76%	5.72%	5.74%	5.75%	5.68%	-	-	-	5.81%
FTE Days Lost	6917	6200	6749	6384	6994	7144	6713	7986	8172	8503	-	-	-	7205
% Short Term Sickness	34.68%	35.06%	34.91%	29.67%	34.13%	31.12%	35.72%	42.20%	36.52%	33.90%	-	-	-	34.80%
% Long Term Sickness	65.32%	64.94%	65.09%	70.33%	65.87%	68.88%	64.28%	57.80%	63.48%	66.10%	-	-	-	65.20%
Estimated Cost of Sickness £	£8,662,364	£586,363	£667,728	£603,515	£645,432	£687,953	£650,689	£796,753	£794,154	£817,735	-	-	-	£694,480

Top 3 Sickness Reasons (FTE Days Lost)	2022/23	2023/24											% Change - (YTD Avg)
	Monthly Avg.	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Anxiety/stress/depression/other psychiatric illnes	2125.3	1961.8	1880.3	1802.1	1810.4	1740.1	1597.4	1736.9	2182.0	2290.8	-	-	-	-11.11%
Gastrointestinal problems	726.2	670.8	659.5	727.1	808.3	619.2	579.1	669.9	621.7	826.0	-	-	-	-5.42%
Cold, Cough, Flu - Influenza	740.3	386.9	339.3	205.4	281.4	377.4	391.8	962.6	667.1	820.8	-	-	-	-33.47%

Education / OD	2022/23	2023/24											2023/24 Average
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Core Mandatory Training	87.66%	87.58%	86.61%	85.88%	85.47%	85.94%	87.01%	88.03%	87.83%	89.46%	-	-	-	87.09%
Appraisal	82.66%	81.27%	76.48%	75.65%	77.70%	77.18%	76.16%	76.04%	78.84%	83.74%	-	-	-	78.12%

Walsall Healthcare NHS Trust

Workforce Metrics

Freedom To Speak Up Engagements	2022/23 Total	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Trust Overall	132	8	10	20	21	13	12	55	21	11				171

Establishment Gap By Staff Group (FTE)	2022/23	2023/24												YTD Change
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Establishment Gap	**-72.75**	**168.82**	**205.03**	**223.05**	**208.68**	**264.37**	**231.61**	**297.90**	**308.97**	**331.05**	**-**	**-**	**-**	**370.65**
Additional Clinical Services	-68.44	-48.41	-43.38	-27.77	-29.87	-18.94	-26.00	14.92	10.95	17.32	-	-	-	83.36
Administrative and Clerical	-16.41	63.31	73.22	74.08	83.36	84.78	88.96	97.42	105.20	109.97	-	-	-	113.83
Allied Health Professionals	-2.15	5.05	7.00	6.18	8.96	8.97	4.31	8.71	13.91	14.49	-	-	-	10.86
Estates and Ancillary	53.71	84.82	87.62	87.93	88.16	89.09	84.53	87.30	88.01	86.77	-	-	-	33.59
Healthcare Scientists	-1.05	0.92	-1.88	-0.44	0.56	0.28	7.09	8.14	5.48	5.96	-	-	-	9.19
Medical and Dental	0.92	34.18	33.40	32.80	23.20	21.65	-6.19	-5.99	1.62	-1.14	-	-	-	-6.91
Nursing and Midwifery Registered	-47.50	26.82	48.42	46.64	30.97	47.22	75.27	82.78	80.54	95.82	-	-	-	130.28
Professional and Scientific	8.17	2.13	0.63	3.63	3.34	5.87	3.64	4.62	3.26	1.86	-	-	-	-3.55
Students	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	0.00

Agency Spend (£000's)	2022/23	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Agency Spend	**£15,777**	**£867**	**£1,186**	**£826**	**£886**	**£504**	**£466**	**£445**	**£389**	**£491**	**-**	**-**	**-**	**£6,060**
Nursing and Midwifery Registered	£6,815	£135	£244	£349	£328	£17	£172	£98	£107	£146	-	-	-	£1,596
Qualified Scientific, Therapeutic and Technical	£1,334	£145	£160	£101	£96	£36	£90	£95	£92	£53	-	-	-	£867
Support to Clinical Staff	£900	£77	£92	£187	£134	£177	£137	£184	£156	£171	-	-	-	£1,314
of which support to nursing staff	£292	£4	-£18	£39	£29	£83	-£21	£43	£64	£49	-	-	-	£272
NHS Infrastructure Support	£2,029	£156	£162	£2	£114	£127	£17	£57	£9	£49	-	-	-	£694
Medical and Dental	£4,699	£353	£527	£188	£215	£147	£50	£10	£26	£73	-	-	-	£1,589
of which Consultants	£1,609	£100	£213	£64	£123	£89	£35	£16	£18	£75	-	-	-	£734
of which Career/Staff Grade	£1,345	£136	£153	£52	£47	£56	£20	-£5	£10	-£1	-	-	-	£467
of which Trainee Grades/Trust Grade	£1,746	£118	£161	£71	£46	£1	-£4	-£2	-£2	-£1	-	-	-	£388

Bank Spend (£000's)	2022/23	2023/24												YTD Total
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Total Bank Spend	**£30,435**	**£2,555**	**£2,681**	**£2,604**	**£2,523**	**£2,870**	**£2,930**	**£2,541**	**£2,641**	**£3,096**	**-**	**-**	**-**	**£24,441**
Nursing and Midwifery Registered	£9,301	£949	£900	£726	£794	£854	£789	£730	£883	£945	-	-	-	£7,570
Qualified Scientific, Therapeutic and Technical	£26	£4	£3	-£2	£3	£8	£1	£1	£13	£3	-	-	-	£34
Support to Clinical Staff	£6,765	£556	£573	£663	£608	£657	£622	£553	£652	£695	-	-	-	£5,579
of which support to nursing staff	£5,801	£459	£489	£568	£515	£558	£517	£469	£542	£581	-	-	-	£4,696
NHS Infrastructure Support	£2,541	£210	£193	£210	£251	£176	£237	£189	£171	£190	-	-	-	£1,828
Medical and Dental	£11,802	£837	£1,012	£1,008	£866	£1,174	£1,281	£1,067	£922	£1,262	-	-	-	£9,431
of which Consultants	£6,273	£522	£646	£619	£440	£763	£866	£639	£560	£657	-	-	-	£5,713
of which Career/Staff Grade	£2,765	£47	£247	£197	£224	£227	£244	£287	£203	£351	-	-	-	£2,027
of which Trainee Grades/Trust Grade	£2,763	£268	£119	£192	£203	£184	£171	£141	£159	£255	-	-	-	£1,690

Walsall Healthcare NHS Trust

Appendix A - Supplementary Comments

- Sickness Absence outturns have been normalised through the exclusion of COVID-19 illnesses. Separate updates of COVID-19 absence rates are shared daily with operational leads.
- Workforce Profile figures are reflective of Permanent and Fixed Term colleagues.
- Turnover figures are 'normalised' through the exclusion of Rotational Doctors, Students, TUPE Transfers and End of Fixed Term Temp contract.
- Absences totalling 28 calendar days or more are classified as being Long-Term.
- The 'Estimated Cost of Absence' is taken from the Electronic Staff Records (ESR) System and is based upon the salary value of absent colleagues but omits potential on-costs.
- Retention Calculation: No. Employee with XX or more months of service Now / No Employees one year ago (Rotational Doctors, Students, TUPE Transfers & Fixed Term colleagues are excluded from both the numerator and denominator)
- Vacancy information reflects budgeted and actual workforce figures taken from the finance ledger, effective month-end. Due to this, establishment gaps indicate gaps within the financial establishment are not necessarily wholly related to ongoing or historical recruitment campaigns.
- Training & Appraisal compliance is calculated using exclusion lists detailed in this document's Appendix.
- As of January 2020, 'Core Mandatory' compliance is reflective of the national Core Skills Training Framework.;

  - Conflict Resolution
  - Fire Safety
  - Equality, Diversity and Human Rights
  - Information Governance and Data Security
  - Health, Safety and Welfare
  - Load Handling
  - Patient Handling
  - Infection Prevention and Control Level 1
  - Infection Prevention and Control Level 2
  - Adult Basic Life Support
  - Safeguarding Children Level 1
  - Safeguarding Children Level 2
  - Safeguarding Children Level 3
  - Safeguarding Adults Level 1
  - Safeguarding Adults Level 2
  - Safeguarding Adults Level 3
  - Prevent Level 1 & 2
  - Prevent Level 3

Walsall Healthcare NHS Trust

Appendix B - HR KPI RAG Rating Scales

Appraisal rate	<81%	81% - 90%	>=90%
Mandatory Training Attendance	<81%	81% - 90%	>=90%
Retention (24 Months)	<75%	75% - 85%	>=85%
Retention (12 Months)	<78%	78% - 88%	>=88%
Sickness Absence %	>6%	5% - 6%	<=5%
Turnover	>11%	10% - 11%	<=10%
Vacancy Rate	>11%	10% - 11%	<=10%

Appendix C - Training & Appraisal Exclusion Lists

Training	Annual Appraisal
• Bank Staff • Students • Anyone on Career Break • Anyone on External Secondment • Anyone on Suspension • Anyone on Maternity Leave • Anyone Long-Term Sick	• Bank Staff • Students • Anyone on Career Break • Anyone on External Secondment • Anyone on Suspension • Anyone Managed Externally • Anyone on a fixed-term contract. • Anyone whom the Trust has employed for less than one calendar year. • Anyone on Maternity Leave • Anyone Long-Term Sick

Walsall Healthcare NHS Trust

Appendix 1 – Enhanced Appraisal Compliance Reporting.

Following the deep dive analysis of compliance levels at divisional level, the report below has been developed to support divisional leadership teams to tale greater focus on the quality and quantity of appraisals completed within 12 months. This reporting template is currently being socialised with leaders ahead of implementation in Q4 of 23/24.

	Criteria 1 - A point in-time compliance rate			Criteria 2 - Three Month Improvement Trend			
Outstanding	>=	90%	*AND*	>=	3	Months of	Improvement
Good	>=	90%	*AND*	<	3	Months of	Decline
Requires Improvement	>	50%	*AND*	<	3	Months of	Decline
Inadequate	<=	50%	*OR*	>=	3	Months of	Decline

	Previous Compliance			Latest Compliance Rate (Dec-23)	Improvement Status	Improvement Statement	No. Colleagues In Date (As @ 24/01/2024)	*Of which are expiring soon*	No. Colleagues Expired (As @ 24/01/2024	Due to Expire During			Confirmed Action Plans
	Sep-23	Oct-23	Nov-23							Jan-24	Feb-24	Mar-24	
Walsall Healthcare NHS Trust	76.2%	76.0%	78.8%	83.7%	Requires Improvement	Below 90%	2820	513	495	35	138	200	0
Chief Executive Directorate	30.0%	22.2%	66.7%	70.0%	Requires Improvement	Below 90%	7	1	3	0	0	1	0
Digital Services	65.5%	60.9%	51.8%	61.9%	Requires Improvement	Below 90%	73	15	38	0	6	0	0
Directorate of Transformation & Strategy	54.5%	58.3%	61.5%	53.8%	Requires Improvement	Below 90%	8	5	5	0	1	0	0
Finance Directorate	52.1%	42.9%	42.9%	50.0%	Inadequate	Below 50%	26	2	24	0	0	2	0
Governance Directorate	20.0%	37.0%	76.9%	77.8%	Requires Improvement	Below 90% but 3 Months of Improvement	21	2	7	0	2	0	0
Medical Directorate	59.1%	64.4%	85.7%	90.2%	Outstanding	Above 90% and 3 Months of Improvemen	36	7	4	1	1	2	0
Nurse Directorate	64.5%	68.8%	71.4%	71.8%	Requires Improvement	Below 90% but 3 Months of Improvement	57	29	21	5	9	12	0
Operations Directorate	28.0%	29.2%	58.3%	54.2%	Requires Improvement	Below 90%	13	1	11	0	0	0	0
People & Culture Directorate	59.7%	61.3%	63.5%	65.1%	Requires Improvement	Below 90% but 3 Months of Improvement	44	13	21	0	4	9	0
Community	83.5%	81.9%	88.3%	92.9%	Good	Above 90%	693	123	41	9	32	54	0
Estates and Facilities	81.7%	78.4%	78.7%	79.9%	Requires Improvement	Below 90%	274	44	54	1	5	19	0
Medicine & Long-Term Conditions	79.4%	82.1%	81.9%	82.6%	Requires Improvement	Below 90%	463	60	87	6	13	23	0
Surgery	69.4%	69.2%	76.4%	88.7%	Requires Improvement	Below 90%	553	91	52	7	29	31	0
Walsall Together	42.9%	85.7%	85.7%	85.7%	Requires Improvement	Below 90%	6	0	1	0	0	0	0
Women's, Children's & Clinical Support Service	81.8%	82.3%	78.8%	83.1%	Requires Improvement	Below 90%	546	120	126	6	36	47	0

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Trust Board Metrics Report – Effective Collaboration	Enc No: 10.1
Author:	Author - Amanda Cater, Head of Performance	
Presenter/Exec Lead:	Ned Hobbs, Chief Operating Officer/Deputy Chief Executive Dr Jonathan Odum, Group Chief Medical Officer Dr Manjeet Shehmar, Chief Medical Officer	

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

Recommendations:

Board members are asked to note the contents of the report and note that metrics included in the report maybe reported in further detail within other subcommittee papers.
Areas for focus are included within subcommittee highlight reports.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☐ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :	Any risks associated with individual metrics reported within the report are detailed within the appropriate sub-committee papers.	
Changes to BAF Risk(s) & TRR Risk(s) agreed	State: **None**		
Resource Implications:	(if none, state 'none') Revenue: **None** Capital: **None** Workforce: implications associated with the capture and reporting of performance data. Funding Source: **None**		
Report Data Caveats	This is a standard report using the previous months or most recent data. It may be subject to cleansing and revision. The report relies on timely and accurate data recording in corporate systems and, for data provided outside of corporate systems, timely provision of the data to the Performance Team for incorporation into the report		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Effective, Caring, Responsive, Well-led
	NHSE	Yes☒No☐	Details: Publication PRN00196 Elective care prioritise 2023/24
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☒No☐	Details: NHS contractual requirements
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Walsall Healthcare
NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert

Introduction

'Board Level Metrics' are a rationalised set of priority metrics for the Board to focus on. The metrics align against our four strategic objectives (Care, Colleagues, Collaboration and Communities) and our Vision. Whilst this is a rationalised set of metrics to generate higher quality discussions and assurance, we also monitor a considerable number of metrics within subcommittee papers. Highlight reports from each committee are included for Board focus. This report includes data in Statistical Process Control (SPC) charts using the NHS 'Make Data Count' style of reporting. Further detail on how to interpret SPC charts icons is explained in the final page of this report. This is the second time this new report has been produced; the content will evolve over time. This report replaces the previous IQPR – Integrated Quality and Performance Report.

Please refer to subcommittee highlight reports for areas of Assure, Advise and Alert

Trust Board Metrics - Key Objectives

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L		Cancer - No. of patients waiting 63+ Days for treatment (CARE) MSFD - Average number of Medically Fit for Discharge Patients in WMH (COMMUNITIES)	18 Weeks RTT - Number of 78 Week Breaches (excluding patient choice) (CARE)	
		Urgent Crisis Response (UCR) - 2 Hour Response Rate (CARE) Vacancy Rates - Overall (COLLEAGUES) Virtual Ward - Total Referrals (COLLABORATION)	18 Weeks RTT - Number of 65 Week Breaches (CARE)	
H / L		ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival (CARE)		

Dashboard metrics for the below Objectives do not contain enough data points to populate the above matrix - Please see exception page for further detail

- Carbon Footprint - 5% reduction in the carbon footprint (COMMUNITIES)
- R&D - Number of Recruits - Commercial (COLLABORATION)
- R&D - Number of Recruits - Non Commercial (COLLABORATION)

Dashboard metrics for the below Objectives are currently in development

- 10% increase on previous year in the percentage of staff responding positively in the annual staff survey when asked if they are able to suggest and make improvements in their area (CARE)
- Delivery of the agreed financial plan (CARE)
- Deliver an improvement on 2022/23 in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing by March 2024 (COLLEAGUES)
- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged (COLLEAGUES)
- Deliver an improvement on 2022/23 in Workforce Equality Standard performance by March 2024 (COLLEAGUES)
- Identify, implement and report on a agreed set of outcome measures for each of the projects within the provider colloborative programme (COLLABORATION)
- Develop and implement a Health Inequalities Strategy with measurable outcomes in 2023/24 (COMMUNITIES)

NHS
Walsall Healthcare
NHS Trust

Trust Board Metrics - COLLABORATION Dashboard

KPI	Latest month	Measure	Trajectory	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Virtual Ward - Total Referrals	Dec 23	273		157			207.50	135.98	279.02
R&D - Number of Recruits - Commercial	Dec 23	1							
R&D - Number of Recruits - Non Commercial	Dec 23	51							

Footnotes

* The Variation SPC icon is based off the target column. The trajectory column has been added for information only

** Targets are sourced from Trust Board approved targets / constitutional standard targets / local expectations

Care Colleagues
Collaboration Communities

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.

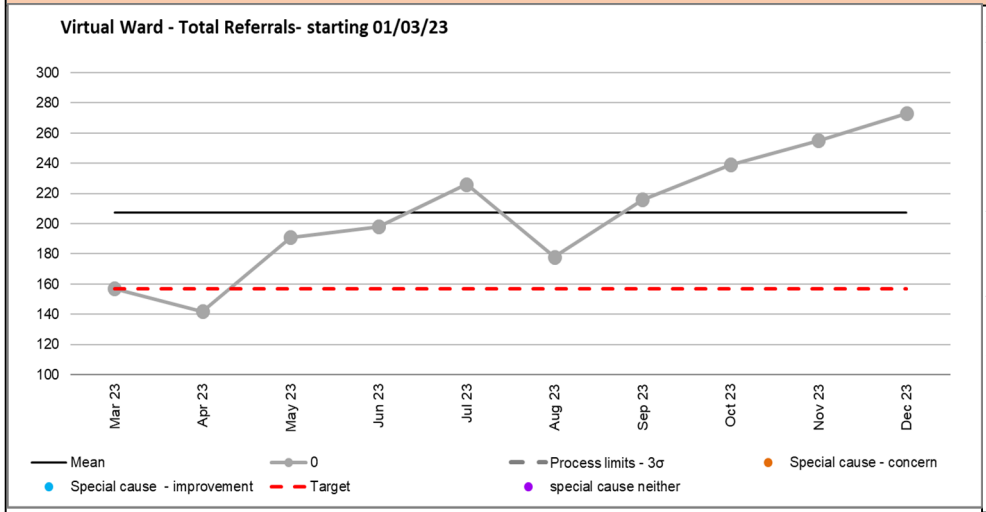
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: COLLABORATION

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

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



Analyst Narrative:

The adult virtual wards continued to offer 75 virtual beds covering respiratory, palliative care, hospital at home and frailty pathways during December. Referrals into the service remained below the service capacity.
Paediatrics currently have 10 virtual beds covering 6 different pathways to prevent / reduce hospital bed admissions . The majority of referrals have been for respiratory conditions (65%).
Baseline data for referrals into the virtual wards for March 2023 was: 157.
December 2023 reported 239 referrals.
The number of patients admitted has grown significantly since their inception providing a safe MDT led discharge pathway for patients making a positive impact on discharge pathways during Winter.
Funding of the Virtual Wards for 2023/24 has been confirmed at a reduced level.
The Virtual Wards are currently operating around 50% of their capacity although there was an increase in December during operational pressures. Work continues with Divisions in order to improve the utilisation of the wards to maximise their benefit.

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

Wards	Planned Go Live	Actual Go Live	Beds Plan	Actual Beds Open	Actual Admissions Dec 23	% Of Capacity Used	Step down vs Step up	Av. LOS (days)	% Face to Face contacts	No. of Readmissions
Acute Respiratory Infections	Jul 2022	Jul 2022	25	20	36	33%	34/2	5.2	95%	3
Palliative Care	Jul 2022	Nov 2022	15	15	42	65.3%	18/24	7.3	N/A	2
Hospital @ Home	Sep 2022	Dec 2022	20	20	43	53.5%	41/2	7.8	92%	4
Frailty	Jul 2022	Jan 2023	40	10	42	94.8%	40/2	7.3	93%	9
D2A	Nov 2023	Nov 2023	10	10	35	80%	31/4	7.4	96%	3

Executive Narrative:

The Virtual Wards are currently operating at just above 50% of their capacity. Work continues with Divisions in order to improve the utilisation of the wards to maximise their benefit. WHT has received national funding to expand its use of "Ask Earl". The planned expansion will enable the software to be used to stream patients into VW's through criteria led referral. It is anticipated that this will ensure that all appropriate patients can benefit from early supported discharge through these pathways.
The Paediatric VW continues to record several successes since its launch. The Team are now looking to increase utilisation with the introduction of additional pathways . A further pathway for home phototherapy (in collaboration with NCOT) has been approved through local governance and going through divisional governance with an expected start date of Spring 2024.
Admissions to Virtual ward have been reflective of lower admissions seen on the base ward during the month of January however the virtual ward team have been present in providing senior nursing support to the ward and PAU in times of need.
Virtual ward continues to receive very positive patient feedback via the docobo device. Discussions are taking place with Patient Experience regarding how this feedback can be captured and recorded within the Patient Experience framework.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: COLLABORATION

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

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

*D2A virtual ward is not reported within the national data.

Virtual wards have been launched utilising funding from the national program.
The wards operate mainly on a step-down approach for patients following an acute admission.

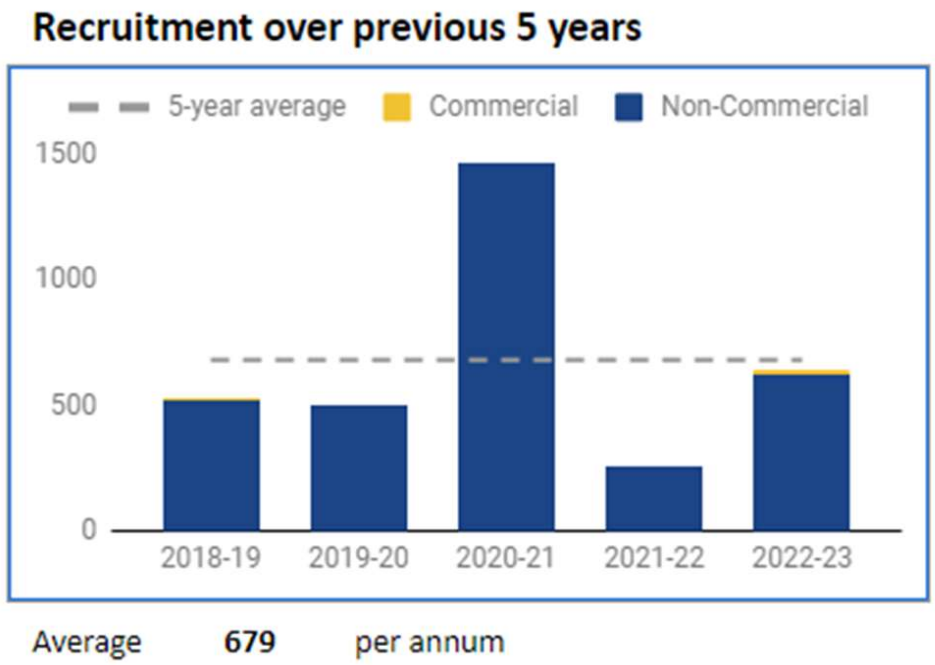
ACTION	BY WHO	BY WHEN
Expansion of Ask Earl	MLTC Team	Q4 (23/24)
Home phototherapy pathway	Paeds VW Team	Q1 (24/25)

Strategic Aim: COLLABORATION

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

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

Graph 1



Analyst Narrative:

The number of active researchers (AHP's, Midwives, Nurses, and Consultants) within the Trust is growing steadily along with the number of recruits into Commercial and Non-Commercial studies (refer to Graph 2&3). An increase year by year starting from the baseline of 2019/2020 (refer to Graph1). Growth of Commercial research within the Trust is meeting the target set following the Lord O'Shaughnessy recommendation of doubling the number of commercial recruits. Research activity continues to increase, with Commercial research (clinical trials) contributing most to this growth. Home grown research (research undertaken by staff) has also seen a sharp rise with more colleagues requesting support from R&D through their research journey, the number of staff undertaking potential home-grown trials has seen a sharp rise at the start of 2024.*-Nominated and shortlisted for the CRN WM Awards-Category-Trust Governance Teams (RWT & WHT) working in collaboration on the Vitiligo Dermatology Study.

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

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

*Participant Research Celebration Event took place on the 28th of November, very successfully event with approximately 20 research participants attending the event.

*Successful in obtaining additional funding from the CRN, this will enable FORCE to continue with the Maternity Hybrid post for another 12 months.

PI Master class planned for March 2024/ Introduction to research programme date set for June.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: COLLABORATION

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

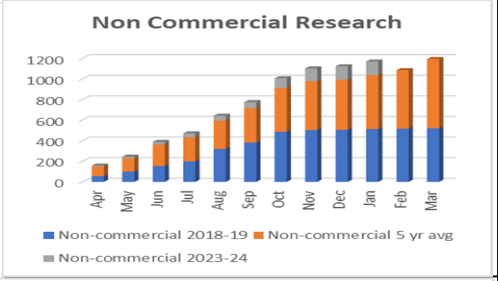
Board Level Metric(s): **Increase the number of researchers and participant numbers beyond the level of achieved in 2019/20 by March 24**

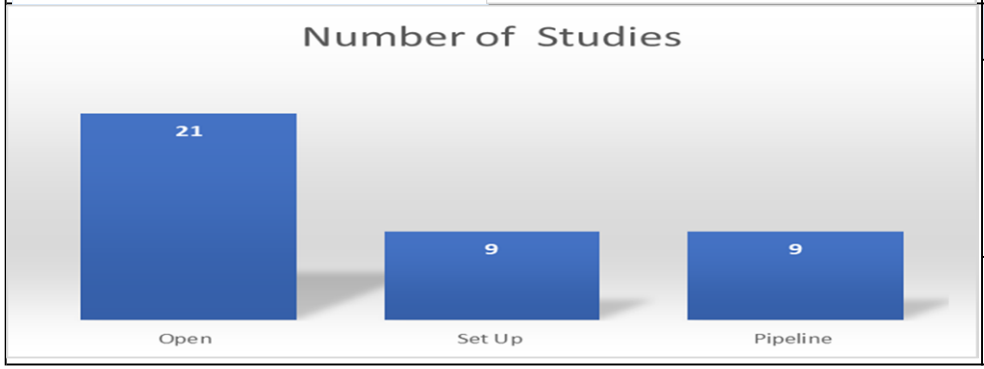
SUPPORTING INFORMATION

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

Graph 2

Graph 3





Executive Narrative:

*The Maternity Hybrid secured for another 12 months (funding received from the CRN), this will have massive implications for the growth and development of research within maternity services.

*Lead research nurse leaving at the end of Match, replacement post has gone out to advertisement.

*Growth of commercial trials continue to excel, however there is a risk that demand will outstrip staff to deliver studies.

*Working closely with Trust R&D partners in submitting collaboration bids, strategy planning, business development opportunities and planning for a research event October 2024.

ACTION	BY WHO	BY WHEN
Introduction to Research training programme - new date June 2024. To be shared across both Organisations	Catherine Dexter	Completed

Walsall Healthcare NHS Trust

Trust Board Meeting to be held in Public
14 February 2024

Title of Report	Charitable Funds Committee - Chair's Report	Enc 10.2
Author:	Paul Assinder	
Presenter:	Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	18th December 2023	

Action Required of Committee/Group			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☒	Yes☒No☐	Yes☐No☒	Yes☒No☐

Recommendations:

The Board are asked to note the contents of this summary report

ALERT

There are no matters to alert the Trustees to.

ADVISE

Fundraising
The Charity remains extremely active in events and fund raising. The Q4 noted Christmas festivities, Boxing and Fashion Show events. A cashless donations kiosk has now been installed in the Hospital Atrium.
The Walsall Mayor's Charity raised £12,000 for our Charity.

Areema Scholarship
The Committee approved the award of the second scholarship bursary to Sheila Kerai, who will commence second year nursing degree study in 2024/25.

Investments Portfolio
Brewin Dolphin manage a small investments portfolio on behalf of the Charity. During 2023/24 the Committee noted these reduced in book value marginally by £14,000 but income raised during the period (dividends etc) was £18,500, 2.63%. The portfolio's balance at 8th December was £706,000.

Approvals for Expenditure.

a) Below £5,000
The Committee reviewed spending under delegated authority totalling £28,801 in Q4.

b) Range £5,000 to £99,000
The Committee considered and approved 3 bids for spending over £5,000. These were:

i) Annual Recognition Awards (up to) £12,000*
ii) Christmas Chocolates for staff £7,500
iii) Patient TV replacements £13,423

- *The Committee asked that commercial sponsorship be sought to fund staff awards, with the Charity underwriting the event.*

ASSURE

2023/24 Charity Report & Accounts
These were reviewed and approved by the Committee, including the annual Letter of Representation to our auditors. Mazars have provided a 'clean' audit opinion on the Accounts and the Committee is grateful to the excellent finance team in the Trust, which supports the Charity.

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	Is Risk on Risk Register: Yes☐No☒ Risk Score (if applicable):		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led Standards
	NHSE	Yes☒No☐	Details: Well-led Standards
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	NHS Constitution	Yes☒No☐	Details: Well-led Standards, Licence assessment, Code of Governance
	Other	Yes☐No☒	Details:

Summary of Key Issues:

As noted above

Walsall Healthcare
NHS Trust

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Report Journey/Destination Significant follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

Walsall Healthcare NHS Trust

EXCEPTION REPORT FROM PERFORMANCE & FINANCE COMMITTEE CHAIR

MATTERS FOR THE BOARD's ATTENTION **Information, issues et.al that either require bringing to the Board's attention or that Board may need to deal with, any matters requiring Board delegation** None
ACTIVITY SUMMARY
Matters presented for information or noting As above
Chair's comments on the effectiveness of the meeting:

NHS
Walsall Healthcare
NHS Trust

Report to Trust Board – to be held in Public On Wednesday 14th February 2024		
Title of Report:	Group Chief Strategy Officer Report: - Black Country Provider Collaborative Update - Quality Improvement Team Update	Enc No: 10.3
Author:	Simon Evans - Group Chief Strategy Officer Report	
Presenter/Exec Lead:	Simon Evans	

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

Recommendations:

1. **Note the continued progress of the BCPC**
2. **To support QI Board Action plan**
3. **Note the progress on the green plan and acknowledge a costed delivery plan is being produced to support the delivery of all recommendations.**

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

Equality and Diversity Impact	None as a result of this paper		
Report Journey/Destination	Working/Exec Group	Yes☒No☐	Date: BCPC Executive Group
	Board Committee	Yes☐No☒	Date:

or matters that may have been referred to other Board Committees	Board of Directors	Yes☐No☒	Date:
	Other	Yes☒No☐	Date: Improvement and Research Sub-Group

Summary of Key Issues using Assure, Advise and Alert
Assure • • Work in the BCPC is progressing and senior clinicians and executives have oversight of all work programmes. • All divisions are actively engaged in improvement work, the reading room pack provides full details • Work continues with partners who have co-designed the Black Country Improvement approach, now working through this and our Wolverhampton and Walsall action plan to align the approach • 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 • The ICB operating model is progressing and will demonstrate the governance and delegated responsibility for each partner within the system including the BCPC • Division 1 held a successful leadership away day to improve their CI knowledge and skills and to define their priorities for improvement work for the coming year • Work continues on non-elective flow, learning from the junior doctor strikes and MADE events. • The first QI quarterly star was awarded to the Obstetric and Neonatal directorate recognising their investment in staff improvement training and several successful QI projects. • To highlight the new regulations and strategies that will impact on Trust resource in relation to the Greener NHS targets.
Alert • Discussions around the delivery of the Financial Recovery Plan are taking place across the BCPC. Resource will be required to support the implementation of the plan. • The QI team are retrospectively mapping the improvement work that they are supporting to the recently published strategic framework short term goals. This reveals an opportunity to better match support to organisational goals and could potentially inform the next round of strategic goal setting. • Investment will be required to fully deliver the requirements of the NHS green Plan – this will need to be risk assessed and prioritised

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards

Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Group Chief Strategy Officer Report:

Report to Trust Board Meeting to be held in Public on 14th February

EXECUTIVE SUMMARY

This report provides an update on three key areas of work:

- Black Country Provider Collaborative Update
- Continuous Improvement Team Update (Reading Room 10.3.1)
- Sustainability and Green Plan Progress Report (Reading Room 10.3.2)

Firstly, an update on the progress of the Black Country Provider Collaborative work programme. This covers the key meetings held over the period and provides an update on the relevant work streams.

Secondly, the report contains an update on the Continuous Improvement Programme. This demonstrates the continued good progress made with the collaborative approach with Walsall Healthcare NHS Trust and includes the NHS England maturity matrix self-assessment, which assesses the Trusts' state of readiness against the 5 domains for quality improvement. This has to be completed by all Trusts, approved by the board and returned by end of October 2023.

BACKGROUND INFORMATION

Section One: The Black Country Provider Collaborative (BCPC) Update – January 2024

The following are the key messages from the Black Country Provider Collaborative (BCPC) activities during January 2023.

a) Clinical Improvement Programme

- Appointed Anna Pierson (DGFT) as pre-operative medical optimisation lead for the BCPC, for a period of 6 months, Anna is linking with network leads for the programme of work.
- Centralisation of Bariatric Surgery at WHT (Walsall Healthcare NHS Trust) discussed at the last Clinical Leads Group (CLG). Awaiting a formal paper to articulate this with possible repatriation from Birmingham & Solihull (BSol), Stoke and Shrewsbury agreed in principle but need to agree further details.
- Further work still required to agree a Networked Service Solution for vascular and stroke services between SWBT (Sandwell & West Birmingham NHS Trust) and DGFT.
- Centralisation of renal robotics service to DGFT is work in progress, work to centralise MDT (multi-disciplinary team) at Dudley, discussion with RWT (Royal Wolverhampton NHS Trust) surgeon moving to Dudley.
- As part of modernisation of urological work, pelvic oncology work is to be centralised formally at RWT, which includes prostate cancer, mini prostate cancer and bladder cancer work, will become further facilitated with other developments.

- Percutaneous Nephrolithotomy (renal stone) work – looking to be centralised at either SWBH or DGFT. A formalised process is needed on how this decision will be made.
- Review of existing clinical leads and networks is underway, to ascertain need for future years work plan to retain a clinically led momentum. Important to recognise the excellent work that has been done through these Clinical Leads, and the significant improvement in trust and relationships across the system.

b) Corporate Improvement programme

- Payroll – looking at consistency work and ESR (electronic staff record) automation standards, investigating alignment within both areas. Exploring structures and benefits of WHT payroll team going to RWT.
- Procurement – Work ongoing to support MOU (memorandum of understanding) agreed with BC Metrics, savings, joint savings and workplans, work on track although limited due to SWBH focus on MMUH (Midland Metropolitan University Hospital). Focussing on Financial Recovery Plan (FRP) opportunities and joint work plan. PA Consulting work establishes a procurement board. Undergoing discussions with provider collaboratives with regards to this. Working with CFOs (Chief Financial Officers) on contract management case as part of the FRP.
- Mandatory Training – a draft business case is in development and will be presented to the Collaborative Executive shortly.

c) Financial Recovery Plan

All partners have now received the latest versions of the FRP along with a draft FRP Board paper. Work continues to refine and test the deliverability of proposed solutions with implications of proposals being reviewed for better understanding.

A joint meeting between the BCPC JPC (Joint Provider Committee) and the BC ICB (Integrated Care Board) is being pursued, with the possibility of a further joint Board workshop to be held in early March also being considered.

d) BCPC Case for Change

A ‘case for change’ is being developed as a key component of the service modernisation and transformation journey that the BCPC has commenced.

A draft will be circulated shortly for review and comment, and upon agreement will be followed by a (pre-consultation) strategic business case, alongside an overall modernisation / transformation timeline / map in due course.

e) Joint Board Development programme

A brief paper on the development of a Joint Board programme was shared. Request is that any suggestions for what might form part of these development sessions should be forwarded to lead Director for Governance as soon as possible.

Further discussion on reviewing suggestions to finalise a programme will take place at the February JPC.

f) Communications workstream

- ICB drafting a paper to establish a joint ‘JHOSC’ (Joint Health & Overview Scrutiny Committee), following this can have one single conversation with the four chairs of the four ‘JHOSC’.

- Awaiting the output of a 'listening exercise' undertaken by STAND (*this is the name of a company*), who have concluded their findings, with the report hopefully to be presented at February's meeting.
- Anticipation of pre-elective period from the 20th of March, in the process of establishing what we can and cannot do prior to this period.

g) Workforce Workstream

- The Collaborative Executive received a Closure report for the ESR (Electronic Staff Record) project, with lots of lessons to learn from and a clear set of recommendations to consider, which were agreed 'in principle'.
- The Collaborative Executive received a proposal for the pursuit of Centralised Recruitment Function as the next part of the consolidation work within the HR & Workforce. It was agreed to move forward in a two-stage process, starting with the delivery of the standardised model function with each partner Trust still having their own, and over time moving to a centralised approach with one Trust being the host/ leading organisation.

h) Black Country Operating Model Implementation

The latest version of the draft BC Operating Model was shared with the Collaborative Executive, with concerns expressed despite comments being made. It was stated that this was more of a 'governance and decision making' structure than an Operating model, but that we would continue to work with the ICB in an iterative way to make local arrangements workable.

Section Two: Continuous Improvement Update.

1. Delivering Continuous Improvement DCI Review[1] – NHS Impact

1.1

Dr Amar Shah (Chief Quality Officer & Consultant Psychiatrist) from East London Foundation Trust has been appointed as the National Clinical Director for Improvement (NHSE) and will be part of the National Improvement Board. The aims of the National Improvement Board are as follows:

- Promote NHS vision and aims
- Inspire and encourage trusts, places systems on improvement journeys
- Strengthen delivery of key priorities using an improvement led focus
- Mobilise network of support partners
- Engage, support and encourage NHS England's improvement journey

1.2

A monthly Improvement Directors Network has been established (1st meeting February) which will be a forum for director-level improvement leads in each provider, system, and region, chaired by Dr Shah. Mr Simon Evans will represent both trusts and will also meet Dr Shah, along with members of the CI team, in April 2024 to discuss the progress of our organisations, learning from the self-assessment process, and to discuss future opportunities.

1.3

The national lead for the NHS Annual Staff Survey has mapped the 5 domains of the NHS Improvement Review as they have a strong emphasis on human factors, such as leadership behaviours, culture, and staff engagement.

There is an opportunity to draw on existing, publicly available data from the NHS national Staff Survey to map certain questions to the five domains to provide insights on the extent to which these are in place and to track progress over time. Progress has been made to develop and test this tool so this information can be used to validate the 'maturity self-assessment' against the five elements of the Impact improvement approach to support an evidence-based response.

2. **QI Board Action plan updates**

- Four volunteers have been recruited at WHT to be the patient voice on QI projects and provide the lived experience referred to and encouraged in NHS Impact domains. They will undertake QSIR Practitioner training and receive an induction into the team, the recruitment process was done in conjunction with the Patient Experience team lead.

- The joint Behavioural framework has been updated to include the following: 'To be Professional, I will….. *Get involved in improvement, sharing my ideas and learning.*

- Monthly QI Forum – The QI Team are developing, with staff, the format of a monthly QI forum with the objective of sharing learning internally and across organisations. The idea is taken from the Virginia Mason programme where all executives hear presentations from teams who are doing, or have finished QI projects. It is emphasised by NHS Impact ie. organisations need a forum to share learning and celebrate successes but learn from projects that may not have gone so well. This will be a joint forum across both trusts which will be powerful.

- **Role descriptors/annual appraisal etc**

  Role descriptors have been developed by the Black Country Improvement System with a proposal to adopt these across all 4 acute trusts (paper to be submitted to Executives for approval). This emphasises to staff moving within the system that 'this is how we do things around here'. The proposal includes a generic statement for all trusts to include within JDs prospectively.

Section Three: Sustainability and Green Plan Progress Report

As of December 2023, the Trust remains on course to deliver 17 of the 19 deliverables. Two of the deliverables remains unlikely to be delivered. These are:

1. Ensuring that the region's owned and leased fleet is made up of at least 90% Low Emission Vehicles. Including 11% of the fleet being made up of Ultra-Low Emissions (ULEV) and Zero Emission Vehicles (ZEV) by March 2024
2. 25% reduction of inhaler carbon footprint

Between 1 April – 31 October 2023, Entonox usage decreased compared to the same period in 2022. Should this trend continue, the Trust will be on course to deliver the 19-23% reduction in Entonox use.

Capital funding will be required to transition 90% of the Trust owned and/or leased vehicles to Low Emissions Vehicle (LEV). The timeframe to deliver 25% reduction in inhaler carbon footprint is too narrow given that there less than 3 months left of the financial year.

.

Green Plan implementation

1. As of 30 November 2023, the proportion of desflurane used in surgery is at 0% below the 2% national target. The Trust will continue implement the reduction measures to remains within the national target.
2. Nitrous Oxide usage is higher than the same period in 2022. Theatre Services has started a pilot project to switch from piped nitrous oxide supply to cylinders and should prove successful, it will be expanded to the remaining theatres. This project will address the issue of waste from the piped system and reduce the volume of use. A study conducted early last year, showed that 97% of the nitrous oxide used in the Trust are wasted through the piped delivery system.
3. Procurement and Supply Chain - 100% of organisations have 10% net zero and social value included in every tender. The Trust is compliant with this requirement and continues to work with suppliers.
4. Sustainability initiatives implemented by the greening services teams are still ongoing. Some are expected to deliver both carbon reduction and cost improvement by 31st March 2024
5. On 21 October 2023, the Department for Environment, Food and Rural Affairs (Defra) announced new food waste disposal measures. The new rules state that recycling through composting or anaerobic digestion will be the only approved method for food waste management. Therefore, prohibiting food waste from being sent to landfill or incineration alongside general waste. It is also not permitted to macerate or digest food waste. Current Trust practice is disposal through maceration at ward kitchen level and incineration at production level which is now prohibited.
   The Trust Catering Department and Waste Management and Recycling Services ran a successful pilot food disposal scheme in selected areas in Manor Hospital to determine the best way to collect, store and dispose of waste to comply with the new measures. The success of the pilot enabled the expansion of the scheme to all wards and areas within Trust premises where food is served. Violia has won the contract to recycle the food waste which will be converted to energy and fertiliser. The contract cost is a revenue cost pressure for the Trust catering department. A full calculation of the impact of this new measure to the Trust s and carbon emissions will be available after 6 months of implementation.
6. Updated guidance on the application of the Carbon Reduction Plan (CRP) and Net Zero Commitment (NZC) requirement has now been published on NHS England website. These requirements are part of the NHS net zero supplier roadmap, which ensures that the NHS Supply Chain plays its crucial part in helping NHS become a net zero health service by 2045.
7. NHS England Net Zero Travel and Transport strategy was published by NHS England on 31 October 2023. The strategy will enable the NHS to have a fully decarbonised fleet by 2035, with its ambulances following in 2040. Several key steps will mark the transition of NHS travel and transportation:

    - **By 2026**, sustainable travel strategies will be developed and incorporated into trust and integrated care board (ICB) green plans.
    - **From 2027**, all new vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances).
    - **From 2030**, all new ambulances will be zero emission vehicles.
    - **By 2033**, staff travel emissions will be reduced by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles.
    - **By 2035**, all vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances) and all non-emergency patient transport services (NEPTS) will be undertaken in zero emission vehicles.
    - **In 2040**, the full fleet will be decarbonised. All owned, leased, and commissioned vehicles will be zero emission.

There is no central funding support to implement the strategy. Each Trust is expected to fund the transition through its own resources.

8. ***Clinical Waste Strategy***
   The Trust recently appointed a waste manager who is tasked to manage the implementation of the Trust Waste Strategy as well as ensuring the Trust waste management systems and practices are in line with the national strategy.

Improving the waste management and regulatory compliance will require revenue investment in training and acquisition of the correct bins. Capital investment is also required to improve and secure the Trust waste yard. Without this investment, the Trust will continue to be non-compliant with its waste management duty of care. An options paper will be produced in due course.

Action priorities of the next 6 months are the following:

1. Update Green Plan carbon reduction targets and action plan to reflect results of sustainability initiatives by 30 April 2024
2. Provide progress on the carbon reduction delivered by sustainability initiatives.
3. Recruit clinical and non-clinical services in “Greening Services Scheme”.
4. Complete roll out of food waste disposal and recycling scheme to comply with disposal regulations
5. Roll out mixed recycling and waste segregation
6. Develop an options appraisal for nitrous oxide/Entonox destruction technology
7. Publish EV charging strategy

These priorities may require both revenue and capital funding as well as other resources such as staffing.

RECOMMENDATIONS

1. **Note the continued progress of the BCPC**
2. **To support QI Board Action plan**
3. **Note the progress on the green plan and acknowledge a costed delivery plan is being produced to support the delivery of all recommendations.**

References to Reading Room Information/Enclosures:

a) **QI quarterly update including action plan**
b) **Sustainability pack**

Quality Improvement Team

ENC 10.3.1

Appendix One

NHS

Quality Improvement Team Update

September 23 – January 24, Financial Year 2023/24

Quality Improvement Team
Joyce Bradley – Head of Quality Improvement

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

Care Colleagues
Collaboration Communities

Content

Care Colleagues Collaboration Communities

Executive Summary

- A busy period of the year that saw the QI team deliver in-house training, training to regional teams and delivery to national groups on QI methodology to undertake improvements
- NHS England passed the QSIR Programmes – the cornerstones of the QI offer at Walsall, to a Not-for-profit organisation – Advancing Quality Alliance (AQUA). Moving forward there will be a cost to the organisation to continue to use the QSIR Programmes.
- Following the above change to the QSIR offer and visit to Leeds Teaching Hospital NHS Trust to understand their approach to Improvement, the QI team have been working on how to encompass more of these tools as well as Health Care Systems engineering into the QI offer for Walsall, initially with a view to expanding across both organisations if appropriate.
- The development of the Walsall Improvement Programme is still progressing, with the first two days being delivered late January (24th and 25th). The first pilot programme will complete in mid-march 2024.
- The team has been busy supporting the facilitation of Improvement sessions across the different divisions as well as corporately.

Update from the Divisional QI Leads

- WCCSS – Work progressing on Osteoporosis fractures project, developing a consistent approach across the Division including development of a local Quality Management System for coordinating Quality Planning, Quality Control and Quality Improvement.
- Surgery – additional support requested for Colorectal surgery, Pre-operative Assessment and T&O surgery.
- Community – 2 Community Divisional Clinical Leads appointed in September – Dr Esther Waterhouse and David Powell. An event was held to promote QI across the division and sought updates on existing registered projects.
- Medicine & Long Term Conditions – 2 MLTC Divisional Clinical leads were appointed in September – Dr Jamil Aslam and Natasha Gallagher. They been promoting the training and the registering of QI projects
- QI Clinical Fellow – Working on the Colorectal surgery pathway and development of template certificates for recognising medical contributions to QI Projects that reflect the curriculum requirements.

Care Colleagues Collaboration Communities

Capacity & Capability

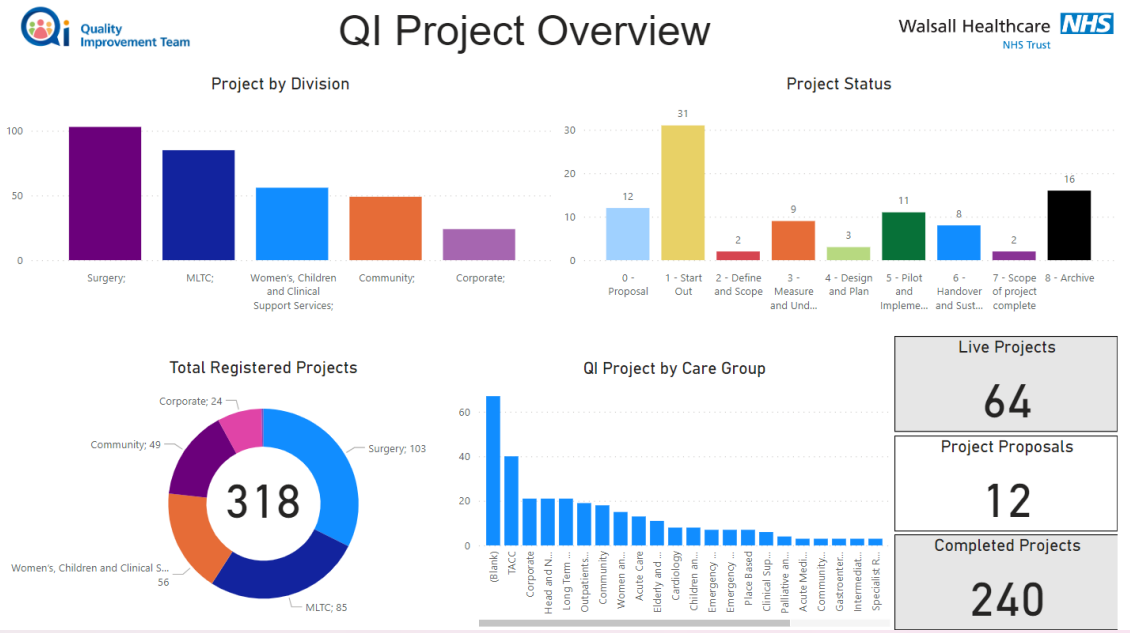
QI Training Delivery

- QSIR Practitioner Cohorts 20 and 21 have commenced and completed during this report interval. 21 delegates completed the programme and 12 need to complete one or two days with the next cohort.
- Bespoke QI Training was delivered through September – December for the Information and Performance teams from across both organisations. This was an opportunity for them all to meet face to face as well as broaden their knowledge and understanding of QI.
- QSIR Fundamentals and Virtuals cohorts continued to be delivered along with the Facilitation of ad hoc sessions a variety of teams to identify improvements to services.
- During November we delivered a QSIR Fundamentals which was specifically for Library & Knowledge managers – from across the country
- A QI session as part of the National Library & Knowledge Management Leadership Programme

Capacity & Capability – continued (1)

QI Projects and Registering them

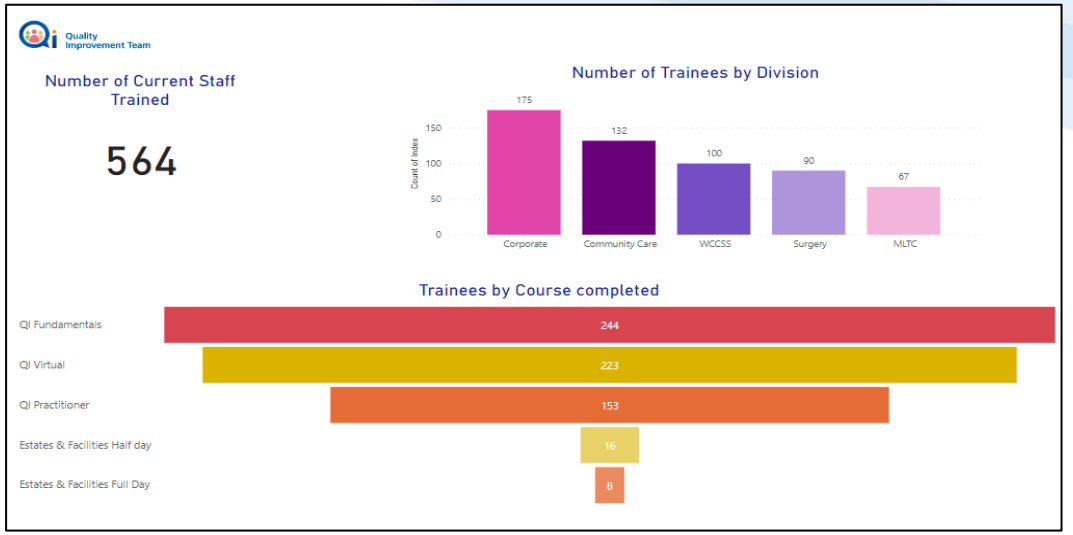
- All historic and live/active QI projects known to the QI Team have been uploaded to the registry
- During Q4 the QI Team has finalised elements of the Project part of the Registry so that Wolverhampton can record their projects in the same system.
- DIT induction included a session from the QI Team to show the new colleagues where to identify ideas for QI work and to see what has already happened.
- Development of dedicated programme of training for Doctors in Training

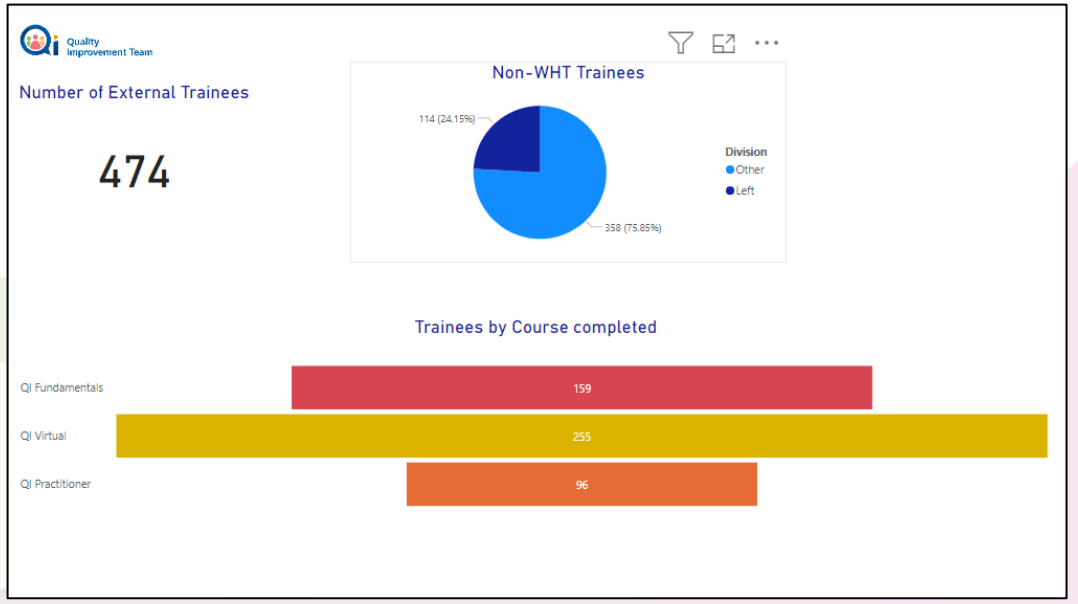


Capacity & Capability – Continued (2)

QI Training – Monitoring Progress

- The total number of Walsall Healthcare staff who have undertaken QSIR Training is 564 which brings us to 12.5% of our staff.
- The register counts individuals once whether they have undertaken more than one programme (i.e. a count of delegates on the courses will be larger than the total).
- This number excludes the staff who have left the organisation (114) or are not employed by WHT (358).
- Staff external to WHT have included colleagues from Sandwell & West Birmingham, Black Country Healthcare NHSFT, Dudley Group NHS FT, NHS England Regional Team, RWT and Birmingham Community NHSFT.

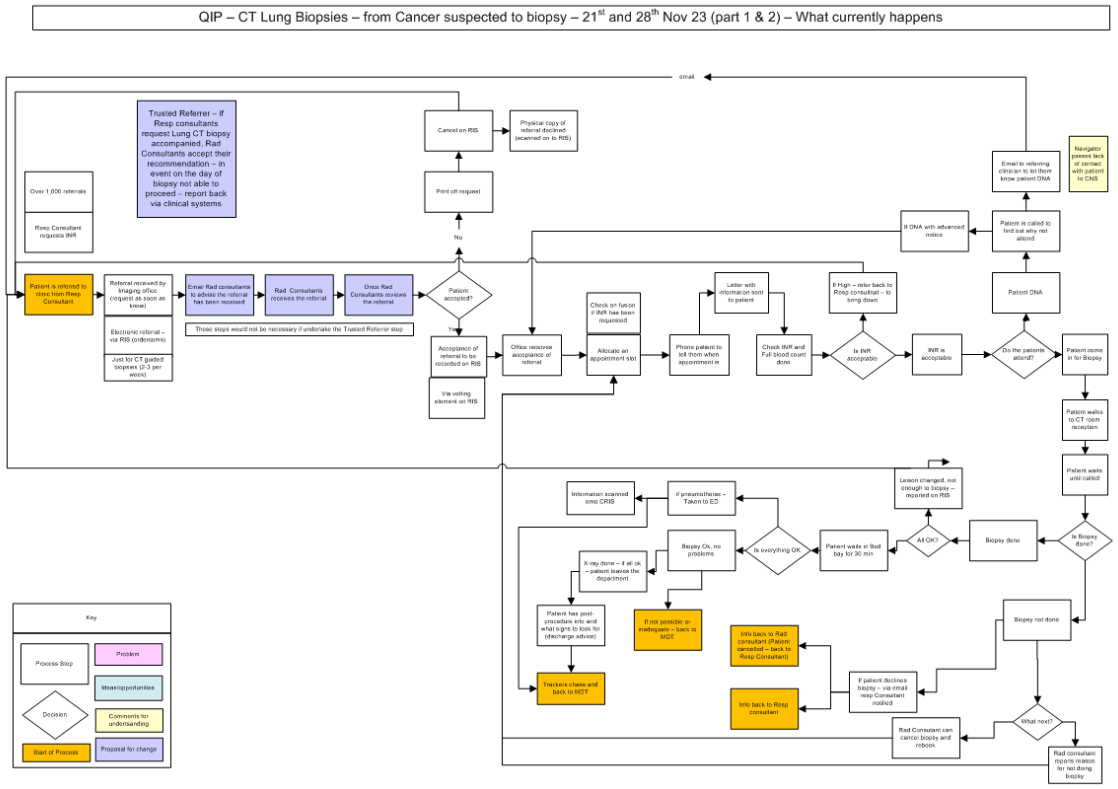




Patient Flow and Staff Engagement

Facilitation of Sessions

- September - Facilitated ICB Discharge event
  First 2 sessions of bespoke QI training for Information & performance
- October – QI presentation to new consultants
  QI Huddle board training for ward pilot areas and installation for wards, Portering services, AMU.
- November – sessions Process mapping CT guided biopsies – 2 (see right)
  Community prehabilitation meeting, discussion on data, look at Surgery Hero app for pre-op assessment
  Day Hospice – survey and data collection for QI projects
  Podiatry – discussion on data, completion of Driver diagram and sustainability tool
-



Patient Flow and Staff Engagement – Continued (1)

Facilitation of Sessions continued

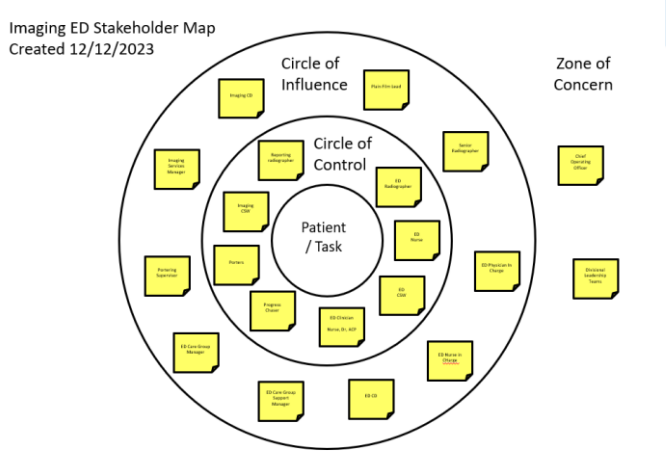
- December - Completed final 2 sessions for Information & Performance

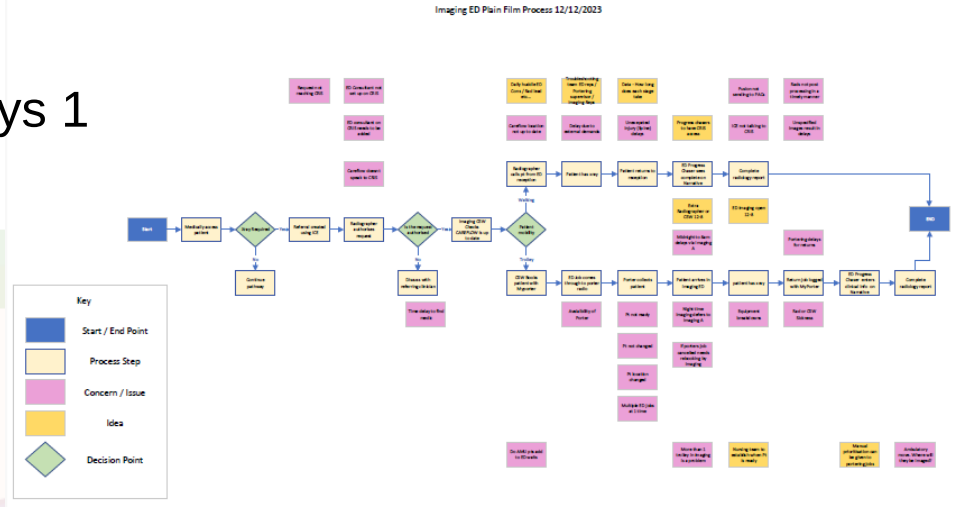
  Stakeholder and process mapping for ED Imaging patient pathway (see right)

- January 24 - Second ED Imaging process mapping session

  HCSE Flow workshop delivered to multi-professional audience

  Pilot of the Walsall Improvement Programme (days 1 & 2)

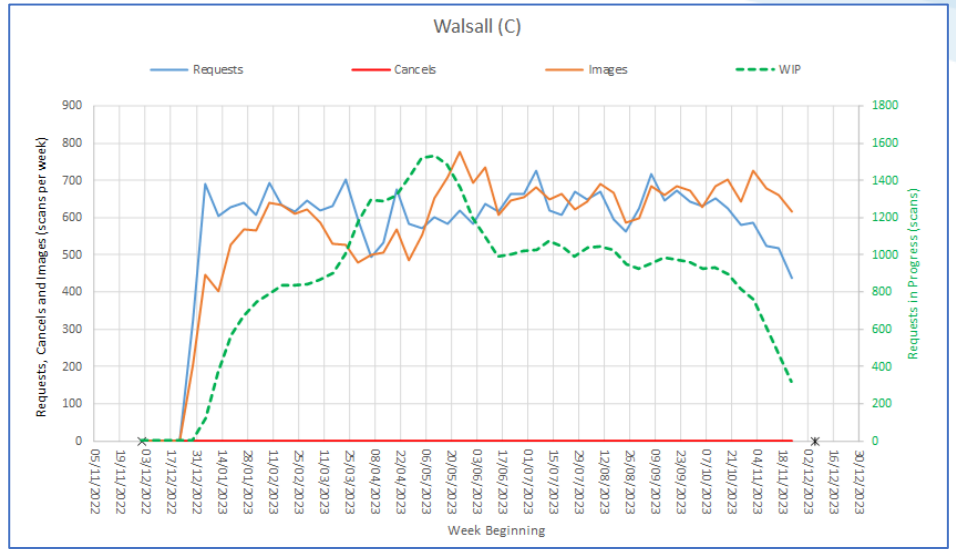


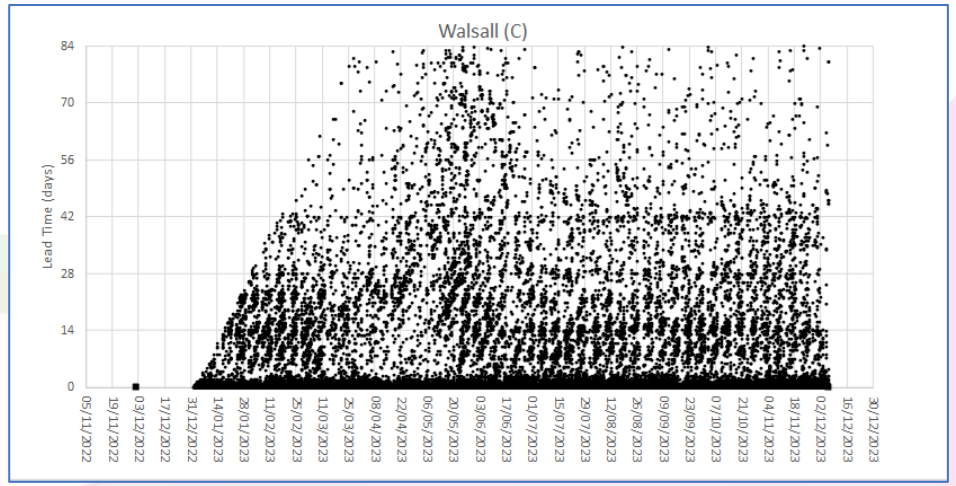


Patient & Work Flow – CT scanning

Health Care Systems Engineering (HCSE) – Imaging

- Our two Level 1 HCSEs are working with Imaging to look at the flow and utilisation through the CT scanner used for In-patients and ED.
- The charts to the right are the Work in Progress (Green line), Requests (blue line) Cancellations (red – at zero) and the images taken (yellow line).
- The activity undertaken shown in the scatter diagram on the right (bottom chart). The data extract wasn't complete which is evidenced by the blank section to the left of the chart.
- The chart shows the urgent cases (dark line at the bottom), then there is a discernible stratification to fall in line with booking policies (7, 14, 28 days and non-urgent). The faint clear diagonal lines are the tracking from weekends.
- The team are working with the PACS and clinical systems team to extract the full data.





Patient & Staff Safety

QI Huddle Boards

- The QI Huddle boards continue to be an intervention which teams want to apply within their area.
- Discussion have been held to look at merging the Quality Team's Quality & Improvement Board with the QI Huddle Board and a Pilot of the QI Huddle Board had been agreed. This will look at the other elements that are then required. This will be piloted on 3 test wards at both WHT and RWT, commencing in September
- The ongoing support to those areas with huddle boards will be provided by members of the QI team or the members of the Improvement Team aligned to that division.

Location	Status	Lead	Division
Neonatal Unit	Active	Sue Worsey / Dr T lane	WCCSS
Gynaecology OPD	TBC	Shanna Fletcher	WCCSS
Delivery Suite	Active	Erica Birch / Emma Doherty	WCCSS
Ward 25 Post Natal Care	Active	Patricia Stych	WCCSS
Imaging	Active	Tracy Matthews	WCCSS
Strategy and Planning	Active	Roseanne Crossey	Corporate
North Locality	Active	Marie Grice	Community Care
South Locality	Active	Zoe Allen	Community Care
East Locality	Active	Liam Myrie	Community Care
West Locality	Active	Debbie Emery	Community Care
0-19 Service	Active	Vicky Bailey	Community Care

Location for Planned Boards	Lead	Proposed Start	Training Status
Portering Services	Damian Jones	Aug 2023	Complete
Performance and Information	Amanda Cater	Aug 2023	Complete
Test Ward 1 – Ward 16	Andrew Lathe	Sep 2023	TBC
Test Ward 2 – Ward 10	Claire Cooper	Sep 2023	TBC
Test Ward 3 - AMU	Melissa Perry	Sep 2023	TBC
Ward 20A	Claire Keeling	Sep 2023	
ITU	Xana Marriott	2023	Partial Completion

Developing the QI Team

Team Development Sessions and other Training

- The QI team at Walsall are pleased to announce that there is another colleague who has undertaken the Accreditation process to be able to deliver the QSIR Programmes. Lee Sealey from the Improvement team, who has a strong background in QI and delivering training will join the delivery team as we move into the new financial yar
- The December 2023 development Session of the wider QI Team focussed on aligning the Board QI Plan with NHS IMPACT five domains for development.
- During December – four Patient Quality Improvement Partners were recruited who will commence the same training as staff and will join teams to be the patient voice in QI projects, once their induction and training is complete.
- The HCSE Programme had enabled 10 colleagues across the organisation to access a foundation Health Care Operations Management at no additional cost. Seven staff have completed and the final three are part-way through this programme.

Plans for January 2024 onwards

Capacity & Capability

- Delivery of Health Care Systems Engineering Flow workshop – a one-day session on improving patient flow in planned care.
- Continue the development of the Black Country Improvement System (BCIS) to confirm how the providers in the Black Country will work collaboratively to support improvement work across the system.

Patient Flow

- Embed HCSE Level 1 tools and consolidate learning by applying them to live projects including CT Scanning and plain film X-ray pathway in ED. These are cross division projects that will include the Divisional QI Leads and the Improvement Team Divisional support.
- The West Midlands Regional Imaging Network have contacted the team for oversight of what is being done within CT imaging
- To map a number of agreed Outpatient clinics with a view to supporting the improvement of flow.

Capacity & Capability – Training FY 2023-24 and beyond

Training Schedule for the rest of 2023-24 and into 2024-25

- The final cohorts of QSIR Practitioner for FY 23-24 commenced in January 2024. Fundamentals continued to be offered every other month and Virtual in between to ensure everyone has access to some level of QI training.
- Woking with the MLCC Education Centre we have identified training dates for a further 7 cohorts of the 5 day programme through FY 24-25
- Health Care Systems Engineering (HCSE) Flow sessions will take place throughput the year
- A training package on ‘Making Data Count’ with a specific emphasis on understanding SPC charts and measurement will be developed during Q1 FY24-25 – target audience is Care Groups
- Working with system partners to ensure equal access to QI training across the system for colleagues and that our training offers are complementary, building on the same underlying principles – measurement over time, the Model for Improvement and engaging stakeholders being the key elements.

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public On 14th February		
Title of Report:	Sustainability Report	ENC 10.3.2
Author:	Janet Smith - Head of Sustainability	
Presenter/Exec Lead:	Simon Evans – Group Chief Strategy Officer	

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

Recommendations:

The Committee is asked to note and discuss the:

- 2023-24 Greener NHS nationally and regionally set priorities and deliverables Trust position as of 31 December 2023 and the resources required to deliver the priorities.
- Trust Green Plan implementation progress

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Lack of resources to transition the Trust owned and leased vehicles to Zero Emissions Vehicle (ZEV) and the EV infrastructure required to support such transition On Risk Register: Yes☐No☒ Risk Score (if applicable):		
Changes to BAF Risk(s) & TRR Risk(s) agreed.	State None if None Risk Description Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	(if none, state 'none') Revenue: Compliance with the new Clinical Waste Strategy will result in revenue cost pressure for Estates & Facilities Division Capital: Capital required to transition Trust owned and leased vehicles to ZEV, the installation of EV infrastructure to support the ZEV transition and installation of nitrous oxide and Entonox destruction technology. Workforce: Funding Source: To be decided		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details: Safe, effective, and well-led
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☒No☐	Details: Compliance with new Clinical Waste Standards
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

NHS
Walsall Healthcare
NHS Trust

Equality and Diversity Impact	There are no legal or equality & diversity implications associated with this paper		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
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.
• To advise on the ability of the Trust to deliver the 2023-24 Greener NHS national and regional deliverables and priority areas • To highlight the capital and revenue investment requirements to deliver the Green Plan. • To strengthen the working relationship with the Black Country ICS Sustainability Network, Midlands Net Zero Delivery Hub, and other national and international Sustainability Groups to maximise opportunities for shared learning and best working practices.
To note, react and adapt to emerging factors affecting the delivery of Sustainable Healthcare in the next five years

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint of clinical services by 1 April 2025
Effective Collaboration	• Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall

Walsall Healthcare NHS Trust

Sustainability Report

Report to Trust Board to be held in Public/Private on 14th February 2024

Brief/Executive Report Details	
Item/paragraph **1.0**	**PURPOSE OF REPORT** The purpose of the reports is to provide an update on: 1. Progress of the Trust compliance to the requirements and priorities of the Greener NHS agenda including an update on 2023/24 national and regional priorities and deliverables 2. Green plan implementation 3. National Clinical Waste Standards 4. Action priorities in the next 6 months.
2.0	**2023/24 Greener NHS National and Regional Priorities and Deliverables** As of December 2023, the Trust remains on course to deliver 17 of the 19 deliverables. Two of the deliverables remains unlikely to be delivered. These are: 1. Ensuring that the region's owned and leased fleet is made up of at least 90% Low Emission Vehicles by March 2024. Including 11% of the fleet being made up of Ultra-Low Emissions (ULEV) and Zero Emission Vehicles (ZEV) by March 2024 2. 25% reduction of inhaler carbon footprint Between 1 April – 31 October 2023, Entonox usage was 2,577,440litres with a carbon emission of 640tCO2e, a 24% decrease in usage compared to the same period in 2022. Should this trend continue, the Trust will be on course to deliver the required 19-23% reduction in Entonox use. Capital funding will be required to transition 90% of the Trust owned and/or leased vehicles to Low Emissions Vehicle (LEV). The timeframe to deliver 25% reduction in inhaler carbon footprint is too narrow given that there less than 3 months left of the financial year.
3.0	**Green Plan implementation** 1. ***Reduction of the proportion of desflurane used in surgery to less than 2% of overall volatile anaesthetic gases by volume by 31 March 2024***. As of 30 November 2023, the proportion of desflurane used in surgery is at 0% below the 2% national target. The Trust will continue implement the reduction measures to ensure that the level of use remains within the national target. 2. ***19-23% Reduction in emissions from Nitrous Oxide by 31 March 2024***. As of 31 October 2023, Nitrous Oxide usage was 610,200 litres with a carbon emission of 299 tCO2e. This is higher than the same period in 2022. Theatre Services has started a pilot project to switch from piped nitrous oxide supply to cylinders and should prove successful, it will be expanded to the remaining theatres. This project will address the issue of waste from the piped system and reduce the volume of use. A study conducted early last year, showed that 97% of the nitrous oxide used in the Trust are wasted through the piped delivery system. 3. ***Procurement and Supply Chain-100% of organisations have 10% net zero and social value included in every tender.*** The Trust is compliant with this requirement and continues to work with suppliers to implement PPN06/21. 4. ***Greening Services Scheme.*** Sustainability initiatives implemented by the greening services teams are still ongoing. Some are expected to deliver both carbon reduction and cost improvement by 31st March 2024 5. ***Food Waste Regulations 2023*** On 21 October 2023, the Department for Environment, Food and Rural Affairs (Defra) announced new food waste disposal measures. The new rules state that recycling through composting or anaerobic

digestion will be the only approved method for food waste management. Therefore, prohibiting food waste from being sent to landfill or incineration alongside general waste. It is also not permitted to macerate or digest food waste. Current Trust practice is disposal through maceration at ward kitchen level and incineration at production level which is now prohibited.

The Trust Catering Department and Waste Management and Recycling Services ran a successful pilot food disposal scheme in selected areas in Manor Hospital to determine the best way to collect, store and dispose waste to comply with the new measures. The success of the pilot enabled the expansion of the scheme to all wards and areas within Trust premises where food is served. Violia has won the contract to recycle the food waste which will be converted to energy and fertiliser. The contract cost is a revenue cost pressure for the Trust catering department. A full calculation of the impact of this new measure to the Trust finances and carbon emissions will be available after 6 months of implementation.

6. ***Procurement. From this 1st of April 2024, the NHS will proportionally extend the NHS Carbon Reduction Plan requirements to cover all procurements***. An updated guidance on the application of the Carbon Reduction Plan (CRP) and Net Zero Commitment (NZC) requirement has now been published on NHS England website. These requirements are part of the NHS net zero supplier roadmap, which ensures that the NHS Supply Chain plays its crucial part in helping NHS become a net zero health service by 2045.
7. ***NHS England Net Zero Travel and Transport strategy*** was published by NHS England on 31 October 2023. The strategy will enable the NHS to have a fully decarbonised fleet by 2035, with its ambulances following in 2040. Several key steps will mark the transition of NHS travel and transportation:

    - **By 2026**, sustainable travel strategies will be developed and incorporated into trust and integrated care board (ICB) green plans.
    - **From 2027**, all new vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances).
    - **From 2030**, all new ambulances will be zero emission vehicles.
    - **By 2033**, staff travel emissions will be reduced by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles.
    - **By 2035**, all vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances) and all non-emergency patient transport services (NEPTS) will be undertaken in zero emission vehicles.
    - **In 2040**, the full fleet will be decarbonised. All owned, leased, and commissioned vehicles will be zero emission.

    There is no central funding support to implement the strategy. Each Trust is expected to fund the transition through its own resources

8. ***Clinical Waste Strategy***

    The Trust recently appointed a waste manager who is tasked to manage the implementation of the Trust Waste Strategy as well as ensuring the Trust waste management systems and practices are in line with the national strategy.

    Improving the waste management and regulatory compliance will require revenue investment in training and acquisition of the correct bins. Capital investment is also required to improve and secure the Trust waste yard. Without this investment, the Trust will continue to be non-compliant with its waste management duty of care.

4.0	**Action priorities of the next 6 months are the following:** 1. Update Green Plan carbon reduction targets and action plan to reflect results of sustainability initiatives 2. Provide progress on the carbon reduction delivered by sustainability initiatives. 3. Recruit clinical and non-clinical services in “Greening Services Scheme”. 4. Roll out furniture, medical devices and equipment reuse scheme 5. Roll out mixed recycling and waste segregation 6. Develop an options appraisal for nitrous oxide/Entonox destruction technology 7. Fully implement the These priorities will require both revenue and capital funding as well as other resources such as staffing.
5.0	**RECOMMENDATIONS** To discuss and note the 1. Greener NHS 2023/24 national and regional priorities and deliverables and the delivery resource implication of each priority target 2. Food waste regulations compliance 3. Green Plan implementation progress 4. Procurement guidance on the application of the Carbon Reduction Plan (CRP) and Net Zero Commitment (NZC) requirement 5. Action priorities in the next 6 months

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14th February 2024		
Title of Report:	Trust Board Metrics Report – Improve the health and wellbeing of our communities	Enc No: 11.1
Author:	Author - Amanda Cater, Head of Performance	
Presenter/Exec Lead:	Stephanie Cartwright, Group Director of Place	

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

Recommendations:

Board members are asked to note the contents of the report and note that further details are reported within subcommittee papers.
Areas for focus are included within subcommittee highlight reports.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☐ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :	Any risks associated with individual metrics within the report will be noted within the appropriate sub-committee papers.	
Changes to BAF Risk(s) & TRR Risk(s) agreed	State: **None**		
Resource Implications:	(if none, state 'none') Revenue: **None** Capital: **None** Workforce: implications associated with the capture and reporting of performance data. Funding Source: **None**		
Report Data Caveats	This is a standard report using the previous months or most recent data. It may be subject to cleansing and revision. The report relies on timely and accurate data recording in corporate systems and, for data provided outside of corporate systems, timely provision of the data to the Performance Team for incorporation into the report		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Effective, Caring, Responsive, Well-led
	NHSE	Yes☒No☐	Details: Publication PRN00196 Elective care prioritise 2023/24
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☒No☐	Details: NHS contractual requirements
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee		

	business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Introduction

'Board Level Metrics' are a rationalised set of priority metrics for the Board to focus on. The metrics align against our four strategic objectives (Care, Colleagues, Collaboration and Communities) and our Vision. Whilst this is a rationalised set of metrics to generate higher quality discussions and assurance, we also monitor a considerable number of metrics within subcommittee papers. Highlight reports from each committee are included for Board focus. This report includes data in Statistical Process Control (SPC) charts using the NHS 'Make Data Count' style of reporting. Further detail on how to interpret SPC charts icons is explained in the final page of this report. This is the second time this new report has been produced; the content will evolve over time. This report replaces the previous IQPR – Integrated Quality and Performance Report.

Please refer to subcommittee highlight reports for areas of Assure, Advise and Alert

Trust Board Metrics - Key Objectives

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L		Cancer - No. of patients waiting 63+ Days for treatment (CARE) MSFD - Average number of Medically Fit for Discharge Patients in WMH (COMMUNITIES)	18 Weeks RTT - Number of 78 Week Breaches (excluding patient choice) (CARE)	
		Urgent Crisis Response (UCR) - 2 Hour Response Rate (CARE) Vacancy Rates - Overall (COLLEAGUES) Virtual Ward - Total Referrals (COLLABORATION)	18 Weeks RTT - Number of 65 Week Breaches (CARE)	
H / L		ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival (CARE)		

Dashboard metrics for the below Objectives do not contain enough data points to populate the above matrix - Please see exception page for further detail

- Carbon Footprint - 5% reduction in the carbon footprint (COMMUNITIES)
- R&D - Number of Recruits - Commercial (COLLABORATION)
- R&D - Number of Recruits - Non Commercial (COLLABORATION)

Dashboard metrics for the below Objectives are currently in development

- 10% increase on previous year in the percentage of staff responding positively in the annual staff survey when asked if they are able to suggest and make improvements in their area (CARE)
- Delivery of the agreed financial plan (CARE)
- Deliver an improvement on 2022/23 in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing by March 2024 (COLLEAGUES)
- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged (COLLEAGUES)
- Deliver an improvement on 2022/23 in Workforce Equality Standard performance by March 2024 (COLLEAGUES)
- Identify, implement and report on a agreed set of outcome measures for each of the projects within the provider colloborative programme (COLLABORATION)
- Develop and implement a Health Inequalities Strategy with measurable outcomes in 2023/24 (COMMUNITIES)

NHS
Walsall Healthcare
NHS Trust

Trust Board Metrics - COMMUNITIES Dashboard

KPI	Latest month	Measure	Trajectory	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MSFD - Average number of Medically Fit for Discharge Patients in WMH	Dec 23	30	50	50			43	31	54
Urgent Crisis Response (UCR) - 2 Hour Response Rate	Dec 23	89.49%	70.00%	70%			82.19%	60.22%	104.17%
Carbon Footprint - 5% reduction in the carbon footprint at WHT	Mar 23	4.3%		5%					

Footnotes

* The Variation SPC icon is based off the target column. The trajectory column has been added for information only

** Targets are sourced from Trust Board approved targets / constitutional standard targets / local expectations

Care Colleagues
Collaboration Communities

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.

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: COMMUNITIES

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

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

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

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

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

Lead Narrative:

Procurement. From 1st of April 2024, the NHS will proportionally extend the NHS Carbon Reduction Plan requirements to cover all procurements. Updated guidance on the application of the Carbon Reduction Plan (CRP) and Net Zero Commitment (NZC) requirement has now been published on NHS England website. These requirements are part of the NHS net zero supplier roadmap, which ensures that the NHS Supply Chain plays its crucial part in helping NHS become a net zero health service by 2045.

NHS England Net Zero Travel and Transport strategy was published by NHS England on 31 October 2023. The strategy will enable the NHS to have a fully decarbonised fleet by 2035, with its ambulances following in 2040. Several key steps will mark the transition of NHS travel and transportation:

* By 2026, sustainable travel strategies will be developed and incorporated into trust and integrated care board (ICB) green plans.

*From 2027, all new vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances).

*From 2030, all new ambulances will be zero emission vehicles.

*By 2033, staff travel emissions will be reduced by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles.

*By 2035, all vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances) and all non-emergency patient transport services (NEPTS) will be undertaken in zero emission vehicles.

*In 2040, the full fleet will be decarbonised. All owned, leased, and commissioned vehicles will be zero emission.

There is no central funding support to implement the travel and transport strategy. Each Trust is expected to fund the transition through its own resources.

Executive Narrative:

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

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

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: COMMUNITIES

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

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

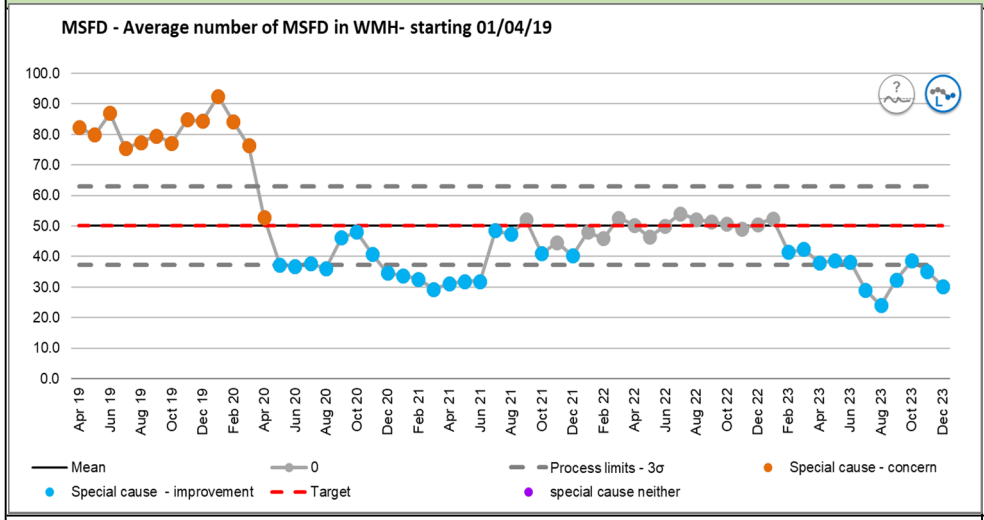
SUPPORTING METRICS	ACTION	BY WHO	BY WHEN
2023/24 Greener NHS National and Regional Priorities and Deliverables NHS England-Midlands circulated the draft 2023/24 Greener NHS Midlands Systems Ambition document which was discussed and commented on by the Black Country ICS Sustainability Network. A final document is yet to be issued. Black Country ICS agreed on Virtual Wards development as the 5th service priority. Out of 19 deliverables, seven has been delivered. Three of the deliverables are unlikely to be delivered. These are: - 1. 19-23% Entonox carbon emissions reduction - 2. Ensuring that the region's owned and leased fleet is made up of at least 90% Low Emission Vehicles by March 2024. Including 11% of the fleet being made up of Ultra-Low Emissions (ULEV) and Zero Emission Vehicles (ZEV) by March 2024 - 3. 25% reduction of inhaler carbon footprint Green Plan implementation: Reduction of the proportion of desflurane used in surgery to less than 2% of overall volatile anaesthetic gases by volume by 31 March 2024. As of 01 October 2023 (latest data from Greener NHS Dashboard), the proportion of desflurane used in surgery is at 0% below the 2% national target Greening Services Scheme. Sustainability initiatives implemented by the greening services teams are still ongoing. Some are expected to deliver both carbon reduction and cost improvement by 31st March 2024 Clinical Waste Strategy The Trust recently appointed a waste manager who will manage the implementation of the Trust Waste Strategy as well as ensuring the Trust waste management systems and practices are inline with the national strategy. Waste audits has started in clinical areas to determine the extent of compliance with standards. The waste manager is working closely with the RWT team on the mechanics of implementing mixed recycling as well as started a dialouge with Walsall Council on waste disposal.	Update Green Plan carbon reduction targets and action plan to reflect results of sustainability initiatives	Sustainability Group/Head of Sustainability	June 2024
	Provide progress on the carbon reduction delivered by sustainability initiatives	As Above	Monthly
	Recruit clinical and non-clinical services in “Greening Services Scheme”.	As Above	Monthly
	Roll out furniture, medical devices and equipment reuse scheme	As Above	March 2024
	Roll out mixed recycling and waste segregation	Waste and Recycling Manager	March 2024
	Develop an options appraisal for nitrous oxide/Entonox destruction technology	Medical Gas Group/Clinical Lead for Sustainability	January 2024
	Roll out nitrous oxide trial in Treatre 5. Document result with the view of rolling out to the rest of the treatres and decommission manifold system	Medical Gas Group/Clinical Lead for Sustainability	January 2024 -June 2024
	Complete roll out food waste disposal and recycling scheme to comply with new food waste disposal regulations	Catering Department and Waste and Recycling Team	Mar-24

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: COMMUNITIES

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

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



Analyst Narrative:

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

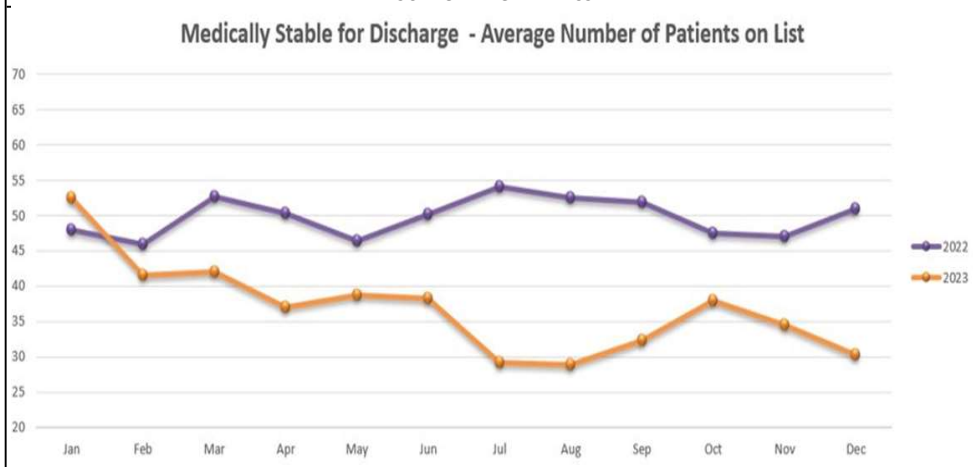
The Service delivered a strong performance in December, reeceiving over 1,000 referrals with the number of MSFD patients at 30 continuing the statistical improvement.

Average length of stay maintained at an average of 2 days demonstrating good flow. (2nd chart) In addition the ICS team achieved their lowest figure on Christmas Eve of 11 patients MFFD.

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

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

SUPPORTING METRICS



Executive Narrative:

Issue:

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

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

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

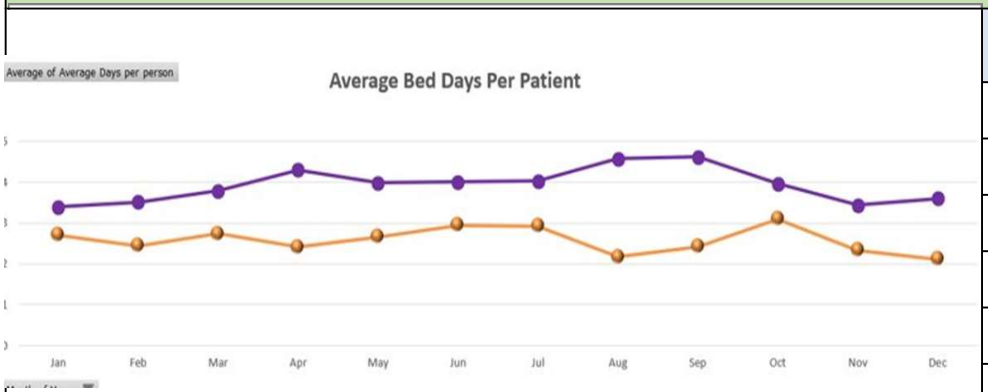
In response to these challenges, the Division has increased the Nursing and Facilitator capacity within the ICS and the team have built strong links with our partners within the region to ensure a smooth transitions of care

NHS
Walsall Healthcare
NHS Trust

Strategic Aim: COMMUNITIES

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

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



ACTION	BY WHO	BY WHEN

NHS
Walsall Healthcare
NHS Trust

Trust Board Meeting – to be held in Public 14 February 2024		
Title of Report:	Walsall Together Partnership Board	Enc No: 11.2
Author:	Rachael Gallagher - Personal Assistant, Walsall Together	
Presenter/Exec Lead:	Professor Patrick Vernon – Chair, Walsall Together	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐

Recommendations:
Trust Board is asked to be assured on the contents of the report and the work of the Walsall Together partnership in contributing to the Trust strategic objective to improve the health and wellbeing of the local communities.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	There are no direct resource implications as a result of this report. The financial pressures and plans to utilise any available short-term funding are routinely discussed across the partnership and reported to the Partnership Board. We now understand that there will not be any transfer of resources from the ICB on or before 1st April 2024, linked to the process of delegation.		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☐No☒	Details: not at this stage
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details: not at this stage
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	**N/A**		
Equality and	In being awarded the Race Code mark, the Trust agreed to increase its		

Diversity Impact	awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. No impact.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: WTPB 17th January 2024
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- Board agreed to establish a Task and Finish Group that will review the service user story, working through some agreed actions, reviewing against the development of the partnership Carers Strategy and exploring the quality assurance aspect.
- As expected operational demand was elevated during December. The mitigations in situ helped keep the medically fit list to an average of 30 patients with an average length of stay at 2 days, with the lowest number recorded of 11 reached on Christmas Eve.
- Board agreed to the proposed refresh of the operational report with an agreed focus on demonstrating meaning behind the data. The Joint Planning Group will help develop the refreshed report.
- Members approved the monthly communications brief to be circulated to the wider partnership.

Advise

- This report covers items discussed in January's meeting.

Alert

-Board supported the delegation proposal to be submitted to the ICB, based on the comments received from members.
-A one hour development session has been scheduled for February to discuss the delegation proposal in further detail in anticipation of feedback from the ICB.
-The Transformation Programme had steady progress in December, albeit the Place Governance project was moved from experiencing obstacles to back on track due to the significant progress made in the development of the System Operating Model
-Concerns were raised about the impending changes (05.02.24) to welfare police checks through the Right Care Right Person programme. Board agreed that communicating the change needs to accelerated.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the	• Develop a health inequalities strategy

Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve clinical service sustainability • Implement technological solutions that improve patient experience

Walsall Healthcare NHS Trust

Walsall Together Partnership Board Highlight Report

Report to Trust Board Meeting in January 2024

EXECUTIVE SUMMARY

1.1. **User story –** January's user story was a story previously shared with WHT (Walsall Healthcare NHS Trust) Board in October 2023. The story was that of patient and carer experiences and it was felt that the story had many reflection and learning points that Walsall Together partnership could consider. The team were presented with the detail of both the patient and carers experiences and some of the learning points identified as part of the internal review processes. Members discussed the story and were unanimous in sending condolences to the carer for the loss and the difficulties that were experienced whilst navigating the system. Members had a lively conversation, with contributions from all partners. It was agreed that a task and finish group is to be established to work through some agreed actions, linking into ongoing partnership work that will feedback to both WHT and the carer involved.

1.2. **Delegation Proposal –** Members were presented with the latest iteration of the delegation proposal for approval. The document shared detailed all aspects of the potential transfer of responsibilities from the ICB to Walsall Together from April 2024. Primary Care colleagues suggested that approving the document on behalf of all general practises was not something that could be agreed on without additional engagement, therefore it was suggested that the document is socialised with Primary Care as a matter of priority to allow for any points from Primary Care to be raised at the earliest opportunity. Board agreed to support the document subject to the addition of including some high-level assumptions and risks.

1.3. **Operational Report –** December's operational data highlights were shared with partners demonstrating the expected elevated demand. Members agreed to the proposed remodelling of how the operational data is reported and presented, addressing comments received about sharing outcomes and utilising the Outcomes Framework within the report.

1.4. **Transformation Programme –** December's transformation reports were circulated prior to the meeting. The programme remains stable with 25 of the 29 live projects on track. The 4 projects experiencing obstacles are due to funding restraints and are under review. Board took assurance that progress is being made within the transformation programme and that the appropriate conversations are being held to try and help mitigate those experiencing obstacles.

1.5. **Right Care Right Person Programme** – Board was updated on the progress made within the Right Care Right Person Programme and the scheduled phases for implementation. To date the programme has good representation of the Black Country places with support in place to prepare for the system changes, although additional engagement work with Primary Care is required to build on communication and understanding of the changes. Concerns were raised about vulnerable residents being missed due to the changes to welfare checks. Board agreed that it was worthwhile investigating a potential pilot project utilising the third sector to help encourage neighbours to check in on the vulnerable in society. An action was agreed to link in with system communication leads to ensure the upcoming changes are shared across the partnership.

BACKGROUND INFORMATION

Under the 'Communities' 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 NHS Trust Board.

RECOMMENDATIONS

Trust Board is asked to be assured on the contents of the report and the work of the Walsall Together partnership in contributing to the Trust strategic objective to improve the health and wellbeing of the local communities.

Any Cross-References to Reading Room Information/Enclosures:

- The Care at Home report contains more detail pertinent to the operational performance of the partnership and implications associated with the ICB delegation (Enc 11.3.1).

NHS
Walsall Healthcare
NHS Trust

Paper to Trust Board Meeting – to be held in Public on 14th February 2024		
Title of Report:	Group Director of Place Report	Enc No: 11.3
Author:	Stephanie Cartwright, Group Director of Place Steve Jackson, Director of Operations, Community Division	
Presenter/Exec Lead:	Stephanie Cartwright, Group Director of Place	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐

Recommendations:

The Board is asked to note the contents of the report, particularly the risks and assurances included.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	There are outstanding funding issues to be resolved for some community services.		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☐No☒	Details:
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Walsall Healthcare NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert

Assure

- ***Medically Stable for Discharge:*** The level of patients awaiting discharge pathways 1-3 remained low at 30 patients. The average LOS for being medically stable was 2 days. The ICS team implemented additional interventions as a result of the junior doctor strikes and achieved 11 patients on MFFD list on Christmas Eve.
- ***Avoiding Hospital Admissions*:** Community services saw a sustained high level of referrals for services such as Care Navigation Centre; Rapid Response team; Integrated Front Door service.

Advise

- ***Virtual Wards:*** The adult virtual wards continued to offer 80 virtual beds covering respiratory, heart failure, palliative care, hospital at home and frailty pathways during December. A further new virtual ward was launched in December for patients discharged on D2A pathways. Referrals into the service remained below the service capacity
- ***Place Development***: the partnership has contributed to the further development and refinement of the Black Country System Operating Model, which aligns well to the ambition for delegation in Walsall.

Alert

- ***Funding for Intermediate Care Service:*** An activity and financial trajectory has been produced with commissioners to monitor activity versus spend for the current financial year. Inclusive of national discharge funding, a £1.7m deficit has been forecast. This is predominately being driven by the cost of care. Discussions are ongoing between the joint commissioners to seek a resolution.
- A proposal for delegation has been submitted on behalf of the Walsall Together partnership to the Black Country ICB for consideration.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Safe and responsive urgent and emergency care • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities

Walsall Healthcare NHS Trust

Group Director of Place

(incorporating Care at Home)

Report to Trust Board Meeting to be held in Public on 14th February 2024

EXECUTIVE SUMMARY

This report provides an overview of the portfolio of the Group Director of Place. It includes information relating to the development of the place-based partnership in Walsall, and also the performance, risk, assurance, and transformation in the Communities Strategic domain during December 2023 and January 2024.

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.

BACKGROUND INFORMATION

Under the Communities strategic objective, Walsall Healthcare NHS Trust (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'.

WHT provides the 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. The WTPB has oversight of operational performance for community services.

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 Walsall Together Joint Planning Group and Strategic Command continue to focus on the impact of operational performance and pressures on the citizens of Walsall and how it affects their health and well-being.

Demand: Demand for Community Locality Services remained stable in December

Capacity:
Locality Teams: The Locality Community Teams delivered 5,456 hours of care and met 96% of the demand in month

Virtual Wards: The adult virtual wards continued to offer 80 virtual beds covering respiratory, heart failure, palliative care, hospital at home and frailty pathways during August. Referrals into the service have increased but remain below the service capacity. The service launched a new pathway in December for patients discharged onto a discharge to assess pathway with the aim of ensuring that patients could continue to reside in their preferred place of care and reduce the

level of readmissions. The pathway managed 37 patients in December with a readmission rate of 8%. Although a small cohort of patients the reduction in readmission has been significant.

Urgent Community Response: In December, Community services saw a significant increase in referrals through the Care Navigation Centre requiring an urgent community response. This expected increase is as a result of collaborative work that community services is undertaking with WMAS.

Discharge & Step-Up Pathways: The level of patients awaiting discharge pathways 1-3 remained low at an average of 30 patients, with the average LOS as being medically fit running at 2 days. The ICS team implemented additional interventions as a result of the junior doctor strikes and achieved 11 patients on MFFD list on Christmas Eve.

Funding for Intermediate Care Service: An activity and financial trajectory has been produced with commissioners to monitor activity versus spend for the current financial year. Inclusive of national discharge funding, a £1.7m deficit has been forecast. This is predominately being driven by the cost of care. Discussions are ongoing between the joint commissioners to seek a resolution.

Patient feedback is currently captured by the Virtual Ward team on discharge from the virtual ward by QR code, email and telephone calls. Feedback is reviewed by the MDT at regular intervals to seek improvements and adjust accordingly any themes. Patient stories/videos have also been captured to showcase the journey of patients feeling safe and cared for in their home under the monitoring of the virtual ward. The clinical leads have presented at several boards and plan to present in February a Fast Track virtual ward patient and family story. The fast track virtual ward is part of a national research workstream funded by NHSI, being conducted by Warwick Business School. The report is due in March 2024, all involved with the MDT have been engaged to contribute to the research interviews.

Some examples of feedback received to date are as follows:

- *The staff were lovely, they really helped me feel safe.*
- *The girls explained my tablets and helped me feel much better.*
- *The tablet was so easy, when I rang the staff, they were kind and helpful, I felt supported.*
- *Thank you for being so helpful, I felt really supported.*
- *I was so pleased to be at home and happy to have the consultant support. First class service.*

Health Visiting: The Walsall Health Visiting (HV) Service has been experiencing operational difficulties linked to a shortage of Health Visitors. The recruitment of Health Visitors is a nationally recognised issue that impacts on service delivery.

The HV Service have reviewed the workforce in line with the national picture, introducing skill mix teams within the health visiting service to enable Health Visitors to fulfil their main responsibilities, which is to create good health through a universal service that is responsive and tailored and addresses the needs of the children, families, and Walsall communities. With the correct implementation of the skill mix within the service, it has allowed for effective processes of delegation, supervision and reporting that is required to safely manage workloads within the skill mix teams. The Health Visitor continues to be responsible, holds accountability for the care delivery to children and families. The aspiration was to develop an innovative skill mix model and improve efficiencies, through workforce development. They have achieved this through Increasing the number of staff nurses at Band 5 to support delivery of the universal mandated contacts. The sustainable workforce model with the expansion of the staff nurse role enabled the team to “home-grow” their own qualified Health Visitors, to date they have recruited 5 Health Visitors from this workforce development and

have placed a further cohort onto the 12-month training program in September 2023 with the expectation of retaining these staff once qualified in 2024.

The service has developed integrated pathways, ensuring the pathways are led by a Specialist Community Public Health Nurse, who holds the accountability but supports the competency development and skill sets of the team members. This also ensures appropriate delegation to practitioners with the right skills, at the right time and in the right place. In addition, allows for clinical supervision to be embedded into practice and review of caseloads ensuring safe, high-quality care is delivered. This way of working has allowed the service to maximise the workforce resources and inform workforce planning, with the ability to develop a service provision tailored to needs.

The Healthy Child Programme 0-19 service has successfully recruited to numerous positions within the pathways that has allowed for service development. At present, they are recruiting to develop a universal pathway in order deliver the Healthy Child Programme effectively and efficiently, ensuring the safety and individual needs of children and families are central to the model of delivery.

Partnership and collaboration have been fundamental to the delivery of the pathways, whilst having the ability to respond to the needs of children and young people. With the strengthening family's pathway already implemented allowing the ability to carry out holistic health assessments, provide public health and health promotion for specific caseload of families who have complex needs. This is mirrored by the Family Hub pathway development, that has supported the development of integrated working, embedded joint Early Help strategy, through partnership and targeted intervention and building therapeutic relationships with families for improved outcomes.

In addition to developing its own pipeline of Health Visitors, the service continues to develop innovative roles for Health Visitors within the service in order to both retain its present workforce but also attract Health Visitors to work within the service. This is alongside programs to support newly qualified Health Visitors, new Health Visitors to Walsall and the development of existing staff in order to reduce attrition of Health Visitors which has reduced the turnover rate within the service.

There is also a greater emphasis and development of partnership working in particular with colleagues from Walsall Council Children's services to enhance information sharing, joint risk assessment and decision making on appropriate interventions for children and families.

PLACE-BASED PARTNERSHIP DEVELOPMENT

Following the submission of a draft proposal for delegation to Walsall Place in August 2023, the partnership has engaged in the further development of a system operating model. Version 10 of the operating model was presented to the Partnership Board in January. It starts the process of devolution of decision making from the Integrated Care Board (ICB) to the wider Integrated Care System (ICS), strengthening the role of system-wide programme boards in the first instance. Walsall Together partners welcome the statement that this will continue to evolve and are supportive of the current proposal on the basis that it moves the system in a direction that aligns with the ambition in Walsall and at a sensible pace.

In January the Walsall Together Partnership Board considered the proposal to the ICB for delegation to the place-based partnership from April 2024. This proposal was also discussed at the Walsall Primary Care Collaborative on 1st February 2024. The proposal was supported at both the Walsall Together Partnership Board and the Walsall Primary Care Collaborative, noting that as the Primary

Care Collaborative continues develop there are elements of the proposed delegation that would transfer to the Primary Care Collaborative for their oversight and responsibility.

A summary of the proposal is provided below.

Delegation to Walsall Together place based partnership from April 2024:

- Community services
- Quality in care homes team and IAH
- Palliative care
- GP Out of Hours
- Urgent Treatment Centres
- Walsall AQP contracts
- Voluntary sector

Transfer to ICB Place (via the ICB Place Managing Director) from April 2024:

- BCF funded services not covered elsewhere
- GP Prescribing plus medicines management team
- Discretionary (non-GMS) primary care services
- CHC

Planning and commissioning responsibilities from April 2024 (via the ICB Place Managing Director) for:

- Commissioning of SDF allocations, where available to the ICB, to include Community Infrastructure, Ageing Well, Health Inequalities, Prevention Funding and Primary Care.
- Lead responsibility for development and implementation of the Walsall Winter Plan
- Lead responsibility for the development and implementation of the Walsall Joint Forward Plan and Health Inequalities Plan

Agreement was also secured for the alignment of ICB staff undertaking Place Development and Place Support functions.

It should be noted that Walsall Healthcare NHS Trust is already the host of the Walsall Together place based partnership, and it is not envisaged that at this stage there would be any change of role for the Trust.

The next stage of the process is awaiting clarity from the Black Country ICB. It is expected that this will include a readiness assessment for the place-based partnership.

Priorities for Walsall Together will be to review and update place governance model to ensure they accurately reflect the final version of the System Operating Model and the detail of any delegated responsibilities. This will be supported by the refresh of the Walsall Together Strategy which is currently being underway.

Additional activities undertaken to contribute to research and policy and to raise awareness of the work in Walsall are as follows:

- Participation in a ministerial roundtable on the Major Conditions Strategy, ensuring prevention in its broadest sense is reflected in the strategy, and encouragement of cross-departmental thinking around implementation.
- Agreement to participate in the NHS Confederation research into the national health inequalities funding process.
- Presentation to the King's Fund to support their research into Place Based Partnerships.

RECOMMENDATIONS

The Board is asked to note the contents of the report, particularly in relation to the proposal for delegation from the ICB to the place-based partnership and the risks and assurances included in the paper.

Any Cross-References to Reading Room Information/Enclosures:

Walsall Together Operational Performance PowerPoint (B Pack: 11.3.1)

ENC 11.3.1

Walsall Together

Walsall Together Partnership Operational Update: January 2024

Stephen Jackson

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 1

Walsall Together

Tier	Activity in-month	Thresholds			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services													
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	6608	5837.25	5739.5	5814.25	5561.5	5219.25	5558	5528.5	5455.75
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	188.00	106.25	282.75	279.75	207.00	290.25	247.25	319.75	220.75
	% of hours demand unmet	>23%	20%-23%	<20%	2.77%	1.79%	4.70%	4.59%	3.59%	5.27%	4.26%	5.47%	3.89%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	12	14							
	No. referrrals received	<100	100-200	>200	17	21							
	No. cases reviewed	<100	100-200	>200	61	69							
Adult Social Care	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				874	860	889						
	Care and Support Assessments and 3 Conversations Completed - Total				243	306	309						
	Monthly Adult contacts completed by Team				1,066	1,167	1,209	1,147	1,178	1,126	1,215	1,094	1,054

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

Walsall Together

Tier	Activity in-month	Thresholds			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Tier 2: Specialist Community Services													
ASC Safeguarding Concerns	Concerns received				303	335	364	351	328	318	361	328	295
	Concerns progressing to s42 eqnuiry				40	58	47	59	57	64	61	65	49
	% of concerns progressing to s42 enquiry				13%	17%	13%	7%	17%	20%	17%	20%	17%
	Safeguarding cases in progress				58	55	93	76	57	59	48	70	28
Tier	**Activity in-month**	**Thresholds**			**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**
Tier 3 : Interimediate Care, Unplnanned Care & Crisis Services													
Care Navigation Centre	Calls received	<435	435-512	>512	1191	1272	1205	1153	1120	1120	1413	1368	1828
Rapid Response Team	Referrals received	<160	160-247	>247	269	292	251	280	281	319	345	324	348
	% admission avoidance	<73%	73%-87%	>87%	83.3%	93.5%	100.0%	90.0%	70.1%	83.1%	92.5%	77.5%	90.5%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50- 57.5	<50	38.00	38.66	38.25	29.11	24.00	32.38	38.68	35.25	30.28
	Average number of days MSFD	>5.75	5.0 - 5.75	<5.0	2.5	2.7	2.95	2.92	2.50	2.43	3.27	2.39	2.11
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	31	32	34	30	22	22	23	23	21
	Domiciliary Pathways - Average service users				283.2	281.5	259	244.2	241	241	217	213.5	224.6
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	40	38	37	30	25	25	25	21	33
	Bed-based Pathways - Average beds in use				67.7	67.75	61.25	67.2	70.5	70.5	68.4	72.5	72.6
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	199	206	180	213	185	213	223	193	206
	Prevent Readmission	35<	35-50	>50	8	5	6	2	7	5	8	0	4
	Early Supported Discharge	40<	40-54	>54	43	37	68	52	44	35	48	70	49
	Assisted Discharge	35<	35-50	>50	34	52	105	54	45	20	23	14	20

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

243 Clever Conversations

104 Home visits Completed

20 sign up to the Social Prescribing programme

43 completed/improved WEMWBS questionnaire

11 Referrals to Money Advice Team

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

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

Diabetes Matters Champion Engagement Programme

30 new referrals received

155 Clever Conversations

117 New customers engaged

1 Community Events attended

1 Referral to Money Advice Team

5 Referrals made to external support service Referrals

11 Referrals made to internal support service Referrals

WHG - Diabetes Matters – Case Study

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

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

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

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

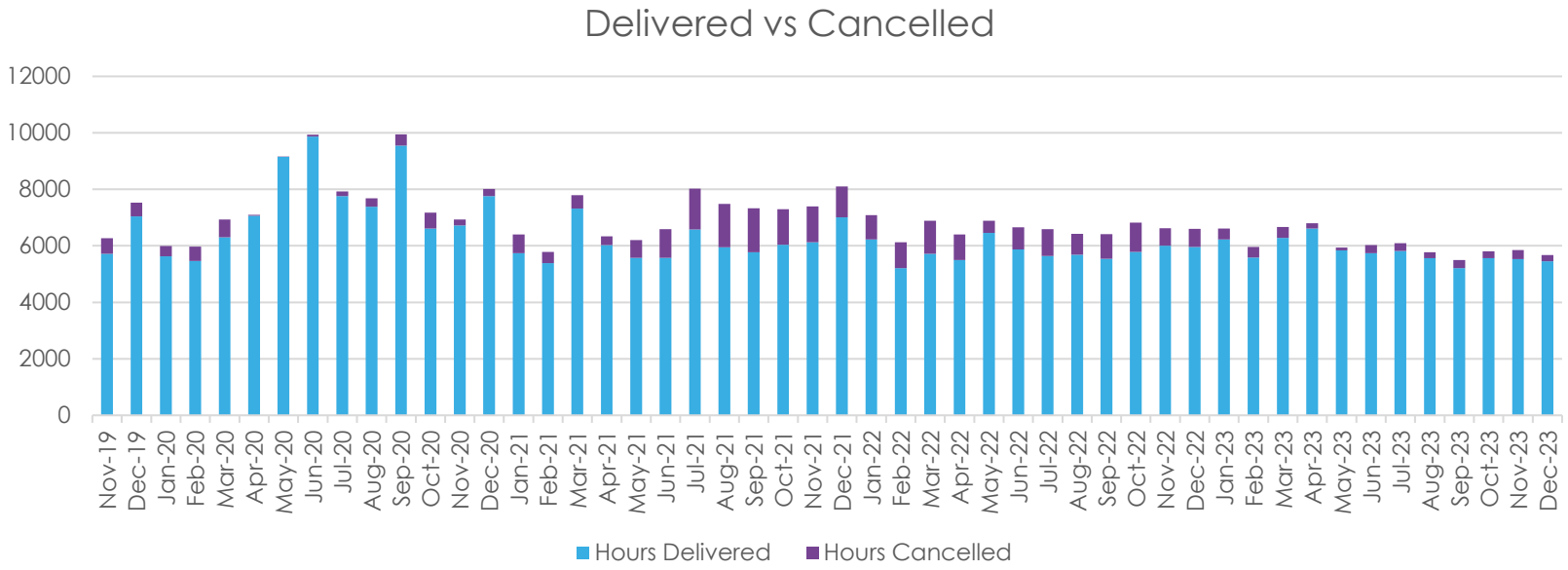
A.C.E - Reducing the impact of poverty on children and families

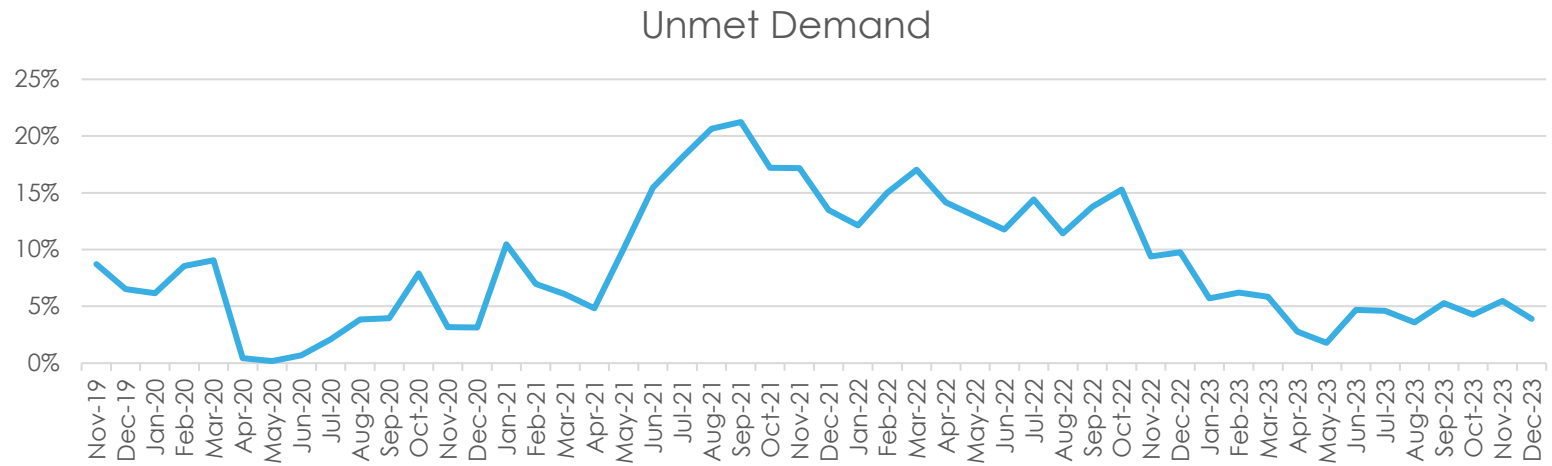
- A.C.E is a proof of concept and a partnership programme designed, delivered by whg and health
- Focus upon improving parents, children's self care of the child's asthma and reducing avoidable hospital admissions
- A referral pathway is established with Walsall Healthcare NHS Trust and whg
- **93**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

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

Tier 1:

Community Nursing Capacity and Demand:





The Locality Teams delivered 5,456 hours during December 2023. The number of cancelled hours increased compared to the previous month.

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

Last updated : January 2023

Tier 1: Making Connections Walsall

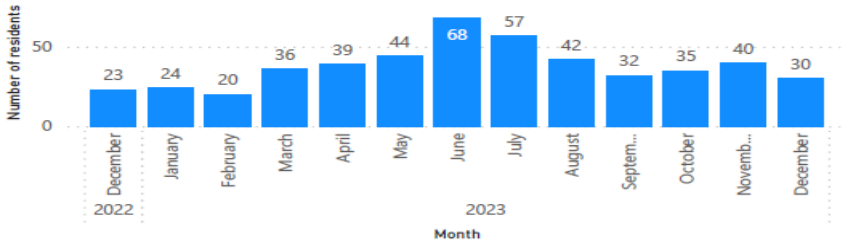
Making Connections Walsall - Client summary

Source: DCRS (Data Collection & Reporting Service)

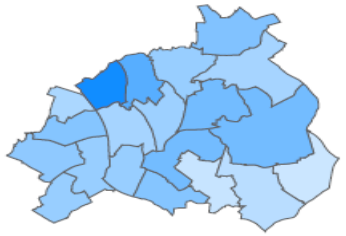
Referral date

01/12/2022 22/12/2023

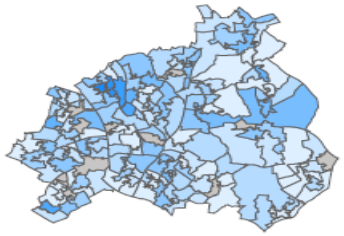
Total residents



Electoral ward

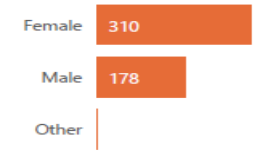


LSOA (Lower Super Output Area)

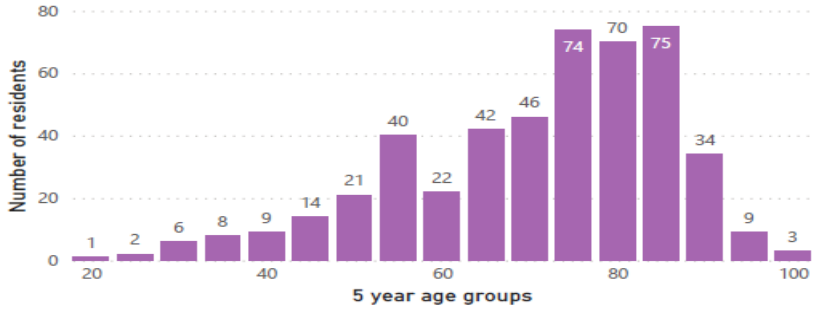


client_type	n	%
Making Connections	490	100.0%
Total	**490**	**100.0%**

Locality	n	%
East	154	31.4%
North	128	26.1%
West	118	24.1%
South	90	18.4%
Total	**490**	**100.0%**



Residents age



ethnicity	n	%
A: White _ British	331	67.6%
99: Not Known	55	11.2%
Z: Not Stated	51	10.4%
H: Asian / Asian British _ Indian	17	3.5%
M: Black / Black British _ Caribbean	13	2.7%
I: Asian / Asian British _ Pakistani	7	1.4%
S: Any other ethnic group	4	0.8%
B: White _ Irish	2	0.4%
D: Mixed _ White and Black Caribbean	2	0.4%
J: Asian / Asian British _ Pakistani	2	0.4%
P: Black / Black British _ Other background	2	0.4%
F: Mixed _ White and Asian	1	0.2%
K: Asian / Asian British _ Bangladeshi	1	0.2%
L: Asian / Asian British _ Other background	1	0.2%
N: Black / Black British _ African	1	0.2%
Total	**490**	**100.0%**

consider_themselves_disabled	n	%
Disabled	213	43.5%
Not disabled	168	34.3%
Not Known	109	22.2%
Total	**490**	**100.0%**

long_term_physical_health_condition	n	%
Yes	352	71.8%
Not stated	114	23.3%
Unknown	14	2.9%
No	10	2.0%
Total	**490**	**100.0%**

Total residents

490

Total contacts

2031

Walsall Council

PROUD OF OUR PAST, OUR PRESENT AND FOR OUR FUTURE

Tier 1: Making Connections Walsall

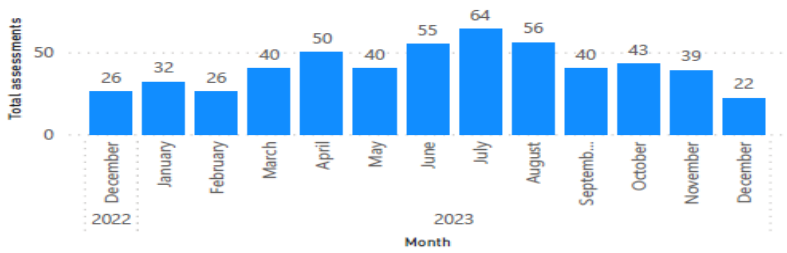
Making Connections Walsall - Assessment & Goals Summary

Source: DCRS (Data Collection & Reporting Service)

01/12/2022 21/12/2023

client_type
- COVID_19
- Making Connections

Assessments



Assessments 533

Locality_Name	n	%
East	156	29.3%
North	147	27.6%
South	105	19.7%
West	125	23.5%
Total	**533**	**100.0%**

local_issue	n	%
Not recorded	313	58.7%
Loneliness & isolation	187	35.1%
Emotional wellbeing	21	3.9%
Bereavement	4	0.8%
Financial concerns	4	0.8%
Housing Issues	3	0.6%
Frightened or nervous	1	0.2%
Total	**533**	**100.0%**

referral_source	n	%
GP or other primary care services	236	44.3%
Local authority Services	177	33.2%
Self	31	5.8%
Intermediate care team	30	5.6%
Community / voluntary services	23	4.3%
Community & District Nursing	15	2.8%
Emotional wellbeing services	13	2.4%
Hospital services	5	0.9%
Fire Service	1	0.2%
Hospital _ Cancer	1	0.2%
Lifestyle services	1	0.2%
Total	**533**	**100.0%**

employment_status	n	%
Retired	348	65.3%
Permanently Sick / Disabled	123	23.1%
Unemployed	35	6.6%
Temporary sick	9	1.7%
Response declined	8	1.5%
Full time carer	6	1.1%
Looking after home or family full time	2	0.4%
Employed: routine / manual	1	0.2%
Volunteer	1	0.2%
Total	**533**	**100.0%**

sign_off_reason	n	%
Only wanted some information	143	26.8%
Not signed off	119	22.3%
Plan completed	78	14.6%
Not ready to make changes	52	9.8%
Could not contact client	51	9.6%
Signpost only	37	6.9%
Plan part completed	20	3.8%
Not eligible	13	2.4%
Inability to continue	10	1.9%
Other	5	0.9%
Client DNAs (Did not attend)	3	0.6%
Client deceased	1	0.2%
Disappointed with rate of progress	1	0.2%
Total	**533**	**100.0%**

Goals 534

goal	n	%
Reduce anxiety/low mood	186	34.7%
Actions to enable goal achievement	115	21.6%
Connect more: Join a group	99	18.5%
Information required	58	11.0%
Be active: Find an enjoyable activity	34	6.3%
Build confidence/independence	22	4.2%
Learn something new: Take a course/Start new hobby	18	3.4%
Give/volunteer more: Volunteer/Help somebody	1	0.2%
Take more notice of the environment: Take time to enjoy the moment	1	0.2%
Total	**534**	**100.0%**

referral_to	n	%
Community / voluntary services	320	59.9%
Local authority services	60	11.3%
Emotional Wellbeing Services	34	6.4%
Other (put details in 'Referral_other')	26	4.9%
Bereavement Support	22	4.1%
GP or other primary care services	18	3.4%
Lifestyle change/support services	15	2.8%
Citizens advice	12	2.2%
Dementia cafe	7	1.3%
Advice and Guidance	5	0.9%
Disability services	4	0.7%
Lunch Club	4	0.8%
Not recorded	4	0.7%
Leisure activity	3	0.6%
Total	**534**	**100.0%**

Tier 2:
Adult Social Care

ASC have received 295 concerns which a decrease in cases on the previous month.

The number of cases progressing to a s42 enquiry lowered from the previous period.

There are currently 49 open 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.

Walsall Adult Social Care

Safeguarding concerns

Reporting period: 01/12/2023 31/12/2023

295
Concerns received

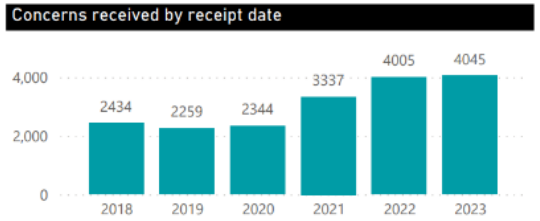
16.61
% leading to S42 enquiry

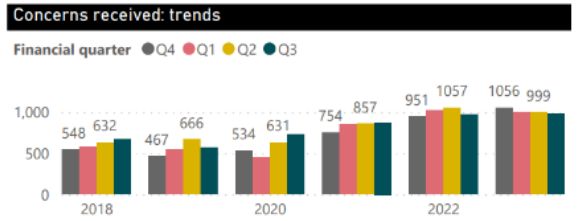
49
S42 enquiries

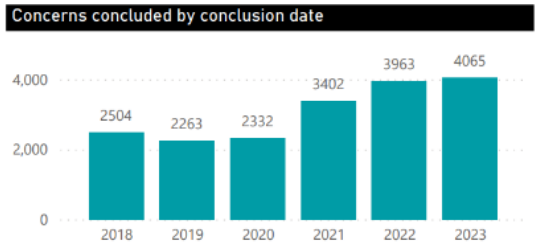
0
Non-S42 enquiries

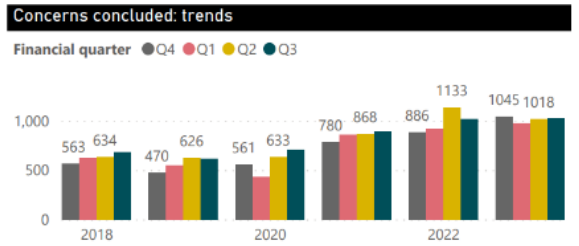
218
NFA

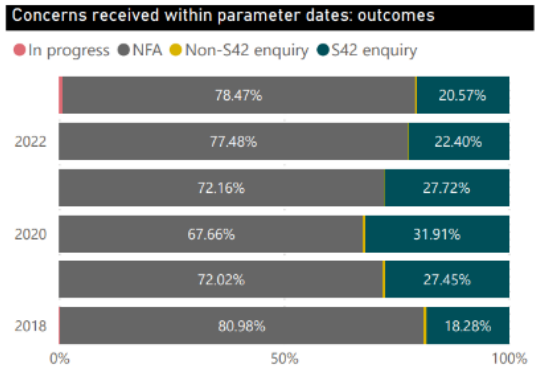
28
In progress

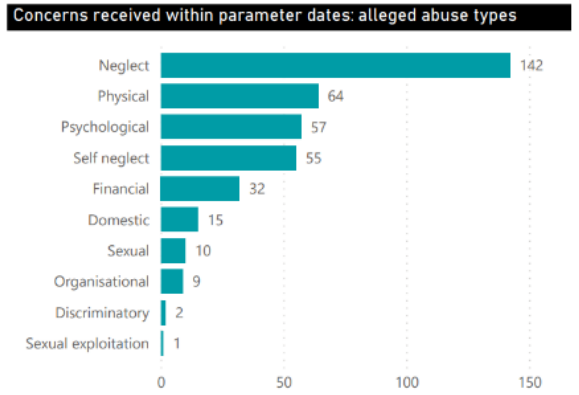












Last updated : January 2023

Walsall Together

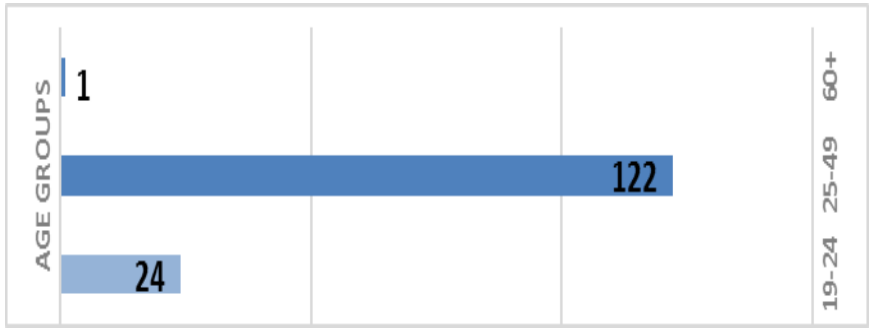
Last updated : January 2024

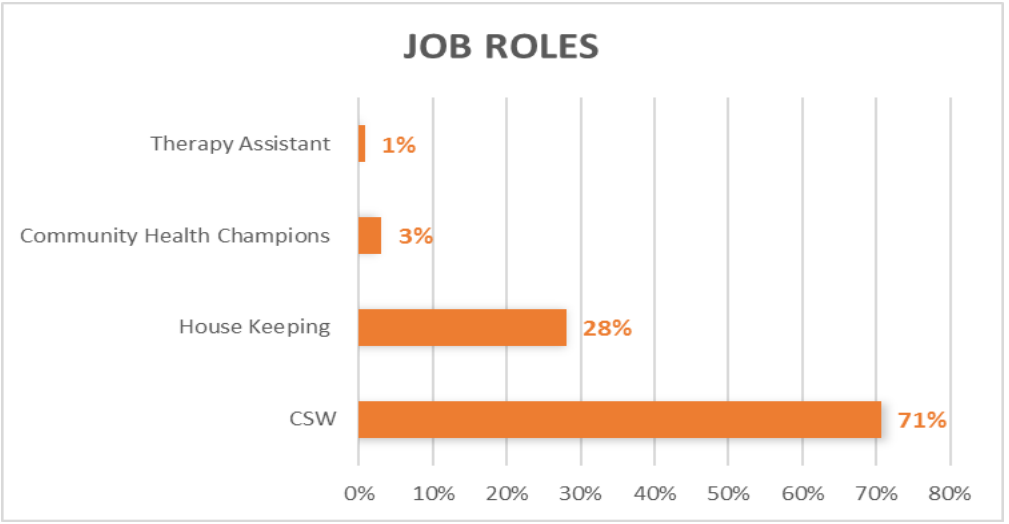
Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2022/23

Indicator	Data Source Data Provider Lead Officer	15/16 Result	16/17 Result	17/18 Result	18/19 Result	19/20 Result	20/21 Result	21/22 Result	22/23 Result	April 23/24 Data	May 23/24 Data	June Q1 Data	July 23/24 Data	Aug 23/24 Data	Sept Q2 Data	Oct 23/24 Data	Nov 23/24 Data	Dec Q3 Data	Jan 23/24 Data	Feb 23/24 Data	Mar 23/24 Data	23/24 Target	Comments
3D (formerly 1C): The proprtion of people who use services who receive direct payments	Mosaic		613	800	785	789	601	586	618	625	634	643	660	664	673	665	670	663					
	AACM		1951	1978	2069	2100	2206	2184	2275	2303	2314	2372	2404	2411	2431	2431	2445	2431					
	Tina James/ Paul Calder/Eve Morris		**31.4%**	**40.4%**	**37.9%**	**37.6%**	**27.2%**	**26.8%**	**27.2%**	**27.1%**	**27.4%**	**27.1%**	**27.5%**	**27.5%**	**27.7%**	**27.4%**	**27.4%**	**27.3%**					
2B (formerly 2A): Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & call off forms	7	11	22	10	24	18	20	27	1	6	9	11	15	19	20	22	23				15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	166,383	166,383	166,383	166,383	166,383	166,383	166,383	166,383					
	Tina James/ Paul Calder/Eve Morris	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**11.9**	**16.1**	**0.6**	**3.6**	**5.4**	**6.6**	**9.0**	**11.4**	**12.0**	**13.2**	**14.0**				**9.1**	
2B (formerly 2A): Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & call off forms	271	309	311	329	301	311	284	302	16	53	76	97	139	168	195	234	269				300	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	59,500	59,500	49,649	49,649	49,649	49,649	49,649	49,649	49,649	49,649					
	Tina James/ Paul Calder/Eve Morris	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**562.4**	**598.0**	**31.7**	**106.8**	**153.1**	**195.4**	**280.0**	**338.8**	**392.8**	**471.3**	**541.8**				**594.1**	
2D (formerly 2B): Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services.	Mosaic	254	113	220	55	76	94	79	106	139	106	114	128	101	119	123	113	124					
	ICS	317	130	266	73	91	125	103	123	162	123	134	147	119	144	138	139	149					
	Kerrie Thorne	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**78.1%**	**86.2%**	**85.8%**	**86.2%**	**85.1%**	**87.1%**	**84.9%**	**82.6%**	**89.1%**	**81.3%**	**83.2%**				**82.0%**	
2E (formerly 1G): Proportion of people who live in their own home or with their family.	Mosaic	473	497	505	502	494	489	490	483	2303	2384	2471	2535	2596	2633	2702	2732	2757					Metric widened to all long term service users under the revised ASCOF Framework Implemented from April 2023. Metric previously concerned LD service users aged 18-64 only
	AACM	551	585	587	596	574	573	576	573	3217	3345	3474	3573	3668	3794	3891	4000	4069					
	Tina James/ Paul Calder/Eve Morris	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**85.1%**	**84.3%**	**71.6%**	**71.3%**	**71.1%**	**70.9%**	**70.8%**	**69.4%**	**69.4%**	**68.3%**	**67.8%**					
4B Proportion of S42 enquiries where a risk was identified and the reported outcome was that this risk was reduced or removed	Mosaic									47	67	58	31	46	33	58	32	31					New ASCOF metric introduced from April 2023
	AACM									52	75	65	35	49	38	63	41	37					
	Donna Gyde									**90.4%**	**89.3%**	**89.2%**	**88.6%**	**93.9%**	**86.8%**	**92.1%**	**78.0%**	**83.8%**					

TIER 2 Workforce Development Work 4 Health

147 secured employment



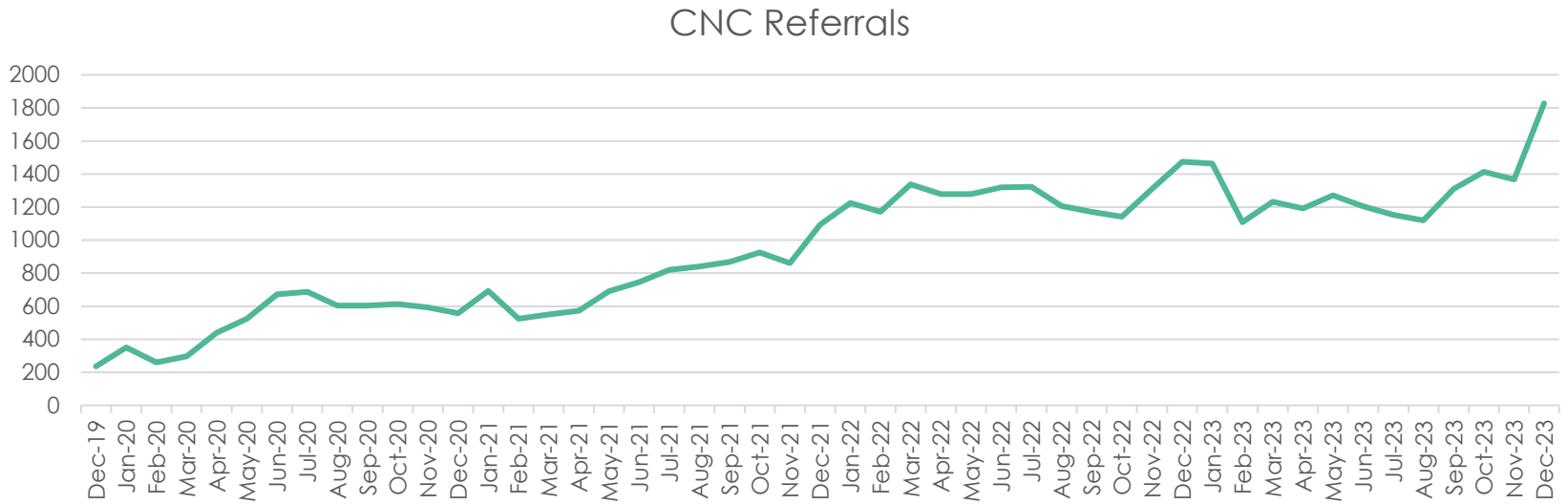


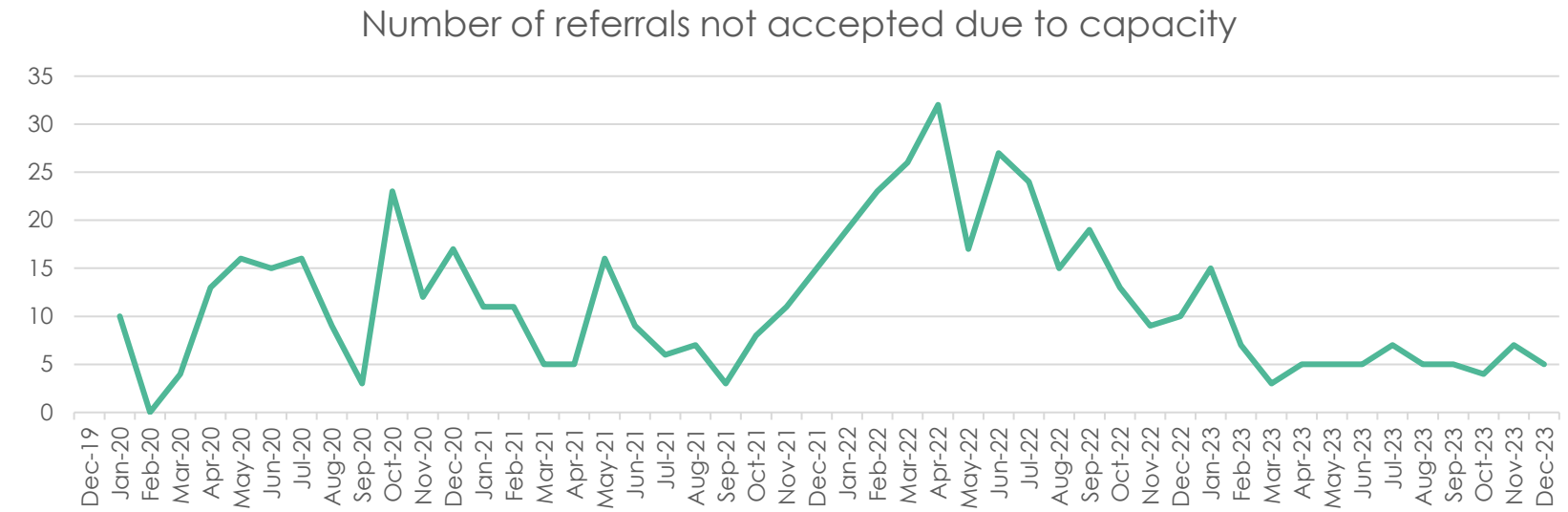
Social Value generated £2,121,530

82% Unemployed prior to commencing NHS job role

56% BAME

Tier 3:
Care Navigation Centre (CNC):





The CNC received a significant increase in referrals in December 2023.

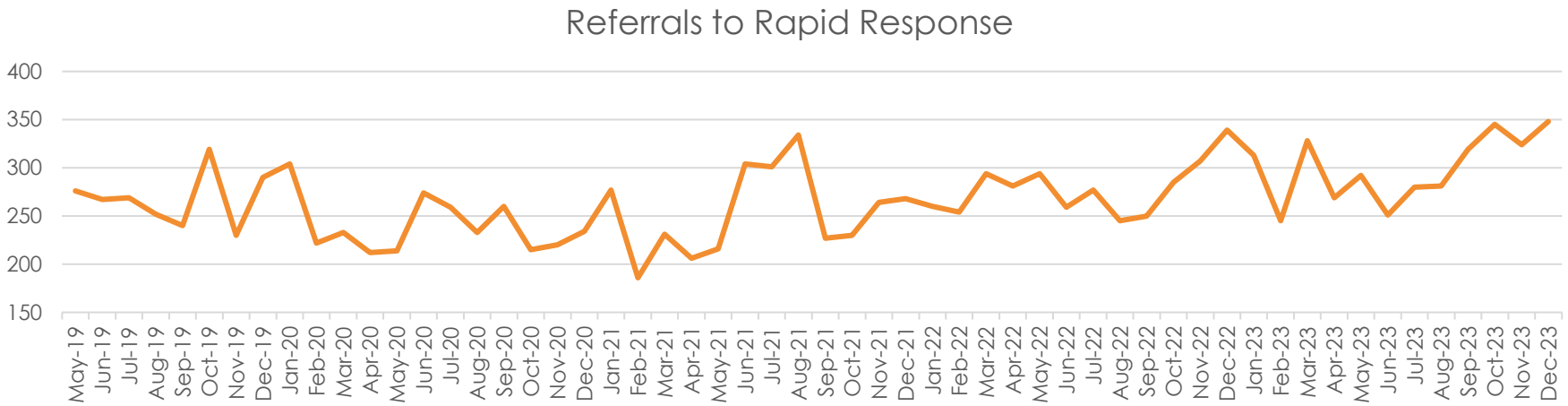
The expansion of capacity that has been embedded has enabled to CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

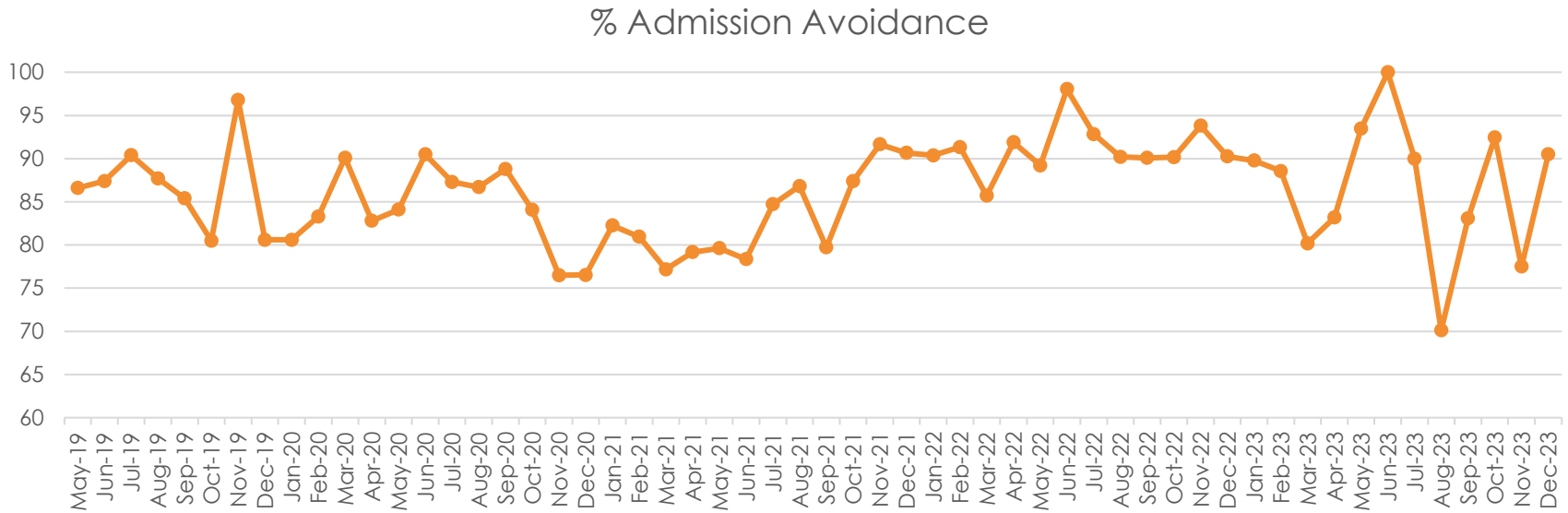
The high call volumes are a result of the enhanced service that has been implemented. This includes the further expansion of CNC capacity streaming patients directly from WMAS into Community pathways and services strengthening of disposition pathways into Rapid Response and Integrated Front Door teams.

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

Last updated : January 2024

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.

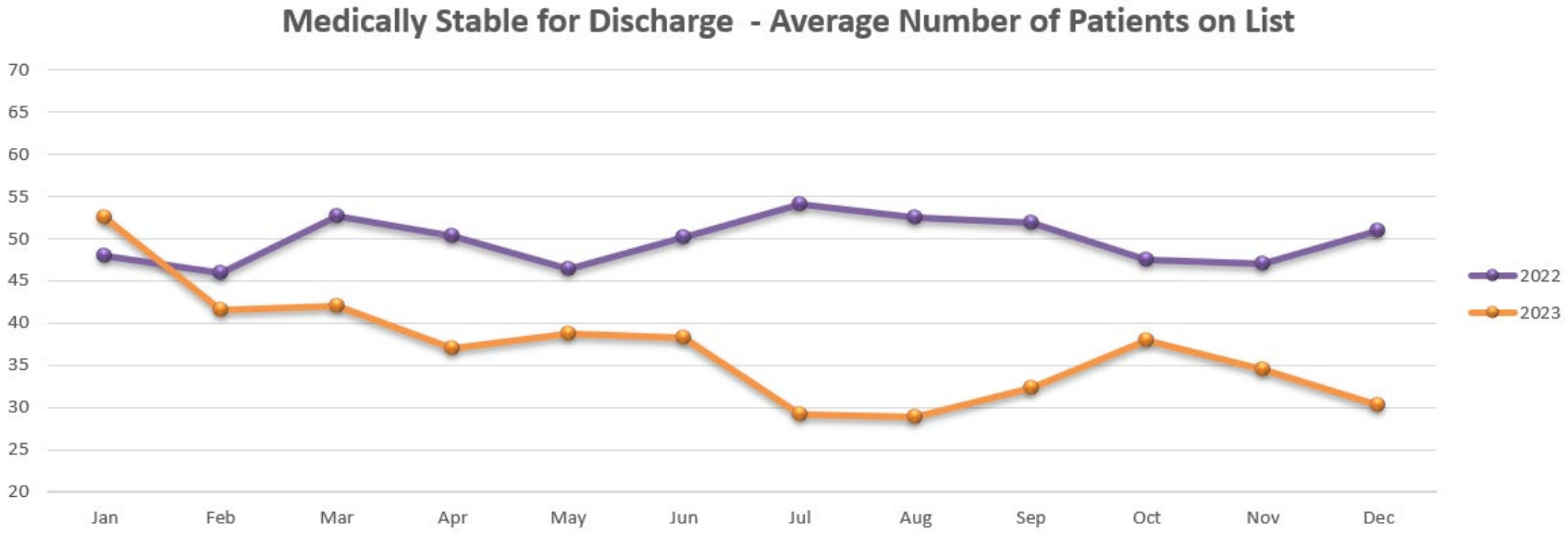
Rapid Response received 365 referrals in December. These are patient with acute exacerbation of symptoms requiring an urgent intervention to potentially prevent a hospital admission. Rapid Response intervention led to 91% of patients avoiding an admission (332).

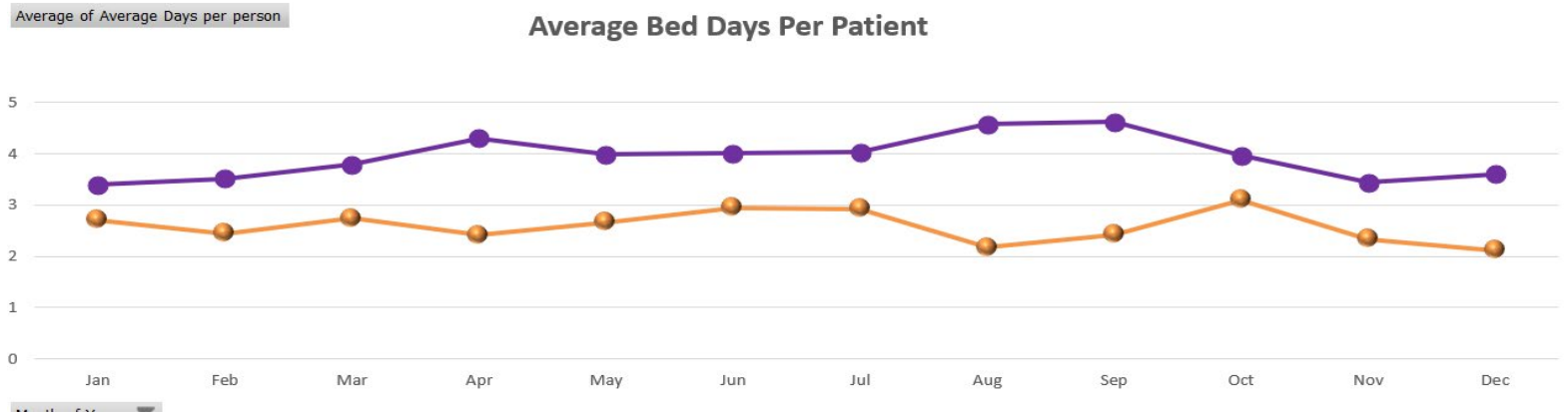
The continuing expansion of our collaboration with WMAS and subsequent increases in referrals has necessitated a review of the operational hour of Rapid Response. It has been established that the service would benefit from moving to a 24/7 model. I project has therefore commenced to merge UCR teams with Rapid Response to expand the operational hours. This project will be completed by the end of the financial year.

Note : Changes in transition from Rapid Response to Urgent Community Response

Last updated :January 2024

Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 30 patients during December 2023





The number of patients on the MSFD list averaged 30 patients during December 2023 with the average length of stay maintained at an average of 2 days demonstrating good flow.

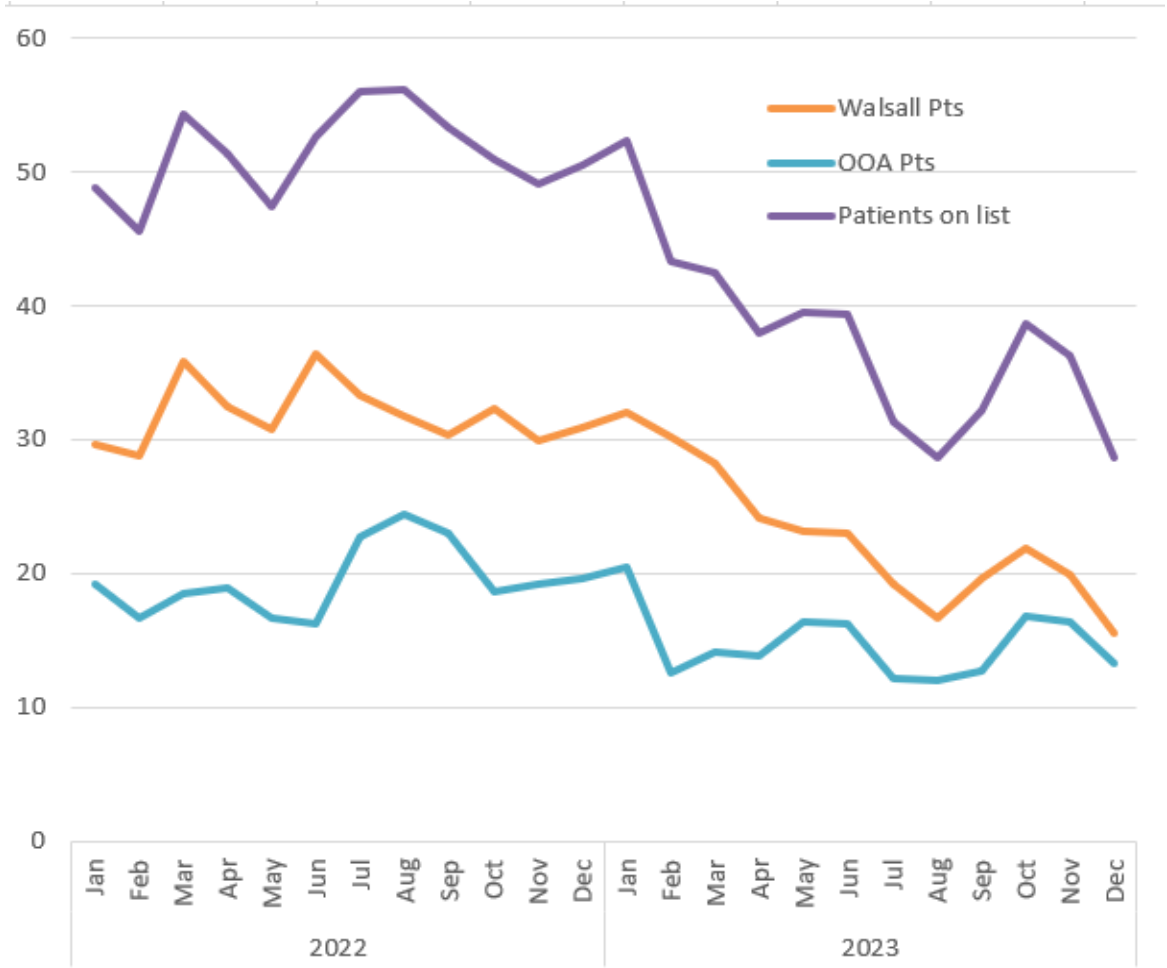
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients. This includes working collaboratively with partner organisations within the system to address the repatriation of patients.

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

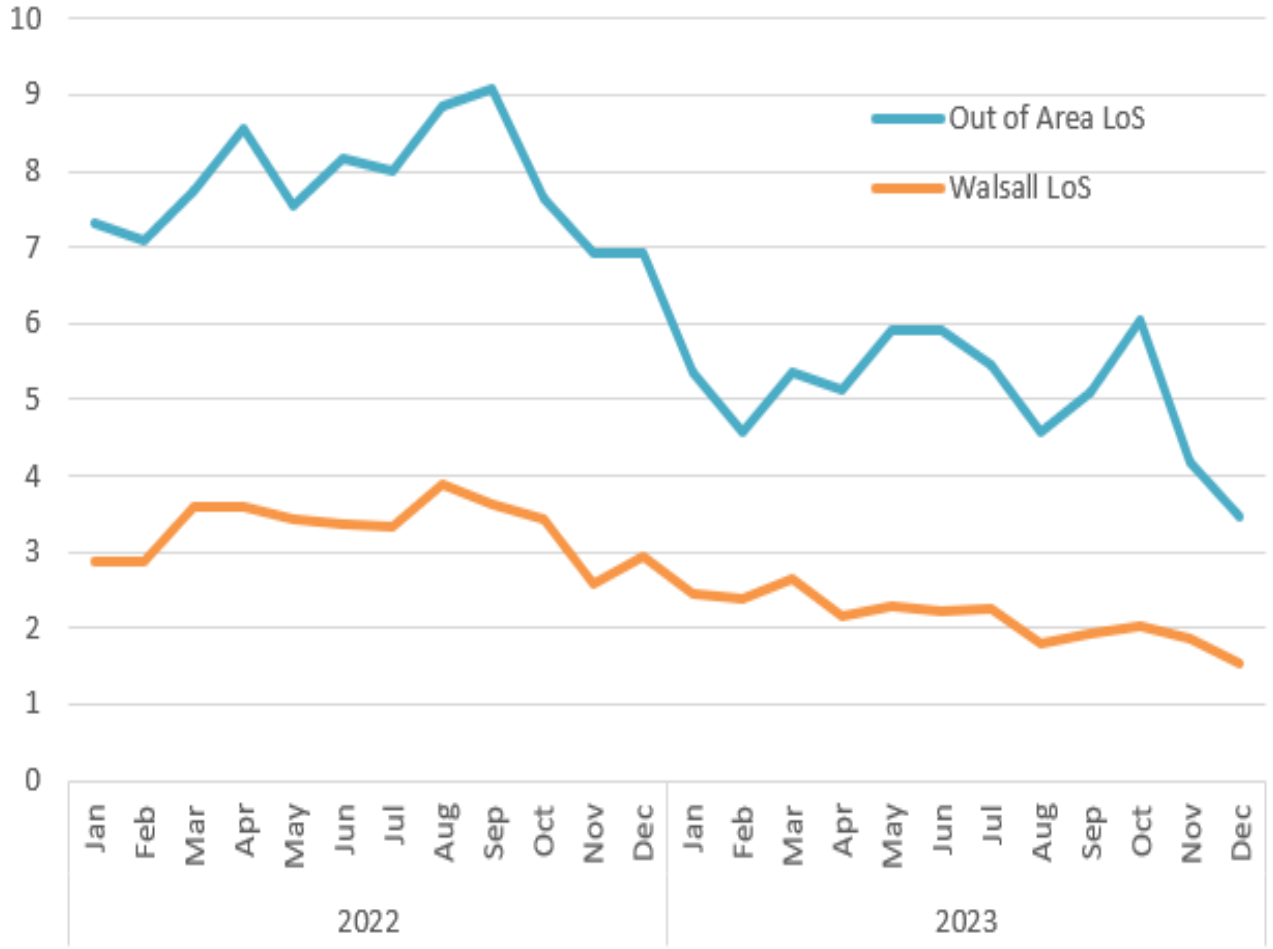
Work is continuing on bolstering up the admission avoidance activity and interventions of the hospital to try and reduce dependency and reduce the demand for packages of care.

Tier 3: Medically Stable for Discharge (MSFD): Walsall vs Out of Area

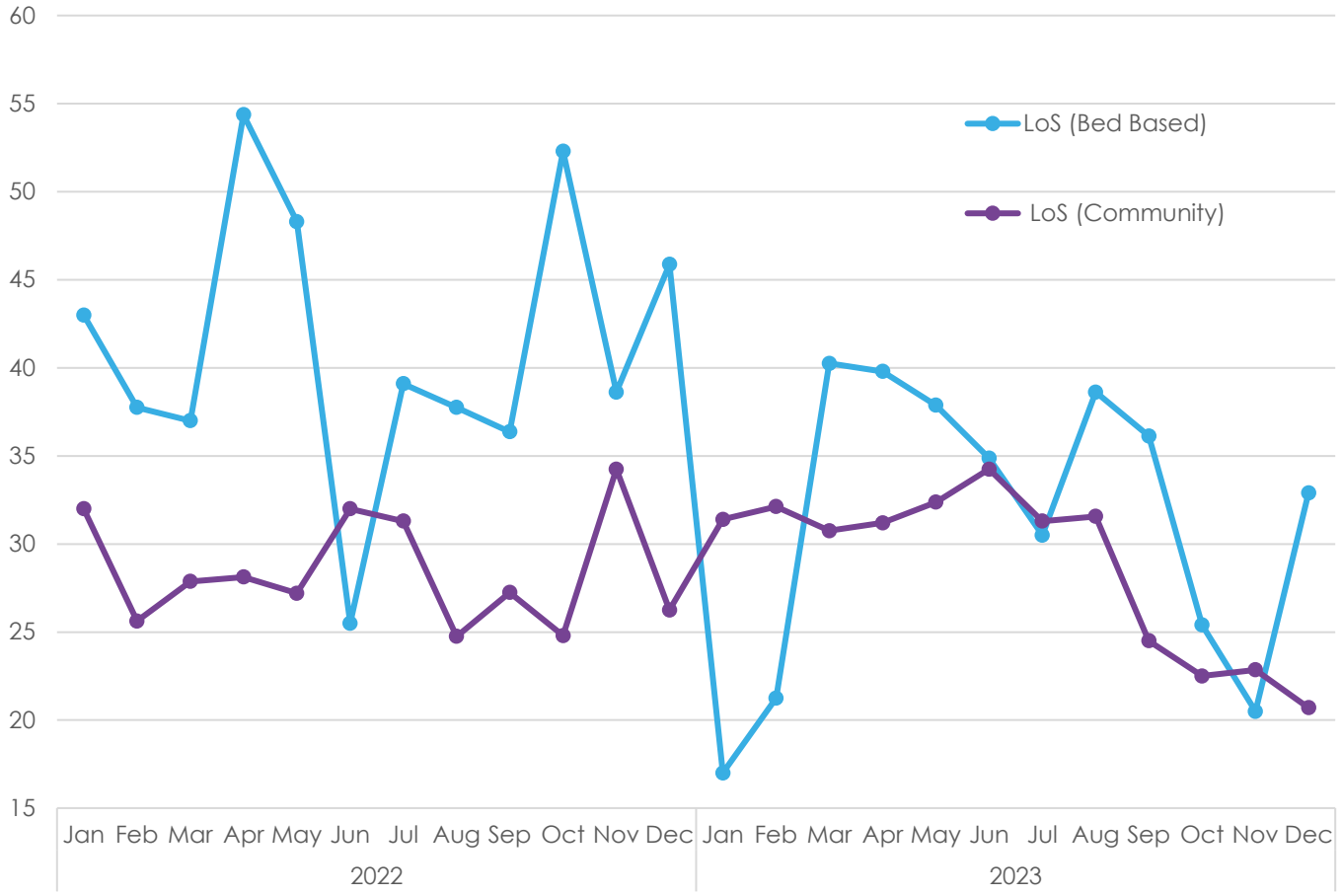
Average Number of Patients on List



Average Length of Stay (LoS)



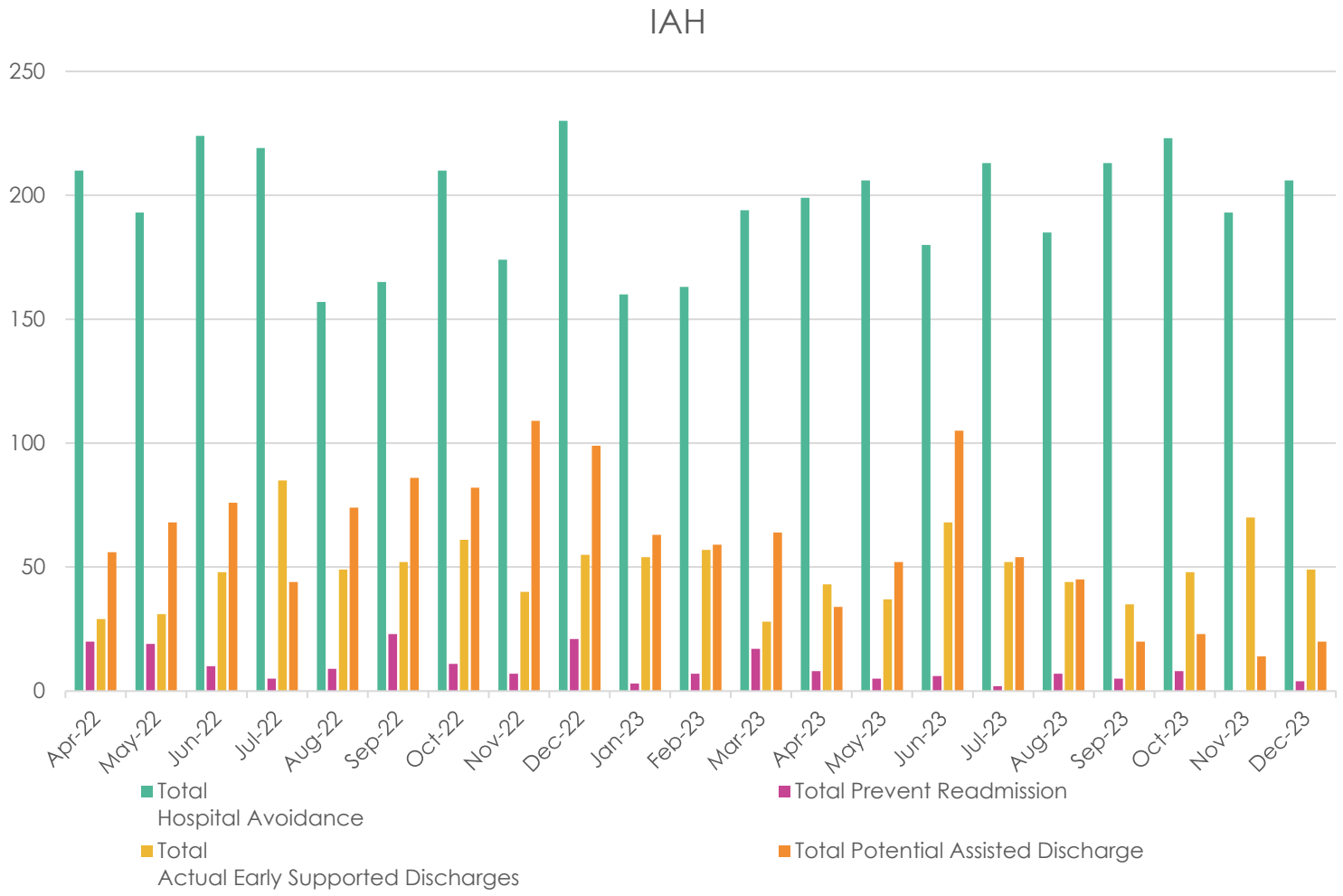
Tier 3: Domiciliary and Bed-Based Pathways



- 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 2024

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 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 2024

Tier 3/4:
Virtual Wards

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

ENC 14.1

Walsall Healthcare NHS Trust

MEETING OF THE FINANCE AND PRODUCTIVITY COMMITTEE HELD ON WEDNESDAY 03 JANUARY 2024 AT 14:30 BOARD ROOM, TRUST HEADQUARTERS, AND MICROSOFT TEAMS

PRESENT

Members	
Mr Paul Assinder	Non-Executive Director (Chair)
Ms Rachel Barber	Associate Non-Executive Director
Mrs Mary Martin	Non-Executive Director
Ms Dawn Brathwaite	Non-Executive Director
Ms Steph Cartwright	Group Director of Place (Part)
Mr Kevin Stringer	Group Chief Finance Officer (Part)
Mr Ned Hobbs	Chief Operating Officer (Part)
Mr Dan Mortiboys	Operational Director of Finance
Mrs Lisa Carroll	Chief Nursing Officer (Part)
Ms Kate Salmon	Deputy Chief Strategy Officer- Improvement and Collaboration
Mr Keith Wilshere	Group Company Secretary
In Attendance	
Mr Stephen Jackson	Director of Operations, Community Services
Mr Stew Watson	Group Director of Estates Development (Part)
Mrs Mel Cox	Executive Assistant
Apologies	
Mr Simon Evans	Group Chief Strategy Officer
Mr Kevin Bostock	Group Chief Assurance Officer
Dr Manjeet Shemar	Chief Medical Officer
Ms Katherine Geal	Executive Assistant

172/2023	**Chair's Welcome, Apologies, and Confirmation of Quoracy**
	Mr Assinder welcomed everybody to the meeting and declared the meeting to be quorate. Formal apologies were received and noted as above.
173/2023	**Declarations of Interest**
	There were no declarations of interest made.
174/2023	**Minutes of Previous Meeting 29 November 2023**
	The minutes from the Extraordinary Meeting held on 20 November 2023 were declared a true record of the meeting held. For the scheduled meeting held on 29 November 2023, Mr Hobbs requested that the Efficiency Update be changed to read: Mr Hobbs provided an update on ERF and the implications on CIP following the recent extraordinary Finance and Productivity Committee, and informed that £12.7M of the £17.2M 2023/24 CIP plan has been identified, with a further £1.3M forecast in pipeline schemes. Mr Hobbs reiterated the Trust commitment to the £14M operational CIP.

	RESOLVED That, having incorporated the changes above, the minutes of the 20 November 2023 and 29 November 2023 be approved as a true and accurate record of discussions and decisions that took place.
175/2023	**Matters Arising**
	There were no matters raised.
176/2023	**Action Log**
	968 Board Assurance Framework- NSR105 That a paper be prepared for March 2024 with a position statement of financial training completed by staff with budgetary responsibility. 998 Forecast Outturn Proposal 2023/24 Mr Stringer to discuss Theatres upgrade clinical and operational risks paper for Trust Board with Mr Hobbs and Finance Team. Mr Mortiboys advised the Theatre upgrade is presented within the Financial Report, including next steps. **ACTION** For further update at January committee. 999 Forecast Outturn Proposal 2023/24 Mr Bostock to arrange discussions with relevant Executive colleagues to align BAF and update Risk Register. Mr Mortiboys confirmed that funding has been approved. **RESOLVED** That the action be closed. 1000 BAF Mr Mortiboys to review BAF NSR105 Scoring. Mr Mortiboys advised that an update will be provided at the next meeting, with the BAF report. **ACTION** For further update at January committee. 1001 Monthly Finance Update Mr Mortiboys to disseminated the most recent draft PWC report in readiness for 15 December 2023. Mr Assinder confirmed that the report has been received. Mrs Martin raised her concern with some aspects of the report. Mr Mortiboys stated that PWC were employed to reduce the Trust deficit, and that the ICB put in a very aggressive balance sheet reduction into the plan, which would never ben achievable. For discussion at upcoming committee meetings.

	RESOLVED That the action be closed. 1002 Monthly Finance Update Mr Mortiboys to bring further details of reductions to next Finance and Productivity Committee. Mr Mortiboys advised that this is an ongoing piece of work and will be included in the Financial Update papers. Mr Mortiboys advised that Grip and Control will be included. **ACTION** For update at next meeting. 1003 Cash Protocol Mr Mortiboys to discuss possible need for media statement with Mrs Sally Evans. Mr Mortiboys advised that this has been discussed at Trust Board. **RESOLVED** That the action be closed. 1004 Constitutional Standards- Community Mr Jackson to provide update of out of area patient LOS to next committee. Mr Jackson advised that this is updated in the report. **RESOLVED** That the action be closed.
PRODUCTIVITY	
177/2023	**Constitutional Standards- Community**
	Report to note. Ms Barber requested that the report include benchmarking and national targets. Mr Jackson stated that there is less benchmarking available for community services. KS suggested that there could be some QI work around virtual ward capacity. **ACTION** Mr Jackson to review benchmarking from the Black Country Out of Hospital Board. **RESOLVED** That the Constitutional Standards- Community Report be received and noted.

178/2023	**Constitutional Standards- Acute, Including Restoration and Recovery**
	Report to note. Mr Hobbs advised that there is challenge in December due to the planned industrial action, as this is the longest period of industrial action so far. Mr Hobbs advised that there has been a round of Outpatient and Elective Procedure postponements and, more critically, there is less resilience in the most challenging week of the year from an Emergency Care perspective, with Consultant level doctors already deployed into core areas for cover. Mrs Martin requested assurance regarding the process for requesting with the BMA that staff are recalled in an emergency situation. Mr Hobbs confirmed that staff can be recalled, through NHSE to the BMA, in an event of a formal major incident with mass casualties, or if a Trust believes that it cannot maintain safe Urgent and Emergency Care. Mr Hobbs advised that in the penultimate round of strikes a number of trusts nationally invoked the process, but the BMA did not agree with any requests. Mr Hobbs assured the committee that he and Dr Shehmar were satisfied with the current plan for cover, though noted that there is less resilience than any previous industrial action periods. Mr Assinder requested that a cost and income statement be provided for Ambulance Intelligent Conveyancing to the next committee to present financial implications of flows to ICB and NHSE. Mr Mortiboys assured the committee that invoices have been raised to South Staffordshire and Birmingham and Solihull at end of Month 9. Ms Barber requested that a review take place of the Constitutional Standards report for both Acute and Community to ensure there is a consistent approach with reporting progress on action plans. **ACTION** Mr Hobbs and Mr Jackson to ensure consistent approach to action plans **RESOLVED** That the Constitutional Standards- Acute, Including Restoration and Recovery report be received and noted.
FINANCE	
178/2023	**Monthly Finance Update- Month 8**
	Report to note. Mrs Martin noted that the report has noted a decrease in Trust income for months, and asked if a bridge was available of 2022/23 income versus 2023/24. Mr Mortiboys assured the committee that the overall funding from the ICB has remained the same, and that last year's movement was for COVID pressures. Mr Mortiboys also assured the committee that Walsall Healthcare NHS Trust received proportionately less income in comparison to other local trusts during the planning process. **ACTION** Mr Mortiboys to share Income Bridge with MM.

	Mrs Martin requested assurance that Senior Executives and Trust Chair are discussing income with the ICB. Mr Mortiboys stated that work has commenced on a piece of work called 'The Walsall Story', detailing the increase in Emergency Care activity, Theatres efficiency, and cost base increases in comparison to other local Trusts. Mr Mortiboys stated that c£9M of PSDS will be spent in year. This is slightly less than the total award, but work continues with the contractor. Mr Mortiboys advised that there were some risks of not fulfilling the whole award. Mr Watson confirmed that there is risk with some large equipment, with order periods of over 30 weeks, but assured the committee that the Trust has experience of working with PSDS, with the order placed this financial year, to be received in the next financial year. Mr Mortiboys stated that a cash request was made to NHSE on 01 December 2023. Mr Mortiboys informed that there is a delayed response from NHSE due to a much higher volume of cash requests made nationally. Mr Assinder requested assurance that the ICB or NHSE nationally will source sufficient cash to Walsall to ensure that bills and staff are paid. Mr Mortiboys stated that there has been no guarantee in writing, but stated that the ICB has been formally informed, money has been borrowed from the ICB, and that cash has been requested formally nationally. Mr Mortiboys stated that an update from NHSE is expected 12 January 2024, and an update will be provided, once received. **RESOLVED** That the Monthly Finance Report- Month 9 be received and noted.
179/2023	**Long Term Financial Plan**
	Report to note. Mr Assinder noted that the report appears to suggest that the Black Country has 'relatively low' levels of deprivation, nationally. This cant be correct. **ACTION** Mr Mortiboys to review wording regarding levels of deprivation and indices measured. Ms Brathwaite requested an update for January 2024 Finance and Productivity Committee regarding PA Consulting assumptions. Mr Stringer informed the Committee that PA Consulting are to finalise their report by close of play Monday 08 January 2024, and an information pack will be disseminated through Trust Board in the two weeks following. Mr Stringer assured that the starting point for planning assumptions will be the PA Consulting plan, and advised that Mr Mortiboys will challenge all individual assumptions with the PA Consulting Team. **RESOLVED** That the draft Long Term Financial Plan be received and noted.
180/2023	**Efficiency Programme Update**
	Report taken as read. Mr Hobbs reiterated the Trust commitment to the £14M operational CIP.

	Mr Assinder stated that 60% of the CIP is recurrent, which is not in line with other local Trusts. Mr Hobbs stated that there have been conversations regarding securing out of area income for Emergency Care, one of the Trust's largest CIPs and, if that can be secured, it will have a material impact on the overall CIP recurrence. **RESOLVED** That the Efficiency Programme Update report be received and noted.
BUSINESS DEVELOPMENT	
181/2023	**Business Case Endorsements**
	No Business Cases for update.
GOVERNANCE	
182/2023	**Trust Risk Register**
	Report to note.
FOR INFORMATION	
183/2023	**Backlog Maintenance Update**
	Report to note. **RESOLVED** That the Efficiency Programme Update report be received and noted.
184/2023	**Any Other Business**
	Nil raised
MEETING GOVERNANCE	
185/2023	**Matters for Escalation to Trust Board**
	The main concern to be reported is the continuing financial pressure, resulting in a worsening deficit position for 2023/24 and our inability to secure sufficient income to support planned activity in 2024/25.
186/2023	**Cycle of Business**
	Document to note.
187/2023	**Reflection of the Meeting**
	Nil raised.
188/2023	**Date and Time of Next Meeting**
	Date: 24 January 2024 **Time:** 14:30-17:00 **Venue:** Board Room, Trust Headquarters and Microsoft Teams

Signed: 

Committee Chair: Paul Assinder

Date: 24 January 2024

Walsall Healthcare NHS Trust

ENC 14.1

MEETING OF THE EXTRAORDINARY FINANCE AND PRODUCTIVITY COMMITTEE HELD ON WEDNESDAY 20 NOVEMBER 2023 AT 16:00 MICROSOFT TEAMS

PRESENT

Members	
Mr Paul Assinder	Non-Executive Director (Chair)
Ms Dawn Brathwaite	Non-Executive Director
Mrs Mary Martin	Non-Executive Director
Mr Kevin Stringer	Group Chief Finance Officer
Mrs Lisa Carroll	Chief Nursing Officer
Dr Manjeet Shemar	Chief Medical Officer
Mr Ned Hobbs	Chief Operating Officer
Mr Kevin Bostock	Group Director of Assurance
Ms Kate Salmon	Deputy Chief Strategy Officer- Improvement and Collaboration
In Attendance	
Mr Stephen Jackson	Director of Operations, Community Services
Mr Stew Watson	Group Director of Estates Development
Mr Dylan Morris	Head of Contracting and Income
Ms Katherine Geal	Executive Assistant (Minutes)
Apologies	
Mr Simon Evans	Group Chief Strategy Officer
Mr Keith Wilshere	Group Company Secretary
Mr Kevin Bostock	Group Chief Assurance Officer
Ms Rachel Barber	Associate Non-Executive Director
Ms Steph Cartwright	Group Director of Place
Mr Dan Mortiboys	Operational Director of Finance

131/2023	**Chair's Welcome, Apologies, and Confirmation of Quoracy**
	Mr Assinder welcomed everybody to the meeting and declared the meeting to be quorate. Formal apologies were received and noted as above.
132/2023	**Declarations of Interest**
	There were no declarations of interest made.
133/2023	**Forecast Outturn Proposal 2023-24**
	Mr Stringer shared the Forecast Outturn Proposal slide pack, and informed the committee that on 08 November 2023, NHS England confirmed by letter that additional funding would be provided to NHS organisations in recognition of the impact of industrial action. The key components of the settlement are: • £800m additional funding, which includes the previously announced £200m winter funding • A reduction in the Elective Recovery Fund target by a further 2.0%

- Relaxation of rules surrounding some ring-fenced resources, allowing local flexibility
- The acknowledgement that local systems may need to take action to deliver improvements, with specific exceptions including the requirement to ensure delivery of Urgent & Emergency Care, Cancer performance, long elective waiters etc.

Mr Stringer outlined the impact assessment of additional funding streams to the committee.

Mrs Martin asked Mr Stringer if the funding offer for industrial action is likely the final financial offer. Mr Stringer confirmed that it was, and the plan was to be submitted for discussion with the ICB on 22 November 2023 on the basis of no further industrial action.

Mr Stringer continued and outlined the proposal to revise the Forecast Outturn Position slide to the committee.

Mrs Martin asked if there was confirmation of the amount of capital that the Trust are planning to defer. Mr Watson informed the committee that capital spend is slowed down in year end, impacting the next financial year. Mr Watson assured the committee that no work on site was ceasing.

Mr Watson briefly outlined the plan for Theatres upgrade; Mr Assinder stated that a piece of work was required to review the clinical and operational risks and any activity associations with deferring Theatre upgrades.

ACTION
Mr Stringer to discuss Theatre upgrade clinical and operational risks paper for Trust Board with Mr Hobbs and Finance Team.

Mr Stringer stated that the Trust are in significant financial deficit, and in Q4 will have to make an application for cash. Mr Stringer confirmed that an update would be made to an upcoming Finance and Productivity Committee regarding the cash application process and the implications for capital prioritisation.

Ms Brathwaite requested clarification regarding the capital programme for the IT upgrade, and asked if it is secured for the entire project. Mr Stringer confirmed that the funding is from a national fund, and that there is no guarantee that funding will be secured for the entire project. Mrs Martin furthered that there was news that £200M had been removed from the national technology bid, though this has not yet been formally confirmed with Trusts.

Discussion was had regarding the need for governance assurance, given the significant, elevated risk.

ACTION

	Mr Bostock to arrange discussions with relevant Executive colleagues to align BAF and update Risk Register. Mrs Martin requested assurance that the PwC and PA report would be received for Finance and Performance Committee review prior to submission to Trust Board. Mr Stringer stated that the PwC report will likely be available for the November committee and the PA Consulting report available for December. Mr Assinder asked if there were any ERF benefits that could be traded against the £4.5M additional ask. Mr Hobbs stated that by lowering the threshold by 2%, it is estimated to drive £1.5M above the lowered threshold. Because of existing ERF income backed CIP schemes, the vast majority will be reflected against the efficiency programme. Mr Stringer outlined the final draft system solution slide to the committee and advised that CEOs and CFOs recently met to consider options to resolve the remaining financial challenge to deliver the system plan. This resulted in the re-framing of the proposed £5M capital to revenue transfer programme put forward by RWT and WHT so that it could be grossed up with the other capital to revenue transfer has been supported by a suite of other options and challenges. Mr Stringer advised that a letter has been received from Mr Mark Axcell, asking if Trusts can reduce the gap of the capital to revenue, if the Trust can evidence in-depth review of expenditure, and if the trust supports a move to a system-wide vacancy review panel for clinical and non-clinical posts. An executive meeting has been arranged to discuss. Mrs Martin stated her disappointment that Trusts across the Black Country have been asked the question, when it is known that clinical and executive colleagues are responsible for ensuring that the Trust provides safe care to our patients, and deciding on this centrally would be impossible. Mrs Martin stated that Plan B detailed in the report would mean waiting lists would grow and that, not only would the Trust not be able to spend on programmes, but WHT would not be able to provide any additional sessions to ease the waiting list. Mrs Martin raised that there is increasing national scrutiny for midwifery, with unfunded positions to ensure there is adequate staffing, and asked for assurance that there were no plans to cut parts of this workforce. Mrs Carroll informed that there is adequate workforce in maternity Services, but there has been a skills mix issue. Mrs Carroll confirmed that there is safe staffing in Maternity Services.
134/2023	**Any Other Business**
	NHSE Return

	Mr Hobbs outlined the NHSE supplementary return, summarising the topline operational implications: • The 4 hour system A&E performance, as described in the winter plan. Mr Hobbs stated that the Trust is committed to 4 hour emergency access as a standard trajectory. The Trust acknowledge that there is a risk, particularly given that the winter planning envelope was not as extensive as it could have been. • The March 2024 Cancer 62 day backlog position set out in the 2023/24 Operational Plan, and The March 2024 Cancer Faster Diagnosis Standard performance set out in the 2023/24 Operational Plan. Mr Hobbs stated that the Trust is already inline or ahead of both trajectories. • Core General and Acute Bed capacity growth committed to within the winter plan- Mr Hobbs confirmed that the Trust are above the number of G&A beds committed to • An ambulance handover average delay trajectory, that is consistent with the overall system-level trajectory has been agreed by the Trust Board. Mr Hobbs stated that the average ambulance handover is between 14-20 minutes, and that October was a challenging month at 20 minutes. Mr Hobbs stated that he believes it reasonable to commit to the trajectory for the next 5 months. Mr Hobbs stated that the supplementary report is to be submitted through Trust Board. **RESOLVED** That the committee recommend the supplementary report be submitted through Trust Board.
MEETING GOVERNANCE	
135/2023	**Matters for Escalation to Trust Board and Meeting Reflection**
	Under delegated authority, the Trust approves the re-submission of 2023-24 financial and operational plan for the remainder of year with some clear caveats. The committee notes assurances around no change to the elective plan as set out previously. The committee expresses concern regarding the service implications and efficiency implications of the phasing back of the capital programme, particularly in respect to the Theatre refresh programme and IT development programme. The committee has asked for assurance regarding the continuation of central funding of IT developments. The Committee approved the programme with the caveat that the Trust undertake a comprehensive risk assessment of clinical and wider service implications. The Committee has made no commitment to any plan B arrangements, and if the capital to revenue transfer programme is not supported by NHSE (or any other detail involved in the plans) that will then need to come back to Board for a different debate around implications to that. There is concern regarding the underlying financial position of the Trust and how that sits as part of next year's contractual discussions with Commissioning colleagues.

	The Committee notes the fragility of the cash position. More detail and sophisticated modelling is required in terms of the rest of the financial year.
149/2023	**Date and Time of Next Meeting**
	Date: 29 November 2023 **Time:** 14:30-17:00 **Venue:** Board Room, Trust Headquarters

Signed:

Committee Chair: Paul Assinder

Date:

ENC 14.1

MEETING OF THE FINANCE AND PRODUCTIVITY COMMITTEE HELD ON WEDNESDAY 29 NOVEMBER 2023 AT 14:30 BOARD ROOM, TRUST HEADQUARTERS, AND MICROSOFT TEAMS

PRESENT

Members

Mr Paul Assinder	Non-Executive Director (Chair)
Ms Rachel Barber	Associate Non-Executive Director
Mrs Mary Martin	Non-Executive Director
Ms Dawn Brathwaite	Non-Executive Director
Ms Steph Cartwright	Group Director of Place
Mrs Lisa Carroll	Chief Nursing Officer
Dr Manjeet Shemar	Chief Medical Officer
Mr Ned Hobbs	Chief Operating Officer
Mr Dan Mortiboys	Operational Director of Finance
Ms Kate Salmon	Deputy Chief Strategy Officer- Improvement and Collaboration

In Attendance

Mr Stephen Jackson	Director of Operations, Community Services
Mr Paul Steventon	Head of Financial Strategy and Services
Ms Katherine Geal	Executive Assistant (Minutes)

Apologies

Mr Simon Evans	Group Chief Strategy Officer
Mr Keith Wilshere	Group Company Secretary
Mr Kevin Bostock	Group Chief Assurance Officer
Mr Stew Watson	Group Director of Estates Development
Mr Kevin Stringer	Group Chief Finance Officer

150/2023	**Chair's Welcome, Apologies, and Confirmation of Quoracy**
	Mr Assinder welcomed everybody to the meeting and declared the meeting to be quorate. Formal apologies were received and noted as above.
151/2023	**Declarations of Interest**
	There were no declarations of interest made.
152/2023	**Minutes of Previous Meeting 25 October 2023**
	The minutes were declared as a true and accurate record of discussions and decisions that took place. **RESOLVED** That the minutes from the 25 October 2023 be approved as a true and accurate record of discussions and decisions that took place.
153/2023	**Matters Arising**
	There were no matters raised.
154/2023	**Action Log**
	Trust Financial Outturn That a Business Case summary be prepared for the Finance and Productivity Committee going forward.

	Ms Salmon advised that an update would be prepared for the next committee. *Board Assurance Framework- NSR105* That a paper be prepared for March 2024 with a position statement of financial training completed by staff with budgetary responsibility. A paper will be prepared for the March 2024 Finance and Productivity Committee *Constitutional Standards- Community* Mr Jackson to review dataset for performance metrics in slide pack. Mr Jackson advised that the metrics will be verbally presented to committee this month, and a line will be added to the performance information pack from next month. **RESOLVED** That the performance metrics be made formally available from next month.
BOARD ASSURANCE	
155/2023	**Board Assurance Framework**
	Full report received for information and noting, with formal review to be noted for the below actions, delegated to Finance and Productivity Committee: NSR101 Cyber Attack Current Risk Rating: 15. Mr Assinder advised that the recommendation is for the risk rating to remain at 15. NSR105 Financial Sustainability Current Risk Rating: 20 Mr Assinder stated that there has been previous committee discussion to raise the risk rating to 25, and asked if there were any comments or concerns regarding this. Mr Hobbs stated that previous agreement was that the risk score would be increased in sync with the Trust declaring not met the financial plan, which is true given change in deficit from £14M to £18.5M. It was agreed by the committee that the risk should remain at 20, following the Risk Scoring Matrix, and as the financial forecast is still under review. Mrs Martin raised concern regarding the assurance and progress rating review, stating that the negative assurances are marked as 'red' for progress, but 'green' for level of assurance, noting that assurance should be 'red'. Mrs Martin noted that the Gaps in Control section of the BAF also required review. **ACTION** **Mr Mortiboys to review BAF NSR105 scoring**
FINANCE	
156/2023	**Monthly Finance Update- Month 7**

Mr Assinder raised that an extraordinary Finance and Productivity Committee was held on 20 November 2023 to consider the new system plan submission, which was vested on increased capital for revenue transfers across the System, from Midlands Metropolitan Hospitals fund, some additional CIP, and vacancy freezes. Mr Assinder stated that a letter had since been received from NHSE that rejected the submission. Mr Assinder advised that the committee did not approve sign up to a Plan B.

Mr Assinder stated that on 15 December 2023 a session had been arranged for Black Country ICB and WMAS to review the PA Consulting Review, with PA Consulting present; it was noted that the review had not yet been made available for reading prior to the 15 December 2023 session. Mrs Cartwright clarified that final assumptions are expected by 01 December 2023, and that review of current assumptions are ongoing. Mr Hobbs added that the report will likely be made available for December Trust Board committee, though will be for review, not approval.

Discussion was had regarding the PwC report, which details £8M of opportunities; Mr Mortiboys confirmed that £3M of these opportunities are deemed viable by the Trust, advising that there will be substantial risk to these opportunities.

Mrs Martin requested assurance that PwC are providing Impact Assessments. Mrs Cartwright advised that Impact Assessments have not yet been received at present, that it would be expected that Trust leads would work through the detail and the Impact Assessments be formally prepared following agreement of assumptions.

ACTION

Mr Mortiboys to disseminate most recent draft PwC report in readiness for 15 December 2023

Mr Mortiboys updated the committee on the latest round of financial recovery, and advised that NHSE had asked for a return, rejecting the revenue transfer of £18M and Midlands Metropolitan Hospital funding, leaving a £28M gap across the Black Country ICB. Mr Mortiboys advised the committee that all choices proposed System were not supported by NHSE. Mr Mortiboys advised that a further submission has been made; awaiting response.

Mr Mortiboys presented the report to the committee and opened for questions.

Mrs Martin requested assurance regarding unfunded rotas. Mr Mortiboys informed the committee that all areas have been covered in WTE meetings commenced in October 2023 and ongoing Financial Recovery meetings, and include review of agency medics and rota changes, which have resulted in reduced agency spend.

Ms Barber asked what opportunities were had regarding resources in relation to controls and processes. Mr Mortiboys advised that there is challenge on spend, and that WTE is being monitoring closely, and that the Trust will be more rigorous regarding headcount going forward.

	ACTION **Mr Mortiboys to bring further details of reductions to next Finance and Productivity Committee.** Mrs Martin requested assurance on Debtors. Mr Mortiboys assured the committee that Walsall Council have paid £2.5M in November 2023 and that further update would be provided at the next committee meeting. Mr Mortiboys updated the committee regarding the ICB debt, with payment made to reduce the debt to £1.6M. Dr Shehmar raised that there is increased temporary non-clinical spend in Pharmacy, and that there are a number of temporary staff in place that a substantive post cannot yet be offered to due to not being in budget. A business case has gone to the recent Investment Committee, which was agreed in principle despite there not being a funding stream. Mr Assinder requested an update on overall substantive establishment. Mr Mortiboys advised that substantive staff has increased significantly in the last 18 months and agency use has reduced. In terms of actual staffing numbers, work around Bank usage will be a challenge; work has been done to bridge the headcount, which will be shared at Finance and Productivity Committee.
157/2023	**Cash Protocol**
	Mr Mortiboys presented the Cash Protocol report to the committee for Board support and approval, and advised that, based on the outturn the Trust is facing, a cash injection is required. Mr Mortiboys advised that there are two possible sources; through sharing cash in the ICB, which the Trust has been advised to do, and the second to request cash from NHSE. A report has been prepared for NHSE to continue to work with ICB colleagues. Mr Mortiboys advised that it is important to note that The Dudley Group Trust have also raised a request for cash. Mr Mortiboys furthered that it would be appropriate for WHT to receive cash support from The Royal Wolverhampton NHS Trust. Mr Mortiboys informed the committee that the cash request was for £28.5M. Mr Assinder requested assurance regarding capital spend. Mr Mortiboys advised that the plan is to still spend capital; furthered by Mr Steventon who advised that the request assumes the original capital spend. Ms Barber asked if there was a PR plan for the cash request. Mr Mortiboys advised that the information would be available to the public via the Trust Balance sheet. Discussion was had regarding the possible requirement to have appropriate communications prepared to manage the message. The committee formally supported the application for cash. **ACTION** **Mr Mortiboys to discuss possible need for media statement with Mrs Sally Evans.**
158/2023	**Efficiency Programme Update**
	Report taken as read.

	Mr Hobbs provided an update on ERF and the implications on CIP following the recent extraordinary Finance and Productivity Committee, and informed that £12.7M of the £17.2M 2023/24 CIP plan has been identified, with a further £1.3M forecast in pipeline schemes. Mr Hobbs reiterated the Trust commitment to the £14M operational CIP. Mr Hobbs advised that, year to date, £6.3M is at the same level of the 4 year delivery last year, and that it is highly likely that this will be the largest CIP delivery in some years. Mr Hobbs informed the committee that the ERF transacted at Month 7 is against the old threshold, and that the view is to seek to transact 50% of ERF as CIP, 40% offset to deliver, and 10% for support costs to ensure the Trust has correctly covered expenditure. Mr Hobbs advised that at Month 7 before the threshold was changed, the Trust were £1M ahead of the ERF plan, and that the Finance team had worked through the implications of the 2% threshold being lowered, which will de-risk some of the £14M forecast. Mr Hobbs stated that the majority of the red risked CIP schemes are within the medical division, and are largely associated with income for urgent and emergency care provided to the population outside of the Walsall borough. Invoices have been prepared for the relevant Systems. Mr Mortiboys confirmed that benefits of the invoices to other Systems has not yet been seen. **RESOLVED** That the Efficiency Programme Update report be received and noted.
159/2023	**Reduction in Temporary Medical Spend**
	Report taken as read. Dr Shehmar outlined the report to the committee, and advised that the Trust remains overspent on medical staffing, mainly driven by locum bookings, but the drivers for this is understood. Dr Shehmar advised that agency spend has reduced significantly. Dr Shehmar advised that some staff rotas in general Surgery have been found to be non-compliant, and new rotas have been put in place to address. Dr Shehmar advised that an issue has been identified with the Allocate system used to record job planning, with the system recording a job plan once the staff member has commenced in post rather than lining up with the job planning cycle. Dr Shehmar assured the committee that a manual record plan has been completed. Dr Shehmar highlighted the innovative ways divisions have managed the job planning cycle which has reduced reliance on temporary staffing, and advised that learning opportunities will be shared across the Trust.
PRODUCTIVITY	
160/2023	**Constitutional Standards- Community**
	Report to note.

	Mr Jackson introduced the report to the committee and outlined the following, below. There have been significant increases in activity, with community s=nursing services delivering 600 more hours in October 2023 in comparison to October 2023. The Care Navigation Centre received an additional 100 calls than in September 2023, and the Rapid Response Team saw a significant increase in referrals, with 321 patients avoiding admission as a result of intervention by the team. Mr Jackson informed the committee that the Integrated Fron Door Service saw the second best performance in October 2023, with 223 patients seen in the Emergency Department by the team and redirected into Community Services for support. Mr Jackson stated that the number of patients on Medically Safe For Discharge (MSFD) was 38 in October 2023, with average Length of Stay (LOS) maintained at 3 days. Mr Assinder asked what was driving the increase in LOS, previously reported at 2.5 days to just over 3 days. Mr Jackson advised that this is in part driven by out of borough patients, advising that there are some issues working with external processes, but assured the committee that there are good working relationships with neighbouring boroughs. **ACTION** **Mr Jackson to provide update of out of area patient LOS to next committee** **RESOLVED** That the Constitutional Standards- Community report be received and noted.
161/2023	**Constitutional Standards- Acute, Including Restoration and Recovery**
	Report to note. Mr Hobbs introduced the report to the committee and outlined the following, below. October 2023 was a challenging month for emergency care, with the highest attendance on record. There was a significant deterioration against the 4 hour wait and ambulance handover standards. Mr Hobbs assured the committee that the Trust still benchmarked highly, though this reflected challenges across the midlands. Mr Hobbs stated that data for November suggests performance has stabilised, though risk remains high in emergency care. Mr Hobbs informed the committee that the Trust was formally accredited as a GIRFT surgical hub in October 2023, one of only 24 Trusts in the country to receive accreditation. Mr Hobbs stated that 62 Day Cancer performance remains in the upper quartile, but advised that Cancer Services benchmark slightly below national median, in part due to Breast and Skin Cancer 2WW pressures. Mr Assinder requested an update on Endoscopy. Mr Hobbs advised that backlog has remained flat over the last 3 months. Mr Hobbs informed the committee that the service

	are most of the way through the formal management of change, and have revised the timetable for Endoscopists, expecting the realise the benefit of increased industrial action from January 2024. Mr Assinder asked if there were plans to provide a hub for Respiratory Syncytial Virus (RSV) per last year. Mr Hobbs advised that because of SDF funding there have been some constraints, so a paediatric hub will not be provided to the same level as last year, but advised that there will be designated respiratory support for paediatrics. **RESOLVED** That the Constitutional Standards- Acute, Including Restoration and Recovery report be received and noted.
162/2023	**ICS Update (Verbal)**
	Ms Salmon provided an update to the committee, and informed of the below: The Black Country Provide Collaborative (BCPC) clinical summit was well attended October 2023. Ms Salmon advised that there has been a review of the repatriation of Sandwell Vascular activity back to the Black Country from UHB. Ms Salmon informed the committee that good progress is being made in the Critical Care Network and Skin Network, with the Skin network redistributing PMO support to their networks as their priorities have been achieved. Ms Salmon stated that there a proposal has been presented to establish Dudley Group as a Renal Robotic Centre of Excellence. Ms Salmon advised that there have been some changes in the Black Country with the development of a new System Operating Model. Mrs Cartwright stated that the final model will be shared with colleagues for review and is for discussion at Trust Board in February 2024 to discuss what will be transferred through delegation from the ICB out to Trust as host and then into the partnership. Mrs Cartwright advised that Walsall Together are already hosted by the model.
163/2023	**Investment Group Update**
	Ms Salmon updated the committee regarding the Business Case Post Implementation Reviews. Dr Shehmar stated that it is extremely useful and reassuring to see the benefits realisation, and that work should be done by the QI team to publish or submit business cases for awards. Ms Salmon stated that work had commenced for a recent AMU Business Case to do this.
164/2023	**Review of Tor for Efficiency Programme**
	Mr Hobbs presented the updated Terms of Reference with tracked changes for formal approval, and informed that an additional paragraph has been added that delineates between Trust CIP and System level FRP and how that will be managed. Ms Carroll requested that a review of job titles be completed. **ACTION** **Mr Hobbs to update job titles throughout document**

	RESOLVED That the Terms of Reference for the Efficiency Group be approved, subject to changes discussed.
GOVERNANCE	
165/2023	**Trust Risk Register**
	Report to note.
ESTATES	
166/2023	**EPRR Update**
	Mr Hobbs updated the committee that the core standard self-assessment presented to committee in September 2023
	Any Other Business
	Nil raised
MEETING GOVERNANCE	
	Matters for Escalation to Trust Board

	• Financial Performance 2023/24 YTD
	  ○ Deficit Plan 2023/24 £14.7m
	  ○ M6 deficit position £20.8m, £8.2m worse than period plan
	  ○ Drivers: excess inflation, cost of industrial action, additional staffing in ED and Paediatrics
	• Cash- projected need for external loan funding likely required in Q4
	• Concern regarding robustness of Trust's Annual Financial Plan
	• Re-casting of 2023/24 Financial Plan to be completed for Board consideration for re-submission to ICB
	• Black Country ICS off plan by £27m
	• Endoscopy Services challenge with 1,700 patients waiting over 2 weeks for scans
	• Cancer Services- 86% met the 62 day wait targets in September 2023
	• Industrial Action- Cancellations to date 2,610 outpatients and 202 surgical procedures

	Cycle of Business
	Document to note.
	Reflection of the Meeting
	Discussion was had regarding the detailed agenda and the need to amend the start time by 30 minutes to allow for more detailed discussion.
	Date and Time of Next Meeting
	Date: 29 November 2023 **Time:** 14:30-17:00 **Venue:** Board Room, Trust Headquarters

Signed:

Committee Chair: Paul Assinder

Date:

Walsall Healthcare NHS Trust

MEETING OF QUALITY COMMITTEE
HELD ON FRIDAY 24 NOVEMBER 2023
HELD VIRTUALLY VIA MICROSOFT TEAMS

Members

Dr J Parkes	Non-Executive Director (Chair)
Dr M Shehmar	Chief Medical Officer
Mrs L Carroll	Chief Nursing Officer
Mr N Hobbs	Chief Operating Officer
Mrs O Muflahi	Associate Non-Executive Director
Ms F Allinson	Associate Non-Executive Director
Mr K Bostock	Group Director of Assurance

In Attendance

Ms S Noon	Executive Assistant (Minutes)
Mrs A Boden	Associate Director, Nursing Operations and Deputy Director Infection Prevention and Control
Mrs J Wright	Director of Midwifery, Gynaecology and Sexual Health
Mr S Jackson	Divisional Director of Operations, Community
Mr K Wilshere	Group Company Secretary
Ms M Metcalfe	Deputy Group Director of Assurance

Apologies

Professor L Toner	Non-Executive Director

575/23	**Chair's welcome, apologies, and confirmation of quorum**
	Dr Parkes welcomed all members and attendees to the meeting and declared the meeting to be quorate. Apologies noted from Professor L Toner. The meeting was recorded.
576/23	**Declarations of Interest**
	Ms Metcalfe highlighted that her husband has been appointed as an Executive Director at University Hospital Birmingham.
577/23	**Minutes of Previous Meeting – Friday 24 November 2023**
	Minutes approved with no amendments.
578/23	**Items for Redaction**
	There were no items for redaction and minutes were approved for publication.
579/23	**Matters Arising and Action Log**
	There were no matters arising. Action 542 Mr Hobbs confirmed that the action plan has been received however the version received was not able to come to committee and stronger assurance has been requested. Chair agreed for this to be presented at January's committee.

	Action 561 Mrs Carroll confirmed that this data will be included from January 2024. Action 563 Mr Bostock confirmed progress has been made and there is better operational engagement between teams across RWT and WHT. There are several incidents, duty of candour and other matters that need to progress however the engagement has commenced and a member of the team is now attending Walsall safety huddles. To remain open, further assurance to be discussed at committee in January 2024.
	Items for Discussion, Approval and Assurance
580/23	**CQC Action Plan Update and Section 29A Notice Response**
	Mr Bostock confirmed that the 29A notice has now closed but Medicines Management Group are following through with the relevant actions. Dr Shehmar confirmed that the Medicines Safety Officer report provides assurance. Critical medications such as insulin and controlled drugs training are a focus, and a programme of work has commenced around anticoagulation. The Medicines Management Policy is the outstanding action from the 29A notice which is complete and going through the governance process.
581/23	**Constitutional Standards and Restoration and Recovery Report**
	Report taken as read. Mr Hobbs confirmed there has been a deterioration in the 4-hour emergency access standard and handover performance however the Trust still benchmarked well against other organisations. November figures have stabilised. The allocation of additional funding associated with a letter from Julian Kelly means that the funding gaps of option 2 of the winter plan are closed and there is assurance that the board approved option is fully funded. The breast and skin tumour sites remain under pressure in terms of referral to treatment time although Mr Hobbs noted that this is a short-term issue, predominantly due to staffing paternity leave and an unforeseen absence.
582/23	**Performance Constitutional Standard Report - Community**
	Report taken as read. Increase in demand during October, delivering over 600 more hours of care when compared to September 2023. Rapid response team achieved 85% 2-hour response against a referral of 345 patients which is above the 70% national target. Integrated 223 patients received and redirected to community services. Mrs Muflahi asked for reassurance that Health Visitors are coming into the system. Mr Jackson confirmed that, compared to 18 months ago, the Trust are in a better position with delivering mandated contacts. All are being delivered face to face because of the skill mix and re-profiling within the 0-19 service and children at risk have always been and remain priority. Recruitment of Health Visitors remains a challenge and the team are utilising 1 cohort per year to 'grow our own'. Trying to recruit Health Visitors via normal routes however this remains challenging due to the national shortage. Mrs Carroll confirmed that looked after children are prioritised, and risk assessments are in place. There have been no changes to prioritisation and executives have approved the plans moving forward which will go to the local authority safeguarding for information. A meeting will also be arranged with the ICB. As a group of Chief Nurses, this is going to be reviewed at a

	system level as this is a national issue. 45% of registered Health Visitors are not working within the NHS. Ms Allinson asked if long covid figures are a one off or if this a potential upwards trend with a need to step up long covid clinics again? Mr Jackson noted that due to funding there is a retained capacity within long covid clinics. There is sufficient funding to continue to deliver the service in its' present form.
583/23	**Safe High Quality Care Oversight Report (to include the Board Assurance Framework, Corporate Risk Register and Performance Dashboard)**
	Report taken as read. There has been a decrease in sepsis compliance at 67.14% compared to 75% in the previous month. The outreach and sepsis teams are working with the low compliance areas. Paediatric ED is an area of focus for paediatric sepsis compliance, particularly education around ensuring episodes of care are closed down. The new nationals PEWS needs to be in place by April and embedded by the end of the next financial year. This will not be an electronic system as SystemC will not be updating their system until version 5 which is beyond the deadline. A paper option or alternative system will be considered for implementation. Christian Ward, Deputy Chief Nursing Officer is responsible for the digital portfolio and is supporting the group. Mrs Carroll has been assured that MyAcademy data is correct and therefore non-compliance with level 3 safeguarding training will result in a letter being sent out. Mrs Muflahi queried the quality impact of the wound formulary replacement product due to cost savings. Mrs Carroll confirmed that the Tissue Viability team led the system wide review and the product being replaced will not impact on the level of quality. Mrs Muflahi noted an increase in tissue viability referrals and asked how the caseload is being manage. Mrs Carroll noted that the caseload is being managed safely at present. Dr Shehmar noted that the Colorectal improvement programme has a new clinical lead and progress is being made. There is audit assurance about consultant delivered ward rounds and length of stay of 5+ days has reduced from 73% to 67% and so far 30-day postoperative mortality has reduced from 6.3% to 2.4%. Ms Allinson asked if it is possible to split out getting patients dressed, eating and drinking properly. LC confirmed this is possible and 'eat, drink, dress, move to improve' was launched across the Trust yesterday and an impact should be visible as months go on.
584/23	**Maternity Services Update**
	Item 7.9, Maternity Services Supporting Documents, were included in the papers as part of CNST evidence and are for information. Mrs Wright confirmed both nursing and medical staffing has improved. Neonatal services are safely staffed but this is utilising locum and agency spends. A business case is in place. Mrs Muflahi noted that it is concerning that the EDI Midwife only has 4 months remaining on their contract. Mrs Wright confirmed that nationally, EDI roles are being withdrawn as it should form part of everyday business and funding from within the division is being considered. Mrs Carroll added that the role is important however the LMNS funding ends at the end of the financial year. LC supports this role and is exploring funding options.

	Mrs Muflahi asked if, from the national CQC survey, is there assurance that the Trust are getting a reflective picture. Mrs Wright does not believe so as the report is not broken down demographically. The division are trying to address this, and Mrs Wright has contacted the national team to build into the surveys moving forward. Mrs Wright asked if neonates sit under midwifery. Mrs wright confirmed it does not and the national profile is maternity neonatal care. Mrs Carroll added that there are different drivers for making this one service however there is no national mandate at present. Neonatal care sits under paediatric services, and it is about how the teams work together and how that relationship can be strengthened further. Accountability sits within the care group and is clearly defined. Dr Shehmar has met with the ICS regarding the LMNS review of stillbirths within the Black Country. Dr Shehmar asked for progress with the single point of access for early bookings for maternity. Mrs Wright confirmed that the Trust are at approximately 670 more women booked compared to this time last year. Mrs Muflahi asked if there is an interpreting service for maternity services that is not language line. Mrs Wright confirmed that there is Wordski that incorporates a physical person or there is language line. There is also a buddy system where staff members that speak another language could support. Issues identified are how people are using the interpreting services such as emergency interpreting which is currently being reviewed by the Quality and Safety Lead.
585/23	**Serious Incident Update**
	Report taken as read. Ms Metcalfe confirmed that there were 5 serious incidents reported, 3 closed. Duty of candour is improving at 82% at part-quarter. Work is ongoing regarding serious incident actions and aligning overdue actions to QI projects as per PSIRF methodology. Mrs Muflahi noted concern around the number of actions from serious incidents that remained open at a recent meeting reviewing maternity and children, across several disciplines, some being open for 5 or 6 months. Mrs Carroll confirmed that at the safety champion bi-monthly meeting incidents and risks are discussed in greater detail. Mrs Wright also noted that on review of actions, evidence is in place and they can be closed therefore Mrs Wright will contact responsible owners. Palliative Care Formulary Mr Bostock would like to sight the committee that a policy will be updated to state that if an external expert body have guidelines scheduled for review and it is not completed by that date, but it is live and active on their website, the Trust recognises this as an active guideline.
564/23	**Corporate Risk Register - Quality**
	Report taken as read, no questions received from the committee.
	ITEMS FOR INFORMATION
	Reports will be taken as read and questions only will be addressed
565/23	**104 Day Harm Update**
	Report to note.
566/23	**Recall Project Update (Complex Case)**
	Report to note.

	Mrs Muflahi asked if funding into the project will continue. Dr Shehmar confirmed that the cohorts that have been looked at are almost complete. Working very closely with Spire private sector who have completed a review around lower limbs which identified issues however the Trust's initial audit for lower limbs showed no issues. Spot audits of other cohorts will be completed to ensure all areas have been covered. If there are no further cohorts for review, the review of patient notes will be completed early next year and the quality process and learning will commence.
567/23	**Medicines Safety Officer Report**
	Report to note.
568/23	**Health Records Improvement Plan**
	Report to note. Mr Hobbs confirmed estates work is taking place to allow Health Records to function in a fit for purpose environment. The speed at which the transfer to electronic records of inpatient episodes of care is not going to be easily accelerated beyond the current programme timetable. Operational issues are being worked on however this only mitigates the risk in the interim period. Mrs Muflahi met with the information governance team and a concern was raised regarding the loose filing covid backlog. Mrs Muflahi would like to know if this has been resolved. Dr Parkes added that this is historical and was happening prior to Covid. Ms Allinson asked if there has been harm to patients from loose papers missing from patient records. Dr Shehmar has previously reported that although harm has not specifically been identified, it compromises and can delay reviews. This is on the risk register. **Sam Smith and Nick Bruce to attend the next Quality Committee for further discussion.**
569/23	**IPC Annual Plan Update**
	Report to note. OM asked if there is any further national C Diff data. Mrs Boden noted a national increase of C Diff. At the last national forum 2 months ago, there was a discussion on undertaking research to determination levels of colonisation of adults given the increase. Mrs Boden has the opportunity to present at joint clinical forum to highlight the wider context.
570/23	**IT Security Improvement Plan**
	Report to note.
571/23	**Safeguarding Quarter 2 Report**
	Report to note.
572/23	**Maternity Services Appendices**
	CNST papers included to support item 6.5 as follows: • Neonatal Medical and Nursing Staffing CNST requirements • Medical Workforce Staffing CNST requirements • Birthrate plus • Perinatal Equality Surveillance Data Set review • Q1 & Q2 moderate and above incidents • Triangulation of claims complaints and incidents • ATAIN Q2 report • HSSIB Monthly report • PMRT Q1 Report • Saving Babies Lives Q1 & Q2 reports. • MVP contract and renumeration arrangements • Safety Action 2 Compliance confirmation • Transitional Care Guideline • CQC Maternity Survey Co produced Action plan. • Safety Action 8 Local Training plan and Action plan to implement emergency scenarios in the clinical area • ICB Maternity Peer Review Report. Nil discussion.

573/23	**Board Assurance Framework & Heatmap**
	Mr Wilshere requested approval of the Board Assurance Frameworks. Dr Parkes to confirm with Mr Wilshere outside of the meeting as to whether there are changes or if they are accepted. Dr Parkes confirmed outside of the meeting that they are approved pending the committee name change to Quality Committee.
	Closing Items
574/23	**Exception Reports from any Subgroup Reporting to Committee**
	No exception reports were received for discussion.
575/23	**Matters for Escalation to the Trust Board**
	• Emergency care during October (however improving in November, Mr Hobbs has data to support this). • Sepsis • EDI Midwife funding
576/23	**Any Other Business**
	Mrs Muflahi wanted to highlight Assistant Practitioner in paediatric respiratory services (Joanne Mason) who took part in the support worker film as she is a positive advocate for Assistant Practitioners.
577/23	**Reflections on meeting**
	Nil discussion.
578/23	**Date of next meeting**
	Friday 26 January 2024, 11.30-13:30 Via Microsoft Teams

Signed: J Parkes

Committee Chair: Dr J Parkes

Date: 26 January 2024

PEOPLE COMMITTEE

MINUTES OF THE MEETING HELD ON MONDAY 27TH DAY OF NOVEMBER 2023 AT 13:30 VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Mr Junior Hemans **(Chair)**	Non-Executive Director
Mr Paul Assinder	Deputy Trust Chair and Non-Executive Director
Mrs Dawn Brathwaite	Non-Executive Director
Ms Clair Bond	Interim Director of Operational Human Resources and Organisational Development
Miss Rachel Barber	Non-Executive Director
Mrs Lisa Carroll	Chief Nursing Officer

In Attendance

Mrs Jane Wilson	Joint Staff Side Representative – Unison
Mrs Pat Usher	Joint Staff Side Representative – Unison
Mr Suleman Jeewa	Lead Freedom to Speak Up Guardian
Dr Tamsin Radford	Occupational Health Consultant
Mr Brad Allen **(Minutes)**	Executive Assistant

Apologies

Mr Alan Duffell	Group Chief People Officer
Mr Kevin Bostock	Group Director of Assurance

091/23	**Chair's Welcome, Apologies and Confirmation of Quorum**
	Mr Hemans welcomed all members to the meeting and thanked them for their attendance. The meeting was declared quorate in line with terms of reference and apologies were noted and recorded above.
092/23	**Declarations of Interest**
	There were no declarations of interest raised by members.
093/23	**Minutes of Previous Meeting – October 2023**
	Having been circulated to members prior to the meeting, there were no comments or amendments from committee. It was **resolved** that the minutes of the meeting that took place on 30th October 2023 be **approved** as a true and accurate record of decisions and discussions that took place.
094/23	**Matters Arising and Action Log**
	Committee noted that there were no outstanding actions requiring discussion.

095/23	**Integrated Care Board Update**
	Ms Bond introduced the report as read and highlighted the following points to committee for their reference: • Ms Bond had been appointed Co-Chair of the Workforce Transformation Group. • An on-going review of financial positions is taking place across the entire network to ensure funds are spent as efficiently as possible. Mr Hemans queried whether there were any expected impacts from workforce analysis reviews. Ms Bond suggested that conversations were taking place to identify alternative ways of working to ensure funds were being spent efficiently. Mrs Brathwaite queried whether these financial reviews were due to impact services for the remainder of the financial year or whether they would continue into financial year 2024/25. Ms Bond advised that reviews were taking place within the current financial year only. Ms Bond then advised members that an offer had been issued from the BMA (British Medical Association) to Doctors nationally, with further balloting for industrial action expected throughout December should this not be accepted. Ms Bond also advised committee that a piece of work relating to Band 2 and 3 colleagues was underway with Unison to be concluded within the coming three months and presented to committee for oversight. Miss Barber referred to the Bands 2-3 review and suggested there could be some financial overspend and requested clarity on the number of Bands 2 and 3 colleagues there are within the Trust. Ms Bond responded to advise that whilst she didn't have the exact figures of colleagues to hand, a number of colleagues had come forward for a role review due to undertaking additional duties. It had also been noted that some Job Descriptions were out of date, therefore were in need of a review, with most Band 2 colleagues being from Clinical Support Worker backgrounds. Mr Hemans queried whether the costs for any increases in banding were to be included within the current financial year or 2024/25. Ms Bond advised that any amendments to costs had been reviewed should any immediate changes be needed, which could result in back-payments covering a number of years. There were no further comments from members.
096/23	**Corporate Risk Register**
	Ms Bond introduced the report as set out and updated committee on each corporate risk within the committee remit for reference.

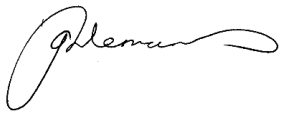
	There were no questions or observations from members. **RESOLVED** That committee note the contents of the report for their assurance.
097/23	**Safe Staffing**
	Mrs Carrol introduced as read and highlighted the following points to members for their reference: • Several Clinical Nurse Fellowship colleagues had already commenced employment at the Trust, with no more international Nurses due to start at the Trust until the next financial year. • Increase to off-framework figures have been reported due to increase in demand in areas such as UECC (Urgent and Emergency Care Centre), Paediatrics and Neonates. • A re-design to the pathways of the Health Visiting Team had been undertaken to ensure that all colleagues meet the needs of their mandated contracts, with the formal report receiving full support from Walsall Executive Team. Mr Hemans referred to mandatory training requirements for Bank colleagues and requested assurance that compliancy figures would improve in the near future. Mr Carroll assured Mr Hemans that improvements would be seen as soon as My Academy access had been granted to colleagues. Mrs Barber questioned how Bank colleagues could be removed from employment should their training compliancy not improve. **ACTION:** **Mrs Carroll to review Bank Colleague compliancy figures and provide an update at the next committee in January 2024.** There were no further comments from members. **RESOLVED** That committee note the contents of the report for assurance.
098/23	**Trust Workforce Metrics**
	Ms Bond introduced as read and highlighted the following points to members for their reference: • Staff turnover rates had reduced to 10.4% overall. • Mandatory and statutory training figures remain challenging, but improvements had been seen in recent months.

	• Overall sickness levels (October 23) were reported at 5.6%, with winter illnesses accounting for the majority of cases. • Appraisal rates for staff had increased slightly on month and were reported to be heading in the right direction. Mrs Wilson referenced Flu Vaccination uptake figures and queried whether any feedback had been received as to why colleagues had chosen to not get vaccinated. Mrs Carroll responded to advise that vaccination fatigue seemed to be one of the main reasons for hesitation, but figures were not too dissimilar across the country. Dr Radford added that some colleagues chose not to disclose their reason when reviewing flu vaccination questionnaires. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
099/23	**Workforce Plan Update**
	Ms Bond introduced the report as read and gave a brief overview of performance, spend and plans to ensure robust governance processes were in place to ensure the organisation was prepared prior to formal submission. A joint Trust ICB meeting had been established to hold inter-organisational discussions, of which data would be provided to committee for reference, with the first round of reviews currently taking place with clinical Divisions. Mrs Usher referred colleagues to demand, and capacity figures relating to mental health support and queried whether any of this additional funding could be reclaimed. Mrs Carroll advised that funds could be reclaimed depending on where patients came from and stated that staff were undertaking additional training to ensure patient safety. Mrs Barber queried whether committee would have the chance to review the governance process that was previously mentioned prior to implementation. Ms Bond responded to advise that committee would have chance to review the process at either January or February 2024 committee depending on progress. There were no further comments from members. **RESOLVED** That committee note the content of the reports for their assurance.
100/23	**Appraisal Deep Dive**

	Ms Bond introduced the item and gave a brief overview of the Trust's current position to appraisal rates and summarised that the organisation had not achieved the 90% target in 3 years, averaging at approximately 77% overall. Ms Bond then gave a detailed briefing on month data, advising how many people had their appraisals undertaken during September and October 2023, citing that the intention was to undertake a review of all areas to identify where a 3-month deterioration in figures could be identified for support. Ms Bond concluded by informing committee that it was the intention to have finalised data on this project by the end of March 2024. Ms Brathwaite stressed the importance of this subject being continually reviewed and that committee have oversight of the final heatmap once produced. Ms responded to assure that all future reports would include heatmap references for committee oversight. Ms Barber requested clarity to the total ratio of appraisers to appraisees to ensure colleague workloads were fair. Ms Bond responded to advise that each area differed in ratio numbers, but gave an example of a ward area that typically had a ratio of 7:34. Ms Barber queried pay progression elements to appraisals and sought clarity as to whether the Trust enforced colleagues meeting their targets during their appraisals before any pay progression was awarded. Ms Bond assured members that the Trust had introduced a performance related pay initiative to ensure colleagues only received payment increments once certain criteria had been met. Ms Barber requested clarity to whether any amendments had been made to Nursing and Midwifery appraisals processes following the Lucy Letby case. Mrs Carroll responded to advise that no appraisal process could be robust enough to identify nor prevent a similar member of staff working in the organisation. Mrs Usher summarised the appraisal figures as a whole as poor and queried what sanctions were in place should managers not undertake effective appraisals, which could in turn impact colleague pay progression. Mr Hemans and Brathwaite stressed the importance of Managers having an up-to-date appraisal to ensure colleagues within their remit received a robust review, as well as feel empowered to speak up should they have any concerns within their job roles. There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance.
101/23	**Staff Survey Update**

	Ms Bond introduced the report and highlighted the following updates for committee reference: • All field work closed on Friday 24th November, with full results expected to be received in February/March 2024. • It was anticipated that the final response rate would be around 47%, with Bank Colleague response rates expecting to be within the region of 17%. Ms Bond placed on record her thanks to colleagues for their support with the initiative. There were no further comments from members.
102/23	**Board Assurance Framework / Corporate Risk Register**
	Ms Bond introduced the reports as set out and highlighted the following updates for committee's information: • Risk 2072: Trust-wide Shortage of workforce capacity and capability. Remains a 9 Moderate having reduced from a 12 Moderate in September 2023. • Risk 2489 - Trust-wide: Staff bullying, discrimination and harassment. Risk has remained unchanged as a 12 Moderate. • Risk 3036 – Reduction in workforce due to industrial action that will impact safe patient care. Risk has reduced in month from 16 High to Moderate 12. Ms Bond advised members that in addition to this, the Joint Behaviour Framework report had been submitted to the Executive Group meeting for oversight, with the formal consultation with staff due to commence in January 2024. There were no further comments from members. **RESOLVED**
103/23	**Assessment of Compliance against NHS England Agency Rules**
	Ms Bond advised members that this would become a standing item at all future People Committees to provide specific information as to how workforce is utilised against agency framework, with a report to accompany the item for committee assurance. Mr Hemans queried who the executive lead for the report would be. Ms Bond responded to advise this was due for discussion with colleagues at the Executive team meeting on 28th November 2023.

	RESOLVED That committee note the contents of the report for their information.
104/23	**Items for Information**
	Having been circulated prior to the meeting, members **resolved** to note the contents of the reports as set out. There were no comments from members.
105/23	**Escalations to Trust Board**
	RESOLVED That committee escalate the following points as part of the highlight report to Trust Board. • Adjustments to workforce working group. • Safe Staffing and Bank Agency staffing. • Workforce Plan data submissions. • Bank and Agency review data. • Skills mix across workforce and how we might allocate workforce across the trust should areas be over established. • Previous and current business case governance process development. • Appraisal deep dives updates and data. • Overall 77% appraisal compliance. • Staff survey figures when initiative closes. • Increase to Bullying and Harassment cases where staff are experiencing increased poor behaviour. • Use of agency rate monthly item at People Committee.
106/23	**Any other Business**
	Committee noted the contributions of Mrs Wilson during her tenure as Joint Staff Side lead and thanked her for her service. There were no further comments from members.
107/23	**Date and Time of the Next Meeting**
	Committee noted that the next meeting would take place on Monday 29th January 2024 at 13:30 via Microsoft Teams.

Signed: 

Mr Junior Hemans – Chair of the People Committee

29th January 2024

Trust Management Committee

Date/time: Thursday 23rd November 2023
Venue: Via Microsoft Teams
Quorate: Yes
Chair: Mr N Hobbs

Mr N Hobbs	Chief Operating Officer/ Deputy Chief Executive
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Mr K Bostock	Group Chief Assurance Officer
Ms M Arthur	Group Deputy Director of Assurance
Ms L Carroll	Chief Nursing Officer
Mr C Ward	Deputy Chief Nursing Officer
Ms C Whyte	Deputy Chief Nursing Officer
Ms S Mirza	Deputy Chief Medical Officer
Ms K Salmon	Deputy Chief Strategy Officer
Mr S Jackson	Director of Operations – Community
Ms K Geffen	Divisional Director of Nursing – Community
Dr N Usman	Divisional Director of Medicine and Long-Term Conditions
Ms R Joshi	Deputy Divisional Director - MLTC
Mr W Roberts	Deputy Chief Operating Officer/Director of Operations, Medicines, and Long-Term Conditions
Mr W Goude	Divisional Director of Surgery
Ms K Rawlings	Divisional Director of Nursing – Surgery
Ms T David-Eyen	Deputy Divisional Director of Women's, Children's & Clinical Support Services
Mr M Ncube	Divisional Director of Clinical Support Services
Mr J Richardson	Deputy Director of Operations, WCCSS
Ms J Wright	Director of Midwifery, Gynaecology and Sexual Health
Ms C Bond	Deputy Director of People and Culture
Ms P Boyle	Group Director of Research and Development
Ms J Longden	Divisional Director of Estates and Facilities
Ms S Chand	Deputy Director of Pharmacy
Ms R Tomkins	Deputy Divisional Director of Nursing, Division of Medicine & Long-Term Conditions
Ms A Boden	Deputy Director Infection Prevention and Control

In Attendance:

Ms E Stokes	Senior Administrator for Group Company Secretary
Ms J Toor	Senior Operational Coordinator for Group Company Secretary
Ms L Ferris	Head of EPRR
Mr P Steventon	Head of Financial Strategy
Ms J Wilson	Joint Staffside Lead

Apologies:

Prof D Loughton	Group Chief Executive
Mr K Stringer	Group Chief Financial Officer/ Group Deputy Chief Executive
Dr J Odum	Group Chief Medical Officer
Mr A Duffell	Group Chief People Officer
Ms S Cartwright	Group Director of PLACE
Mr K Wilshere	Group Company Secretary
Ms L Nickell	Group Director of Education and Training
Mr N Bruce	Group Director of Digital Technology
Dr M Shehmar	Chief Medical Officer
Ms P Usher	Joint Staffside Lead
Mr D Mortiboys	Interim Finance Director
Mr F Ghazal	Divisional Director of Women's, Children's & Clinical Support Services
Ms S Webley	Divisional Director of Operations – Surgery
Ms S Giddings	Head of Midwifery
Mr S Evans	Group Chief Strategy Officer
Ms C Yale	Divisional Director of Nursing – Paediatrics and Neonates

707/23	**Chair's welcome, Apologies and confirmation of Quorum**
	Mr Hobbs welcomed everyone to the meeting and apologies were noted.
708/23	**Minutes of Trust Management Committee held on 26 October 2023**
	Mr Hobbs confirmed the minutes of the meeting held Thursday, 26th October 2023 as an accurate record. **Resolved: that the minutes of the last meeting held on 26th October 2023 be received and APPROVED.**
709/23	**Matters Arising and Action Log**
	Mr Hobbs received the action log and updates were noted as follows. Action 940 - Ms Wright and Ms Giddings to provide an updated timeline on the implementation of the Birth Rate Plus review. **Ms. Wright advised that the Trust had contacted Birth Rate Plus in September 2023 and they had provided a quote to complete this within the financial year 2023/24 at a cost of £11K.** This action was closed. Action 939 - Mr Hobbs, Dr Shehmar and Ms Carroll to ensure that the Respiratory Support Unit Business case was on the ICBs strategic commissioning committee agenda. **Mr Hobbs advised that the business case had been received and endorsed at the Integrated Care Board (ICB) Strategic Commissioning Committee on 9 November 23 and would be considered as part of prioritisation for 2024/25 investment funds.** This action was closed. Action 929 - Ms Boden to provide assurance from the Infection Prevention Committee of divisional oversight of prescribing practice and the access of MicroGuide for all prescribers. **Ms Carroll confirmed that Ms Boden had undertaken an audit of Clinical Trust Computers to ensure user access to MicroGuide. She said MicroGuide would be included in future Junior Doctor inductions to promote use of the system.** This action was closed. Action 941 - Ms Carroll and Joint Staffside Leads to have a final review of the WHT-OP1001 V2 Uniform and Dress Policy. It was noted that Ms Carroll had been delegated authority by Mr Hobbs, as Chair of TMC to publish the final policy following a final review. **Ms Carroll confirmed that the changes had been made to the policy following a meeting with Joint Staffside Leads and the updated policy had been uploaded to the intranet.** This action was closed. **Resolved: that the Action Log be reviewed and updates received and noted.**
710/23	**Policies, procedures for approval and information**
	Mr Bostock provided a summary of the policies report and asked that the listed policies be reviewed and approved. The following procedural documents which have gone through the full review process were recommended for approval during PMCG. 1. WHT-MP01 V4 Nil by Mouth Policy - Adults Patient 2. WHT-OP998 V1 Electrical Safety Policy 3. WHT-CP05 V8 Deprivation of Liberties Safeguards (DOLS) Operational Policy 4. WHT-OP94 V4 Supportive Mealtimes/Making Mealtimes Matter Policy 5. WHT-OP1008 V1 Patient Safety Incident Response Policy. 6. WHT-CP1004 V1 Fast Track Release of a deceased adult, child, baby or foetus policy 7. WHT-MP1002 V3 Medicines Purchasing for Safety Policy. 8. Procedure for the Clinical Supervisor Supervising the Administration and Vaccination of the Comirnaty® Original/Omicron BA.4-5 (15/15 micrograms)/dose V1.1. 9. Covid 19 Vaccination Recipient Pre-Screening & Consent Form 2023-2024 V7. 10. Preparation and Administration of Comirnaty® Original/Omicron BA.4-5 (15/15 micrograms)/dose vaccine Trust Wide Sop V1.1. 11. WHT-IP1005 V6 Decontamination of Medical Devices Medical Policy 12. Sedation for Scans and Painless Procedures in Children Trust Wide Sop V5.0 **Resolved: that the above listed policies be received and APPROVED.**
711/23	**Chief Nursing Officer Report**
	Ms Carroll advised that the Trust had reported 7 *C-Difficile* cases in October 23 of which 2 cases had been deemed avoidable and 5 had been deemed unavoidable and said that the learning from the unavoidable cases had been shared amongst staff. Ms Carroll reported that the timeout antimicrobial ward rounds that were conducted by microbiology and pharmacy continued to showcase more unavoidable cases than avoidable cases monthly. She said the Trust had shared the actions with the Integrated Care Board (ICB) who had been assured with the processes the Trust had in place. Ms Carroll advised that the Trust had received positive feedback from an internal visit from the.

	Ms Carroll advised on the increase in cases of measles and said that staff were advised to get vaccinated however this was not mandatory. She said 22% of the paediatric workforce had not been vaccinated and these staff members would be invited to receive the vaccination from occupational health. She explained that as measles was highly contagious, risk assessments for working in frontline practices would be undertaken for those staff who refused the uptake of the vaccination. Ms Carroll reported that the Covid-19 and Flu vaccine was available for staff until 15 December 23. Ms Carroll advised that as the Executive Lead for Special Educational Needs and Disability (SEND) within the Trust, she continued to meet with the SEND team monthly to update them on ongoing work. Ms Carroll reported that the Trust had received a letter from The Thirlwall Public Inquiry advising that the Inquiry would commence its' investigation into all Trusts neonatal units following the Lucy Letby case. She said Dr Shehmar and Mr Hobbs would be required to formally respond to the 44 questions that had been submitted to the Trust as part of the initial data gathering for the inquiry. Ms Carroll advised that there would be a Local Maternity and Neonatal System (LMNS) Black Countrywide review of perinatal mortality commencing in 2024. Mr Hobbs reported that Ms Carroll had appeared on the mainstage of the National Chief Nurse Officer Summit. He said this was a testament to all the hard work of colleagues who continued to deliver high quality and urgent emergency care across the organisation. **Resolved: that the Chief Nursing Officer Report be received and noted.**
712/23	**Infection Prevention Report**
	Ms Boden advised on the Trusts increase in *C-Difficile* cases, and said the Trust had begun to review overall positivity versus overall sampling and a decline in trend had been noted. She said this had been highlighted with caution as the Trust moved into the peak of the winter period. Ms Boden reported that the Trust had experienced a ward closure due to Norovirus , and said that the Infection, Prevention and Control Team had been assured with the processes put into place and how staff had followed the Norovirus policy. She said the index case on this occasion had been associated with a relative who had attended the day prior and had not advised that they had symptoms prior to the visit. Ms Boden advised that some of the entry point resources had been revitalised to encourage patients to not visit the hospital if they had any Norovirus symptoms and that this information would also be relayed to patients ringing the Trust through switchboard. Ms Boden advised that the Integrated Care Board (ICB) had visited the Trust on 13 November 23 following the Trust's increase in cases. She said the ICB had advised that they would be visiting every provider Trust across the Black Country to review actions surrounding *C-Difficile*. Ms Boden reported that the ICB had been assured with the interventions the Trust was undertaking and no nursing practice issues had been highlighted. Ms Boden reported that she and Dr Plant had presented a clear breakdown across divisions signifying the areas requiring improvement in relation to antimicrobial stewardship. She said the Trust had demonstrated overall improvements with Key Performance Indicators (KPI's) and the refined level of detail of indication for certain antibiotics. Ms Boden advised that the Trust had a small set target of 6 pseudomonas cases for 2023/24 due to its' previously good track record of pseudomonas blood stream infections. She said that compared with national benchmarking the Trust had been scored 16 out of 136 Trusts with lowest rates of pseudomonas infections. Ms Boden reported that the Little Voices initiative had won the gold award for patient experience at the Infection Prevention Society (IPS) awards ceremony. Ms Carroll said it had been great to see the Infection Prevention team presenting at the IPS ceremony. **Resolved: that the Infection Prevention Report be received and noted.**
713/23	**Safeguarding Report – For Information Only.**
	Resolved: that the Safeguarding Report be received and noted.
714/23	**Maternity Services Report**
	Ms Wright provided a position update on the Trust's Clinical Negligence Scheme for Trusts (CNST) requirements and advised that included within the Maternity Services Report was the below evidence requirements. • Neonatal Medical and Nursing Staffing CNST requirements • Medical Workforce Staffing CNST requirements • Birthrate plus safe staffing and calculations

- Perinatal equality surveillance data set review
- Q1 & Q2 moderate and above incidents
- Triangulation of claims complaints and incidents
- ATAIN Q2 report
- HSSIB monthly report
- PMRT Q1 report
- Saving babies lives Q1 & Q2 report
- MVP contract and renumeration arrangements
- Safety action 2 compliance confirmation
- Transactional care guideline
- CQC maternity survey co-produced action plan
- Safety action 8 local training plan and action plan to implement emergency scenarios in clinical area
- ICB maternity peer review report

Ms Wright reported that the Trust's Medical Staffing and Neonatal Nurse Staffing currently did not meet the British Association of Perinatal Medicine (BAPM) standards with the existing substantive staffing. She said the Trust did meet BAPM standards with nurse bank and locum staffing and a business case was in progress to ensure that BAPM standards were met within the substantive staffing workforce. She said the Trust had safe staffing and continued to work to secure the funding required.

Ms Wright advised that a full anaesthetic cover rota was in place in obstetrics and the medical workforce was fully staffed with no gaps in the rota and staff could refer to the stepping down policy on the Trust intranet if there were concerns. She reported 2 new members of staff would join the obstetric medical workforce in November 23.

Ms Wright reported midwifery staffing as compliant for birth rate plus requirement. She said that data for December 23 would reflect the figures more accurately and said that the Trust continued to maintain substantive staff.

Ms Wright reported 8 Maternity Support Workers (MSW) had been recruited to maternity services. She advised of significant MSW vacancies and said that the Trust continued to work to recruit against these and that the outstanding vacancies had not caused any issues within the service. She advised that the Trust had maintained 1:1 care in labour and the shift coordinator was supernumerary on all occasions.

Ms Wright reported that the Trust had met the national requirement for staffing and had been recorded at 87% against the 85% acuity target. She reported that Practical Obstetric Multi-Professional Training (PROMPT) compliance had been recorded as over 90% for all professional groups.

Ms Wright reported on the safety championship work the Trust was undertaking and that meetings were continued to take place with Ms Muflahi the Maternity Safety champion and Ms Carroll Chief Nursing Officer completing patient safety walkabouts and that data was reviewed from patients and staff on which areas maternity services could improve.

Ms Wright reported that service user feedback continued to be shared with staff to improve the service and the Trust's Equality, Diversity and Inclusion (EDI) Midwife continued to work with disadvantaged service users and ethnic minority service users to ensure their voices were heard. She said the Trust had seen an increase in morale from the changes made. Ms Wright said the Trust had seen an increase in family and friends testing responses raising from 5-6 responses to 36-37 responses per week.

Ms Wright advised that all Trust Committee reports would include the Trust's perinatal surveillance data to ensure full transparency of what was happening within maternity services.

Ms Wright reported on the Trust's Avoiding Term Admissions to Neonatal Units (ATAIN), Saving Babies Lives and Perinatal Mortality Review Tool (PMRT) data. She said that the Trust's ATAIN data was above the National recommendation of 6%.

Ms Wright reported the Trust had received 1 Healthcare Safety Investigation Branch (HSSIB) case. She advised that the baby had received no negative outcome from the incident and had been well enough to return home and would continue to be monitored by the Trust.

	Ms Wright reported that the Trust continued to support The Royal Wolverhampton NHS Trust (RWT) as they had seen an increase in the predicted number of births for 2024. She said the increase had been due to the launch of the Badgernet Maternity App which was a self-referral app that automatically referred women into the service early which had resulted in an excess of women that RWT were able to accommodate via scanning. Ms Wright said the Trust would continue to work collaboratively with RWT as this would be an ongoing issue. She said the Trust had transferred 45 births from RWT to Walsall Healthcare NHS Trust (WHT) in October 23. Ms Wright advised that the Midwifery Led Unit had a planned opening date for January 2024. Ms Wright reported that the Trust had secured additional Clinical Negligence Scheme for Trusts (CNST) year 4 payment of £284,596.80K. She said this had been awarded to the Trust for successfully achieving all 10 safety actions. Ms Wright advised that the Trust had recently completed a Local Maternity and Neonatal System (LMNS) Peer Review. She said the review had been very successful for the Trust and great feedback had been received. She reported that any recommendations that had been highlighted continued to be worked against. Mr Hobbs commented on the importance of all divisions and services across the Trust which contributed to maternity care to continue to ensure women and babies received the best possible outcomes. **Resolved: that the Maternity Services Report be received and noted.**
715/23	**Research and Development**
	Ms Boyle reported that 2023 had been the Trust's best year for recruitment into commercial research. Ms Boyle advised that initial local analysis indicated that the Trust continued to recruit participants who reflected the population the Trust served and analysis work would be presented to the Clinical Research Network (CRN) to inform the wider Equality, Diversity and Inclusion work regionally. She said the Trust did not yet have the data for patients whose first language was not English. Ms Boyle advised that the Trust had received additional funding from the Clinical Research Network to support the Research Midwifery Post. She said the post had been extremely successful with excellent recruitment into non-commercial studies. Ms Boyle reported that she had met with Aston University in November 23 to progress actions that had been raised following the collaboration event. Ms Boyle congratulated Dr Boswell who had co-authored an article that had been published in the BMJ Supportive & Palliative care. **Resolved: that the Research and Development be received and noted.**
	Divisional Reports (Section Heading)
716/23	**Divisional Quality and Governance Report – Medicines and Long-term Conditions**
	Dr Usman reported that Venous Thromboembolism (VTE) assessment within 24 hours remained a major challenge for the Division and that a VTE audit had been completed on Ward 29 and Acute Medical Unit (AMU) that highlighted VTE assessment within 24 hours was 93% and 96% of patients that required anticoagulation had received this with 100% of these patients receiving this within 24 hours. Dr Usman advised that the Pharmacy and the Infection, Prevention and Control (IPC) team continued to undertake antimicrobial stewardship audits and the data continued to be received and triangulated with prescriptions. Dr Usman reported that Legionella had been identified within the modular block and surveillance of water testing had found high counts of Legionella pneumophila in showers on Ward 1 and Ward 2. He said this would delay the Trust from moving into the newly refurbished Same Day Emergency Care Unit. Dr Usman reported 1 sharps incident on Ward 4 which had been an intentional act by a patient to harm staff. He said the police had been involved following the incident. Dr Usman reported that there continued to be discrepancies with staff lists on My Academy for assurance of training compliance. He said that Ms Bond had assured the Division that all areas of concern had been cited. Dr Usman advised that timely patient observations had reduced to below the Key Performance Indicator (KPI) of 90%. He said that this had been recorded at 66% within the Emergency Department and an improvement plan had been actioned to address the concerns.

	Dr Usman reported that there had been a reduction in the Division's ability to achieve antibiotics within 1 hour. He said this had been recorded at 69% on Medical Wards and 84% in the Emergency Department (ED). Dr Usman advised that Ms Tomkins would continue improvement work to ensure standards were kept. Dr Usman advised that Paediatrics Sepsis Management in ED had seen significant improvement and a manual audit had highlighted 94% compliance. Dr Usman reported that the Medicines Management training compliance target had been met and the Trust had reported 48 medicine management related incidents in November 23 which had significantly improved from the 300 incidents that had been reported in the past. Dr Usman advised that work continued against the backlog of incidents within the Division with only 20 outstanding and 3-5 incidents which dated back to 2018. He said the Division had almost closed down all Serious Incident action backlogs. Mr Mirza advised that with the Digital Operational Team, they were looking at any backlog of letters on the Dragon System. Dr Usman advised that the Division of Medicine had recruited 2 additional support secretaries to support the typing of any outstanding letters within Gastroenterology. Mr Goude reported that an update on this matter would be presented at the next Divisional Board meeting. Ms Evans asked if any letters that had not been sent out to patients in a timely manner were being reviewed on a risk basis. Mr Hobbs asked that the divisional Directors meet outside of the meeting to identify outstanding letters following outpatient appointments by each clinical division and that the details of these findings be shared with him. Ms Evans suggested that the matter also be raised at an Executive team meeting. **ACTION: Mr Hobbs asked that Mr Mirza work with the divisional directors to identify the number of letters outstanding following an outpatient appointment for each individual clinical division. He asked to receive an update report the week following Novembers TMC meeting.** **Resolved: that the Divisional Quality and Governance Report – Medicines and Long-term Conditions be received and noted.**
717/23	**Divisional Quality and Governance Report – Community Services**
	Ms Geffen reported on 1 serious incident reported in October 23 which dated back to an incident that occurred in May 23. She said further information would be reported back following the investigation that was underway. Ms Geffen advised that the Integrated Care System (ICS) had a projected budget deficit of £1.7M and the Trust continued to work with commissioners regarding the projected overspend. Ms Geffen reported that there had been 13 medication errors reported in October 23 and all incidents had been discussed at the Divisional patient safety huddle and had been graded as near miss, no harm or low harm. She said there had been no moderate harm risks recorded in October 23. Ms Geffen advised that 2 new risks had been added to the divisional risk register. She said these risks related to the funding for the integrated front door service and immediate care budget. Ms Geffen reported that Safeguarding Adults level 3 training was now above the 90% trajectory. Ms Carroll congratulated community services who were the first division to reach the target threshold for Safeguarding Adults level 3 training. Ms Geffen advised that Walsall Council had made the decision to extend the Health Child Programme (HCP) 0-19 contract for a further 2 years. **Resolved: that the Divisional Quality and Governance Report- Community Services be received and noted.**
718/23	**Divisional Quality and Governance Report – Surgery**
	Mr Goude reported that the Trust had been awarded Get It Right First Time (GIRFT) Elective Surgical Hub Accreditation following a GIRFT site visit in October 23. He said the Trust had received positive feedback surrounding teamwork and engagement of multi-disciplinary team meeting (MDT).

	Mr Goude advised that the Trust had experienced ongoing challenges with capacity for 2 week wait appointments for suspected breast and skin cancer referrals. He said extra breast clinics had been planned with mutual aid requested and the imminent start of telemedicine would improve the position of skin referrals. Mr Goude reported that Venous Thromboembolism (VTE) compliance for the Division of Surgery in October 23 as 87%, an increase of 4% from September 23. Mr Goude advised that the Colorectal Improvement Group had been formed and had begun to show positive initial metric improvements. Mr Goude reported that the Trust had identified a cluster of 4 surgical site infections in elective orthopaedic patients and that the relevant actions had been taken and no further infection had been highlighted. Mr Goude advised that there were delays to diagnostics within Endoscopy which had increased cancer and elective pathway timeliness. He said the Endoscopy expansion was due to delivered from January 24 which would improve the position. Mr Goude reported that the Trust had not met the standards for cancer performance for 2 week waits, 62 day referral to treatment and 28 day faster diagnosis. He said the Trust was still performing better than neighbouring Trusts. Mr Goude advised that Practical Obstetric Multi-Professional training (PROMPT) compliance within the Anaesthetic team was 33% in October 23 against a required standard of 80% and that an action plan was in place to address the poor compliance. Ms Carroll said that PROMPT training was a Clinical Negligence Scheme for Trusts (CNST) requirement and the Trust needed to ensure an MDT approach to PROMPT training. **ACTION: Mr Goude and Ms Wright to agree a plan for 2024 PROMPT training.** Mr Goude reported that the Division was working on financial recovering and advised that they had a current overspend of £4.5M at month 6 with a forecasted overspend of £9.4M for 2023/24. Mr Hobbs said that endoscopy capacity constraints could not be a reason suspected cancer patients did not receive their scope on time. He said that cancer patients needed to be prioritised and the Medicines and Long-term Conditions team were reviewing this. **Resolved: that the Divisional Quality and Governance Report – Surgery be received and noted.**
719/23	**Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services**
	Mr Ncube advised that Venous Thromboembolism (VTE) compliance remained above the 95% expected target and the Division had maintained 100% for complaints compliance. Mr Ncube reported that the Black Country Pathology Services (BCPS) continued to receive a high proportion of urgent cases and the Trust had set up a working group to look at the various workstreams to support the improvement and delays to cancer pathway delays. Mr Ncube advised that medicines reconciliation within 48 hours was not reaching the Key Performance Indicator of 60% due to staffing levels and sickness. He said a business case had been submitted to identify funding for pharmacy services and supporting medicines management across the Trust. Mr Ncube reported that a working group had been established to ensure that all guidelines and standard operating procedures that were available on the intranet were accurate and were updated by the owners on a regular basis. Mr Ncube advised that there were ongoing pressures within the Paediatric Medical and Nursing workforce due to increased activity and unfunded business cases. Mr Ncube reported that at month 7 the Division had underspent by £100K with a £6M overspend year to date. He said work continued with the finance team to highlight measures the Division could take to reduce the overspend. Mr Ncube advised that the Trust had identified issues relating to the aseptic unit which had failed in 2022 due to the isolator and air handling unit requiring replacement. Mr Ncube reported that the Trust had sourced supplies

	externally which included chemotherapy but the aseptic unit would not be able to sustain everything that was required. He said work was underway with estates to ensure the repair works were carried out in a timely manner. Mr Hobbs highlighted the urgency for a definitive replacement plan to be actioned for the replacement of the isolators and air handing units. **Resolved: that the Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services be received and noted.**
	Finance Reports (Section Heading)
720/23	**Integrated Performance and Quality Report – For Information Only.**
	Resolved: that the Integrated Performance and Quality Report be received and noted.
721/23	**Trust Financial Position – Month 7**
	Mr Steventon advised that the Integrated Care Board (ICB) had a planned year to date position of £57M and this had been overspent by £32M which had increased the total to £89M. He said that Walsall Healthcare NHS Trust (WHT) were £24M overspent. Mr Steventon reported that the Trust was over performing on income through Elective Recovery Fund (ERF) performance and Health Education England (HEE) funded items which were within the Trust's expenditure. Mr Steventon advised that pay overspends had been a result of temporary staffing and industrial action. He said the Trust had a non-pay overspend supporting the activity that was continued through clinical supplies and services. Mr Steventon reported that the Trust had suffered from inflationary pressures which included drugs, business rates and strike action which were unfunded inflation. He said the Trust had c£2.7M of pressures due to Emergency Department (ED) demands and the paediatric unit that had been staffed to safe standards. Mr Steventon reported that the Trust had a £2K adverse variance against the Trust's Cost Improvement Programme (CIP) delivering the year-to-date position and that the Trust's deficit in-month was lower than the previous 4 months of the current financial year 2023/24. He said the Trust's run rate was improving and was in line with the Trust's forecast of £31M. Mr Steventon reported that temporary staffing within the Trust had reduced in month and was below the agency cap. He congratulated colleagues for helping to deliver the lowest level of agency spend the Trust had seen for several years. He said that the Trust would look to initiate the cash protocol for Quarter 4 and a report would be presented to the Finance and Productivity Committee and Trust Board for approval. Mr Steventon reported that the ICB and National team had begun the challenge to bring the overall ICB plan back on track. He said the Trust had proposed to reduce the capital resource limit by £2.5M which would result in limited capital available. Mr Hobbs advised that the Trust had formally declared that the original deficit plan of £14M would not be met. He said the Finance and Productivity Committee had endorsed a plan that was £11M worse than the original plan which would total a £25M deficit. Mr Hobbs reported that divisional financial recovery meetings were focused on whole time equivalent use pay, use of temporary workforce and use of rosters that had not been through the governance approval process. He said the consequences of revenue overspends impacted the Trust's ability to ensure capital investments into buildings and equipment which would help modernise the Trust. Mr Hobbs advised that the Trust had levied invoices with neighbouring Integrated Care System (ICS) for the amount of urgency and emergency care the Trust had had completed on their behalf. He said the Trust was working with the ICB to understand what the equivalent would be within the Black Country as the Trust was a significant absorber of other parts of the Black Country's urgent and emergency care work. Mr Goude queried whether elective workload needed to be reviewed as for the Trust to maintain a strong 78-week performance would be costly in terms of staffing. Mr Hobbs advised there would be no financial benefit to reducing elective care. He said the Trust needed to ensure that the best possible productivity out of core substantive elective services was achieved. Mr Goude asked if the theatre capital programme would be continuing with the predicted start date of work scheduled for March 24. Mr Hobbs reported that the Trust remained fully committed to the upgrade. **Resolved: that the Trust Financial Position – Month 7 be received and noted.**
722/23	**Walsall Together**

	Mr Jackson reported that the revised Walsall Outcomes Framework was available online for colleagues to view. He said the framework had been through the various clinical mechanisms within Walsall Together and would be used as the Trust moved towards delegation for the Integrated Care Board (ICB) to redesign services to ensure they met the outcomes of the Walsall population. Mr Jackson advised that Walsall Together had been crowned winners in the Integrated Place Based Partnership Award at the Health Service Journal (HSJ) awards 2023. Mr Hobbs congratulated Walsall Together for the award win and said that HSJ awards were National awards and highly competitive. He said the Trust would not be able to achieve timeliness of emergency care within the hospital setting without the ability to discharge patients easier than other Trusts. **Resolved: that the Walsall Together Report be received and noted.**
	Workforce Summary (Section Heading)
723/23	**Workforce Metrics Report**
	Mr Hobbs reported that year to date average appraisal compliance levels had been recorded at 77% against a target of 90%. He said specific divisions had been tasked with appraisal recovery plans through the performance review process. Mr Hobbs encouraged all divisions to ensure appraisal compliance was high on the priority list. Mr Hobbs advised that the deadline for the staff survey was 24 November 23 and recent data had shown a completion rate of 45.5%. He encouraged all colleagues to take part in the survey to ensure individual voices were heard. **Resolved: that the Workforce Metrics Report be received and noted.**
	Business Cases (Section Heading)
724/23	**Post Implementation Reviews (PIR's) of previously approved cases**
	Ms Salmon provided an update on the Outpatient Pharmacy Options appraisal paper and the Post Implementation Reviews that had been scrutinised at Investment Group on 15 November 23. Ms Salmon advised that outpatient pharmacy dispensing had been temporarily relocated to the Purple Hub in November 2020. She said a business case had been submitted in November 2022 to request capital funds to support refurbishment and staffing costs to ensure the department was compliant. She said that £441K of capital costs had been required to become a fully functional satellite pharmacy, however due to the Trust's current financial strains the Investment Group had agreed on the option to revert all activity back to the main pharmacy and use the space as a dispensary to support discharge for Wards 7 to 17. Ms Salmon advised that work would commence with Mr Perry and the Patient Experience Team to ensure that these changes were well communicated and signposted to ensure the least amount of impact on patients. Ms Salmon reported that the 4 Post Implementation Review Cases which had been discussed at the Information Governance meeting as increased staffing levels for infection control £165K investment, Emergency Department Nursing Workforce £1.7M investment, Emergency Department Medical Workforce £1.2M investment and the Operating Theatre Staff Investment £5M investment. She said all cases had been well received and would be presented to the Finance and Productivity Committee for approval due to the sizeable investment of each case. **Resolved: that the Post Implementation Reviews (PIR's) of previously approved cases be received and noted.**
725/23	**Group Chief Strategy Officer Report**
	Ms Salmon reported on the spotlight videos presented at a recent Clinical Summit which had detailed the work and benefits of recent provider collaborative work that had been undertaken. Ms Salmon reported that the Black Country Provider Collaborative (BCPC) continued to focus on vascular services within Ear, Nose and Throat (ENT). Ms Salmon advised that there was a proposal for establishing a Robotic Renal Surgery Centre of Excellence at The Dudley Group NHS Foundation Trust. Ms Salmon reported that the System Operating Model (SOM) had been through some iterations and had been provided on behalf of the Trust by Mr Evans and Ms Cartwright. She said the SOM would describe the key elements of the Integrated Care System (ICS) operating model. Ms Salmon advised that the plan had not yet been signed off and would not be enforced until April 24. Ms Salmon advised that a Black Country Provider Committee would be established and expressions of interest had been sent to all directors across the 4 acute Trusts to be a part of the Black Country Provider Committee. She said the Committee would have delegated authority responsibility from each individual Trust Board. **Resolved: that the Group Chief Strategy Officer Report be received and noted.**

726/23	**Emergency Planning, Resilience & Restoration Steering Group (EPRR)**
	Mr Ferris reported that the Trust had been scored non-compliant in 2023 Emergency Planning, Resilience & Restoration (EPRR) self-assessment core standards. He advised that a detailed action plan was being worked to with 30 actions to work through before March 24 to ensure governance of the self-assessment. Mr Ferris advised that the action plan would be added to the Corporate Risk Register and be managed through that process. **ACTION: Mr Ferris to formally raise a corporate risk due to the non-compliant assessment against core standards and for the revised assessment to be added to the Finance and Productivity agenda for the meeting to be held on 29 November 23.** Mr Ferris reported that there were 4 areas within the Trust that required improvement to be compliant as these had triggered the Trust's overall non-compliance. He advised the 1st of these areas as the Major Incident Plan and the emergency plans across the Trust which needed to be up to date and tested to evidence the Trust's learning. He reported the 2nd, 3rd and 4th areas as the Trust's Data Protection and Security Toolkit, Business Continuity Plans and Chemical, Biological, Radiological and Nuclear (CBRN) capability. Mr Ferris advised that he had asked colleagues at the Integrated Care Board (ICB) and NHS England to complete a pre-assessment prior to next year's EPRR self-assessment in March 24 to ensure the Trust was on track and had improved from the non-compliant rankings. Mr Hobbs asked that Trust Management Committee members approve the revised self-assessment as the Trust had previously self-assessed at partially compliant and following conversations with NHS England the Trust had been rated as non-compliant. **Resolved: that the Emergency Planning, Resilience & Restoration Steering Group (EPRR) be received and APPROVED.**
727/23	**Winter Planning and Pressures – Veral Update**
	Mr Roberts advised that option 2 of the Winter Plan had been approved at the Trust Board meeting in September 23. He said the Trust had received a letter from the National team and the plan would be fully funded and pose no financial risk to the Trust. Mr Roberts reported that no risks had been raised from divisions regarding delivery against the initiatives within the Winter Plan. He said the Trust had opened a number of winter beds earlier than expected and this had seen an impact on divisional resources to support the beds. Mr Roberts advised that NHS Midlands had offered Trusts the option to express what could be put into place to open more beds to support the National target for winter. He said the Trust had submitted a bid in response to NHS Midlands for £900K for the remainder of 2023/24 or £2.7M on a recurrent basis to support the opening of additional beds. Mr Roberts advised that inpatient beds were funded for 12 weeks and this would propose challenges for the Trust. Mr Hobbs reported that October 23 had been a challenging month for the Trust from an emergency care perspective. He said the Trust had delivered timely access to emergency care throughout November 23 and said that this performance needed to be sustained. Mr Hobbs advised that weekend and bank holiday cover during the Christmas period would be expected to be covered as close to normal working as clearly resourced within the Winter Plan. **Resolved: that the Winter Planning and Pressures – Verbal Update be received and noted.**
728/23	**Board Assurance Framework & Heat Map**
	Mr Bostock presented the Board Assurance Framework (BAF) & Heat Map for information. Mr Hobbs advised that following conversations at a previous Finance and Productivity Committee Meeting questions had been raised to consider if the risk score for upper financial sustainability needed to be amended following the Trust's submission of a re-forecast with an adverse variant to the Trust's deficit plan of 2023/24. Mr Bostock reported that the current risk score was 20. **ACTION: Mr Steventon, Mr Mortiboys and Mr Stringer to review the current risk score for Financial Sustainability.** **Resolved: that the Board Assurance Framework & Heat Map be received and noted.**
729/23	**Any Other Business**
	Mr Hobbs advised that no other business had been raised.
730/23	**Date of next meeting: Thursday, 25 January 2024 – 09:00-11:00**
	Mr Hobbs confirmed the next meeting of the Trust Management Committee would take place Thursday, 25 January 2024 09:00-11:00.

ENC 14.5

Walsall Healthcare NHS Trust

MEETING OF THE CHARITABLE FUND COMMITTEE HELD ON FRIDAY 08 SEPTEMBER 2023 AT 10:00 HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members	
Mr P Assinder	Non-Executive Director **(Chair)**
Ms F Allinson	Non-Executive Director
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Mr K Stringer	Group Director of Finance and Deputy Chief Executive
Mr D Mortiboys	Operational Director of Finance
In Attendance	
Ms K Geal	Executive Assistant **(Minutes)**
Mrs G Westley	Fundraising Manager
Ms M Lam	Financial Accountant
Ms A Akinyemi	Senior Financial Accountant
Ms K Dhillon	Financial Accountant
Ms C Jennings	Social Inclusion Manager, Walsall Housing Group (Part)
Ms L Perager	Management Accounts Assistant (Part)
Ms M McManus	Director of Transformation and Place Development, Walsall Together (Part)
Apologies	
Ms K Aplin	Fundraising Support Officer
Ms T Faulkner	Head of Communications/ICC Information Officer

29/23	**Welcome, Apologies and confirmation of quoracy**
	Mr Assinder welcomed everyone to the meeting and introduced Ms Allinson, Ms Lam, Ms Akinyemi and Ms Dhillon to the group. The meeting was declared quorate and the apologies are noted above.
30/23	**Declarations of Interest**
	There were no declarations of Interest raised.
31/23	**Minutes of the previous meeting: 12 June 2023**
	RESOLVED That committee approve the minutes as set out.
32/23	**Matters Arising and Action Log**
	Terms of Reference Mr Assinder to confirm attendance of a second Non-Executive Director to attend all upcoming Charitable Fund Committee meetings. Mr Assinder has invited Ms Allinson to attend all further meetings. **RESOLVED** Quarterly Review of Expenditure Below £5k approved by Fund Managers

	Ms Geal to distribute applicable appendix to complete report Ms Geal has distributed the appendix to the committee. **RESOLVED** Quarterly Review of Income & Expenditure Ms Westley, Ms Faulkner and Ms Aplin to consider options for spending remaining funds. Ms Westley confirmed that options have been considered, outline in report to committee. **RESOLVED** Quarterly Review of Income & Expenditure Mr Andrews to review Captain Tom money, with view to reallocate due to time allocated to spend funds. Ms Westley confirmed that options have been considered, outline in report to committee. **RESOLVED** Report on Investment Portfolio Year to Date Mr Andrews to ensure that RBC Brewin Dolphin present at Charitable Funds Committee Mr Mortiboys confirmed that Brewin Dolphin were confirmed on the December 2023 Charitable Funds Committee agenda. **RESOLVED** Report on Investment Portfolio Year to Date Ms Geal to add RBC Brewin Dolphin to Cycle of Business. Mr Mortiboys confirmed that Brewin Dolphin were confirmed on the December 2023 Charitable Funds Committee agenda. **RESOLVED** Report on Investment Portfolio Year to Date Mr Andrews and Mr Baker to review investment and reserves policies and consider best options for cash reserves. Mr Assinder confirmed that, after modelling work was completed, it was agreed to hold £0.5M of cash reserves. **RESOLVED** Fundraising Update March-May 2023 Ms Faulkner to review access to food bank and enquire if donations are continuing, and if there are any ongoing concerns.

	Ms Westley confirmed that an update was provided in the report. **RESOLVED** Any Other Business Ms Evans to discuss Long Service awards with Mr Loughton and update at next committee Ms Evans has discussed with Mr Loughton and it has been agreed that the vouchers historically provided to staff will cease from immediate effect and will be aligned to the same process that is provided to RWT staff. **RESOLVED**
33/23	**Committee Annual Report, Terms of Reference, and Business Cycle**
	The cycle was confirmed as accurate and approved by the committee.
34/23	**Quarterly Review of Expenditure Below £5K approved by Fund Managers**
	Report received for assurance. Ms Allinson raised concern that there was no detailed information within the report about where money was being spent. Items were detailed only by an accounting code in the appendix. Mr Mortiboys assured Ms Allinson and the committee that reports to committee going forward would include clearer detail on where money was being spent. **RESOLVED** That the items have been approved under delegated authority.
35/23	**Expenditure Requests £5k to £99,999**
	Report received for assurance. Mr Assinder stated that the only request was made by the Education and Training Department for £42,602 for some AV equipment in the Manor Learning and Conference Centre. There was committee consensus that it was not appropriate for Charitable Funding, and that such funds should be sourced through the Trust Capital route. **RESOLVED** That the committee decline the request for Charitable funding.
36/23	**Expenditure Requests over £100k**
	There were no requests presented.
37/23	**Quarterly Review of Income and Expenditure**
	Mr Mortiboys outlined the report to the committee, and informed that funds remain broadly in line with where they were at the end of March 2023, and that expenditure has not been particularly significant with only £8K of requests under £5K and one request over £5K.

	Mr Mortiboys further commented that there is a need to increase expenditure as funds are higher now than they have been traditionally, and stated that the last 18 months has seen a fluctuation in the market following the invasion of Ukraine, and the change in interest rates have meant that holding cash has become attractive. Mr Mortiboys informed the committee that the Enoch Evans legacy is still to be finalised, and confirmed that this will increase funds by c£200K. Mr Assinder raised concerns regarding the ack of of charitable bids received, and asked what could be done to promote the charity with fund managers across the Trust. Ms Allinson stated that more work could be done to enhance patient experience through the QI programme with funding from charitable funds. Ms Westley informed the committee that the Find Out Fridays were to be re-commenced, with members of the finance team spending time in the Charity Hub, present to discuss funding with Fund Managers. Ms Westley raised that the monthly Charitable Funds report should be re-commenced and emailed to Fund Managers to inform of how much charitable funds was available to them. Mr Assinder noted that, per Appendix 2 of the report, that there is £30K outstanding from national COVID money, and £58K outstanding for the NHS Charities residual funds.
38/23	**Review of Investment Portfolio**
	Mr Mortiboys informed the committee that there has been little movement between end of March 2023 and the end of June 2023, moving only by £3.5K from the year end position. Mr Mortiboys stated that, whilst it is disappointing to see numbers go down, it is at a similar position to last year. Mr Mortiboys informed the committee that he would raise at his meeting with Brewin Dolphin, and review their contract to confirm when an analysis can be carried out on investment performance. This will be shared with the committee at its December meeting. Mr Assinder and Mr Stringer agreed that it may be that more should be expected of the broker, and a review should take place, with performance benchmarking identified. **ACTION** **Meeting to be arranged with Brewin Dolphin to discuss investment portfolio achievements, and paper to be prepared for December committee.** **RESOLVED** That the review of the investment portfolio be noted
39/23	**Annual Report and Accounts Timetable**
	Mr Mortiboys informed the committee that a set of accounts are now available, to be shared with Audit in September 2023. Mr Mortiboys informed the committee that the audit usually takes 4 weeks. Mr Mortiboys requested that an Extraordinary Charitable Funds Committee be arranged post audit, for a report to be prepared for Trust Board December 2023.

	RESOLVED That the accounts audit be reviewed by Extraordinary Charitable Funds Committee in October 2023 and a report prepared for Trust Board December 2023.
40/23	**Fundraising Update and Annual Report June-September 2023**
	Ms Westley informed the committee that the annual report does not yet include the finance information. This information will be disseminated once received, for reading. Ms Westley introduced the committee to the report and updated on the below points: • Volunteers- there are now 8 supporting the fundraising team • Find Out Friday- this will be involving the Finance Team to inform Fund Raisers of funds available, how to spend etc. • Fund Raising Support Group- To be developed and fundraising champions to be identified • Marketing Pack- Some issues with TVs in Outpatients- pack to be launched by next meeting • COVID 19 remaining funds- Staff Memory Garden to be made in internal gardens • Donation Kiosk- Near completion. Can donate even if hub closed, by card • Goscote Hospice- £10K for garden furniture • End of Life Requests- Two large requests recently made, including a wedding on a ward including buffet, and video message by Ed Sheeran for End of Life patient • Food Bank- Relaunch to be advertised to properly support staff who require support including Health & Wellbeing • Events- Would be great if Board team could support upcoming events **RESOLVED** The committee agreed that money from the COVID funding be used for a Staff Memory Garden.
41/23	**Walsall Together Update**
	Ms Jennings outlined Walsall Housing Group, WHG, to the committee and outlined the work done by the service, as part of the Kindness Counts programme, including providing support to people in the community who are identified as feeling lonely and isolated. Ms Jennings informed that there has been recruitment of local people with lived experience, trained as champions to support with health and wellbeing outcomes. Measured against ONF4, by the time end of intervention, loneliness or isolation has been improved across the city. Mr Assinder asked how, given the funding was a one-off provision of money, if the programme was sustainable. Ms Jennings advised funding a Champion is at £20K, and work to sustain remains a challenge, but is a low-cost intervention for large outcomes. Ms McManus confirmed that there are excellent patient outcomes achieved by Walsall Together with WHG and other partners.

	Ms Allinson asked where the local champions were based. Ms Jennings informed that champions were based within their local communities and carried out both face to face discussions with the community, and via telephone/Online, if required. Ms Allinson stated that the Kindness Champion programme could be replicated in the Trust. Ms McManus stated that organisations such as WHG can recruit and support a community champions model on behalf of the Trust. Ms Evans advised that the Patient Experience team should be included in a project like this.
42/23	**Any Other Business**
	Mr Mortiboys informed that a number of families raised money for an external 'garden' door in ICU; there have been a number of issues. Mr Mortiboys stated that Estates have designed the project, however Building Control has refused to sign off the plans and a more complex project has commenced to meet the safety terms. This will now cost more than the family have raised; there is potential to use more charitable funds to support this or using capital funds. A meeting will need to be arranged with donors to advise. **ACTION** **Ms Evans, Ms Westley and Mr Mortiboys to discuss outstanding legacies monies and prioritisation of works, Mr Mortiboys to provide an update at next committee, and for discussion at Capital Review Group** Ms Westley advised that work is ongoing to provide 60 patient televisions across the Trust.
43/23	**Matters for Escalation to Trust Board**
	Colleagues to be reminded of the availability of charitable funds resources
44/23	**Date and Time of Next Meeting**
	Date: 18 December 2023 **Time:** 10:00-12:00 **Venue:** Teams

ENC 14.6

Walsall Healthcare NHS Trust

MEETING OF THE AUDIT COMMITTEE
HELD ON MONDAY, 4 SEPTEMBER 2023 AT 14.45PM
HELD IN PERSON MLCC ROOMS 3 and 4

PRESENT

Members

Ms M Martin	Non-Executive Director/ Chair
Mr P Assinder	Non-Executive Director
Dr J Parkes	Non-Executive Director
Mr J Hemans	Non-Executive Director

In Attendance

Mr K Stringer	Group Chief Financial Officer/ Deputy Group Chief Executive
Mr N Hobbs	Chief Operating Officer/ Deputy Chief Executive
Mr K Bostock	Group Chief Assurance Officer
Mr D Mortiboys	Interim Director of Finance
Mr K Wilshere	Group Company Secretary
Mr N Bruce	Group Director for Digital Technology
Mr B Vaughan	Counter Fraud RSMUK
Mr M Surridge	Mazars
Mr C Quinton	SLR & Costing Accountant
Mr M Gennard	Internal Audit, RSMUK **(In Attendance Virtually)**
Ms L Gough	Internal Audit, RSMUK **(In Attendance Virtually)**
Ms L Ibbs-George	Divisional Manager, Estates and Facilities **(In Attendance Virtually)**
Ms E Stokes	Senior Administrator **(Minutes)**

Apologies

Mr A Hussain	Internal Audit, RSMUK

033/23	**Chair's Welcome**
	Ms Martin welcomed all to the meeting and noted the apologies provided.
034/23	**Declarations of Interest**
	Ms Martin confirmed that no further declarations of interest had been received. **Resolved: that the declarations of interest be received and noted.**
035/23	**Minutes of the Previous Meeting held 27 June 2023**
	Ms Martin approved the minutes of the last meeting held on 27 June 23 as an accurate record. **Resolved: that the minutes of the meeting held 27 June 23 be received and APPROVED.**
036/23	**Matters Arising and Action Log**
	Ms Martin received the action log and updates were noted as follows. **Action 836 –** Mr Wilshere and Ms Toor to meet to review the Meeting Cycle and liaise with report authors to confirm paper timings. **Mr Wilshere confirmed the Cycle of Business had been reviewed and a process was in place to inform reports authors of reports in a timely manner.** This action was closed. **Action 834 –**Mr Green to send a final version of the Annual Report to Mazar for audit by 28 June 23. **Ms Martin confirmed Mr Green advised this action had been completed.** This action was closed. Mr Bostock advised that following submission of the Annual Report NHS England had requested the Trust be clearer on the internal control processes. He said there had been a slight amendment, but this had not changed the results.

	Action 833 – Mr Green to process the final financial adjustments prior to sharing with Ms Martin and Mr Assinder for Trust delegated approval. **Ms Martin advised Mr Green had completed this action.** This action was closed. **Action 830 –** Ms Martin to discuss the Internal Audit Progress and Medical Records Management with Mr Hussain RSM. **Ms Martin confirmed a conversation with RSM had taken place and RSM would follow up the actions required.** This action was closed. **Action 831 –** Ms Martin to discuss with Mr Hussain to convene a meeting with Mr Hobbs to reassess the Theatre Utilisation Update Report and provide an update to the committee. **Ms Martin advised that a meeting with RSM and Mr Hobbs had taken place.** This action was closed. **Action 696 –** Mr Mortiboys to update the committee on FJ Limited's contract with the organisation in 6 months' time with regard to Single Tender Actions. **Mr Mortiboys advised that procurement was in place and the Trust would have a patient transport company appointed by December 23.** This action was closed. **Action 832 -** Mr Green to liaise with Ms Evans for appropriate dissemination and upload of the External Audit Completion Report onto the Trust website. **Mr Green and Ms Evans advised this had been completed and closed on the system.** This action was closed. **Action 835 –** Mr Wilshere to provide update on what action plan is in place to improve compliance and response to the Declarations of Interest Report. **Mr Wilshere advised that the next report was on the agenda and further discussions and agreement was required for any expansion of the requirement for Fit and Proper Person levels of compliance.** This action was closed. **Resolved: that the updates to the Action Log be received and noted.**
	Counter Fraud Reports, Approvals, Actions, Discussions
037/23	**Review of LCFS Work Plan – Progress Report**
	Mr Vaughan reported on the Counter Fraud 2023/24 work plan which included a summary of the fraud prevention, detection and investigation work undertaken by Local Counter Fraud Specialist (LCFS) RSMUK. Mr Vaughan advised that the Trust had made little progress in the implementation of the agreed management actions and there were significant issues that required attention. He said the actions that remained were the required updates to the E-Rostering Policy, roll out of the Allocate E-Rostering system across the Trust, verification of bank and agency shifts prior to payment and identification of potential duplicate payments. Mr Vaughan reported that 7 new referrals had been received from May 23 which had related to working whilst sick, misuse of Trust resource, false identify and fraudulent bank timesheets. He said the referrals received had come from a range of sources and all referrals were ongoing with 6 referrals closed following the Audit Committee meeting 27 June 23 with no further action had been required. Mr Vaughan advised that these referrals needed to be addressed as these had left the Trust open to susceptibility. Mr Assinder asked if the number of referrals received a year was within the number expected of the Trust. Mr Vaughan advised that for the size of the Trust the number of referrals received was what would be expected. Mr Stringer asked if there were consistent themes emerging from the referrals received. Mr Vaughan reported that many of the referrals received focused on false bank timesheets. Mr Vaughan advised that the Counter Fraud Culture survey had been issued across the Integrated Care Board (ICB). He asked that Walsall Healthcare NHS Trust (WHT) colleagues complete the survey through the link and Quick Response (QR) code provided.

	Mr Vaughan reported that following completion of the RSM Gifts and Hospitality survey the data would be used to examine the level of awareness amongst staff on the acceptance of gifts and hospitality. He said the 2023 survey had received 2,738 responses across 27 organisations. Mr Vaughan advised that the LCFS had attended the Midlands Fraud Forum seminar focused on Compliance, Ethics and Fraudulent Crypto-Currency Platforms. He said that Fraudulent Crypto-Currency and mandate fraud was beginning to increase. Ms Martin asked for assurance that the recruitment process would continue to be monitored to ensure all applicants attending for interviews provided the correct ID documentation. Mr Vaughan said that work would continue with the Trust and internal auditors to ensure processes remained in place and were followed. **ACTION: Mr Vaughan to provide Mr Stringer with the level (banding) of the individual involved in the fraudulent use of ID documentation.** **Resolved: that the Review of LCFS Work Plan – Progress Report be received and noted.**
038/23	**Internal Audit Plan – Final**
	Ms Martin advised that the Internal Audit Plan was to be received by committee members for information following circulation of the Internal Audit Plan in May 23. **Resolved: that the Internal Audit Plan – Final be received and noted.**
039/23	**Board Assurance Framework – Focus on Themes and Trust Risk Register**
	Mr Wilshere advised that following a discussion with Ms Martin a review of the current Board Assurance Framework (BAF) was conducted to identify areas where there was evidence of the following. • Controls and Assurance in place not providing the intended assurance and positive evidence. • Negative Assurances where the lack of evidence and assurance has not been addressed. • Gaps in control and mitigation where the planned interventions lacked evidence of implementation. Mr Wilshere reported that there had been 4 main themes that had been identified from the initial review which had focused on the controls and mitigations. He said a further 6 themes had been identified following a further review of the negative assurances and gaps in control. Ms Martin advised that the BAF had been shared with Mr Hussain to highlight the major key themes to be covered within the internal audit plan. Ms Martin asked how the Trust would continue to address the ongoing risk cited on the mental health provision and access for patients of all ages. Mr Hobbs advised that the Trust had an internal structure in place and a joint mental health nursing team across The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) continued to support patients. He said there was a joint Executive structure with the Mental Health Trust and the relationship between the Trusts continued to improve but further work was required to ensure the Trust provided comprehensive quality care to mental health patients. Mr Bostock reported that the Mental Health Provision risk was outside of the Trusts control. He said the Trust had put all mitigations required into action and was in regular dialogue with NHS England and the Integrated Care Board (ICB). He said the Trust had incurred additional costs as a result of the additional mitigations actions the Trust had taken, and this had been escalated to NHS England. Ms Martin asked if Trust Security Staff with no appropriate qualifications or background continued to support mental health patients on the Wards. Mr Hobbs advised that this had ceased across the Trust.

	Ms Martin advised that the 2-year timeline for the implementation of digitalization of medical records across the Trust was a considerably long duration and had become a risk to patient safety. Mr Bruce reported that the timeline for the implementation of the new modular build that would accommodate the scanning bureau had been given a December 2023 completion date. He said that Ms Smith (new Group Head of Health Records) continued to work with the digital team to ensure the implementation of the MediViewer which would allow the Trust to view patient records that had been scanned and the utilisation of the case note tracking function. Ms Gough reported that the internal auditors continued to work with Ms Smith against the actions that the Trust had formulated into the overarching action plan. Ms Martin asked if the operational cost of the digitalization of medical records was within the Trusts budget. Mr Mortiboys advised that the capital cost for the digitalization of medical records and the modular build had been budgeted within the 2022/23 financial year. Dr Parkes asked if individual patient admissions were recorded digitally or on paper records. Mr Hobbs advised that Emergency Department admissions were recorded digitally but all further inpatient care was recorded within the individual patient paper record. Mr Bostock advised that oversight of the implementation of digitizing patient records should be monitored through the Quality, Patient Experience and Safety Committee (QPES). Dr Parkes agreed, as Chair of QPES. Ms Martin reported on the challenges of the Trusts financial controls and cost improvement programme and asked if any of the risks were outside of the Trusts control. Mr Assinder advised that the Trust needed to implement a long-term strategic plan to support the Trusts long-term financial plan. Mr Stringer advised there were several actions that required completion within the ICS and the Trust would ensure cash balance. Ms Martin asked for an update on the review of the functionality of the EDI (Equality, Diversity and Inclusion) Steering Group. Mr Hemans advised that the People and Organisational Development Committee (PODC) continued to monitor the review. Ms Martin asked if there was a confirmed implementation date for Datix IQ. Mr Bostock reported that Datix IQ would be live across the Trust from 1 November 23. Mr Wilshere thanked Mrs Toor and Ms Stokes for their support with the task. **ACTION: Mr Wilshere to present an updated version of the themes from the Board Assurance Framework following upcoming reviews to the first Audit Committee in 2024.** **Resolved: that the Board Assurance Framework – Focus on Themes be received and noted.**
	Items to Note Regarding Increasing Risks from Other Committee and the Board
040/23	**Update on increasing areas of risk that require new controls, mitigation, or assurance audit – Performance & Finance Committee**
	[redacted] **Resolved: that the update on increasing areas of risk that require new controls, mitigation, or assurance audit – Performance & Finance Committee be received and noted.**
041/23	**Update on increasing areas of risk that require new controls, mitigation, or assurance audit – Quality, Patient Experience and Safety Committee**
	Dr Parkes advised there were no further additional concerns for the Audit Committee to note.

	Resolved: that the update on increasing areas of risk that require new controls, mitigation, or assurance audit – Quality, Patient Experience and Safety Committee be received and noted.
042/23	**Update on increasing areas of risk that require new controls, mitigation, or assurance audit – People and Organisational Development Committee**
	Mr Hemans advised there were no further additional concerns for the Audit Committee to note. **Resolved: that the update on increasing areas of risk that require new controls, mitigation, or assurance audit –People and Organisational Development Committee be received and noted.**
043/23	**Update on increasing areas of risk that require new controls, mitigation, or assurance audit – Trust Management Committee**
	Mr Hobbs advised there were no further additional concerns for the Audit Committee to note. **Resolved: that the update on increasing areas of risk that require new controls, mitigation, or assurance audit – Trust Management Committee be received and noted.**
044/23	**National Cost Collection Assurance for 2022/23 – Pre-submission report**
	Mr Assinder asked if the Trust had the source information and support from outside of the finance function. Mr Quinton advised that the Trust continued to use the costing model software provided by Log X which had helped with the processing of data. **Resolved: that the National Cost Collection Assurance for 2022/23 – Pre-submission report be received and noted.**
	Security Reports, Approvals, Actions, Discussions
045/23	**Security & Car Parking Progress Reports – Quarter 1**
	Ms Ibbs-George reported that in June 23 a total of 576 patient watch hours had been reported at a cost of £14k. she said that the total number of patient watch hours had decreased in June 23 to 144 following the implementation of the management system between security and clinical teams. Mr Stringer reported on the high number of car parking warning notices being issued to staff with 785 warning notices issued in July 23. Ms Ibbs-George advised that this had been a result of staff not displaying car parking permits when parked on site. She said work with the communications team was ongoing to remind staff to ensure permits were visible. Ms Martin asked for assurance on the concerns relating to the performance of the CCTV on site. Ms Ibbs-George reported that that a new recording unit was in place and 1 recording unit still required repair and work with Skanska was ongoing to ensure this was completed. **ACTION: Ms Ibbs-George to share a timeline of when the repair work of the CCTV recording unit will be complete.** **Resolved: that the Security & Car Parking Progress Reports – Quarter 1 be received and noted.**
046/23	**Cyber Security**
	[redacted] Mr Bruce reported on the implementation of two factor authentication for remote access. He said work was ongoing to implement 2 factor authentication for NHS Mail and this would become mandatory across the Trust by March 24. Mr Bruce advised that the group cyber security joint service had been successfully established. He said the Trust was the only organisation to offer an out of hours cyber security service across the

	West Midlands. Mr Bruce reported that NHS England had asked the Trust to participate in a case study surrounding best practise for cyber security response. He said the cyber security and operations centre for the NHS had asked that the Trust participate in events in the future. Mr Bruce advised that internet web filter configuration improvements had been completed to prevent users from accessing websites or downloading software that would lead to data leakage or remote compromise. He said the Trust had also restricted the use of high bandwidth websites that comprise the Trusts network bandwidth availability. **Resolved: that the Cyber Security Report be received and noted.**
047/23	**Data Security and Protection Toolkit (DSPT) – Final Submission and Improvement Plan**
	Mr Bostock reported that the final DPST compliance position submitted on 30 June 23 was 'standard not met' and the Trust was non-compliant with 17 of the 113 assertations. He said following the launch of the action plan the Trust had moved up to approaching standards and regular reviews monitored through the Information Governance Steering Group continued. Mr Bostock advised that the Trust was on trajectory to be fully compliant by the end of 2023/24. Ms Martin asked if the planned cloud solution for backups would be completed at The Royal Wolverhampton Trust (RWT) following implementation at Walsall Healthcare NHS Trust (WHT). Mr Bruce advised that the Trust planned to standardise the backup arrangements across WHT and RWT. He said the technology used was different to what was used at RWT and this could become a financial challenge for the backup platform with work continuing to articulate and quantify the challenge of the business case not being accepted due to the Trusts current financial position. Mr Mortiboys advised that the Trust did not have leeway to invest resources outside of the current financial plan and the Trust would need to find available resources within the current financial plan if this was required. **ACTION: Mr Bruce to advise if resources are available within the current financial plan to support the planned cloud solution backup.** **Resolved: that the Data Security and Protection Toolkit (DSPT)- Final Submission and Improvement plan be received and noted.**
	Internal Audit Reports, Approvals, Actions & Discussions
048/23	**Review of Internal Audits Progress Reports**
	Ms Gough advised that 2 reports had been finalised from the 2023/24 internal audit plan. She said the listed finalised reports had given a negative assurance opinion following the little progress made. 1. Follow up of Rostering including Bank and Agency Booking. 2. Data Quality (Integrated Quality Performance Report) – Venous Thromboembolism (VTE). Ms Gough reported that 3 reviews were underway, and the progress of the internal audit plan was progressing as expected. She said of the 79 actions on the internal audit management action tracker 35 had been closed and 28 had received a revised implementation date. Ms Gough advised that 3 actions were overdue and verbal response had been confirmed from Ms Smith that an overarching action plan would be provided to internal auditors. Ms Gough advised that a request to defer the strategic leadership framework plan until quarter 1 of 2024/25 due to the development of the collaborative committee. She said that internal auditors would use the allocation of days to complete alternative work that required follow up. Mr Gennard advised that 12 days had been budgeted for the Strategic Leadership Framework. **Resolved: that the Review of Internal Audits Progress Reports be received and noted.**
049/23	**Data Quality (Integrated Quality Performance Report) – Venous Thromboembolism (VTE)**
	Ms Gough reported following conclusion of the review 5 medium priority and 1 low priority actions had been identified. She said these related to areas including the update of Policy and Procedure documentation, timely and accurate reporting of VTE performance data, recording and reporting over VTE re-assessment and VTE assessment training.

	Ms Gough advised that the policy had not been clear regarding what was being reported. She said the Trust was reporting against an assessment within 24 hours of admission, but the policy indicated that it should be within 4 hours of admission. Mr Hemans asked when the policy had been last reviewed. Ms Gough reported that the policy had last been reviewed in 2021. Ms Gough reported that there was no evidence of reporting or monitoring of reassessment for patients that present a risk. She said there was lack of evidence of reporting to the Thrombosis Group who had been identified as they key group to monitor compliance. Ms Gough advised that there had been inconsistences in the figures reported in April 23 due to an error within the BadgerNotes system. She said the error was rectified and the metric reproduced but there was no evidence provided to confirm the error and correct figure had been reported back to the Trust Board. Ms Gough reported that following staff interviews it had been highlighted that VTE data was not continually inputted live and had been highlighted to be entered onto the system retrospectively. She said this impacted the target of 24 hours after admission. Mr Wilshere asked which staff were entering the data retrospectively. Ms Gough confirmed that medical staff were entering the data retrospectively onto the computer. Mr Hobbs advised that the absence of VTE assessments had not been identified as a harm factor. **ACTION: Ms Martin asked that Dr Shehmar and Mr Mirza attend the December 23 Audit Committee meeting to outline their VTE action plan timeline.** **Resolved: that the Data Quality (Integrated Quality Performance Report) – Venous Thromboembolism (VTE) be received and noted.**
050/23	**Follow up of Rostering including Bank and Agency Bookings**
	Ms Gough advised that a rostering review had been undertaken to follow up on the progress made to implement the previously agreed management actions which had resulted in a negative assurance opinion. She said there was a final condensed action plan which consisted of 8 actions that had significant risks associated with the below. • E-Rostering Policy • Roll out of the Allocate E-Rostering System to all areas of the Trust • Timely rostering, including approval of rosters and finalisation of shifts worked • Verification of bank and agency shifts prior to payment • Identification and prevention of potential duplicate payments Ms Gough reported that the Trust had purchased Allocate licenses but did not have the infrastructure and staff to ensure the roll out to all Wards and departments. Mr Mortiboys advised that the Trust would begin the implementation across the Trust from April 24. Ms Gough advised that a drop box was in use for timesheets, and this had presented a high-level risk of fraud. Mr Mortiboys reported that the Trust would use an electronic confirmation and sign-off system to elevate the paper trail caused by checking signatures. Ms Gough reported that there were risks highlighted surrounding authorised signatories and no further checks were in place to ensure the person was authorised to sign off timesheets. She that there was no process in place to identify duplicate claims. Mr Mortiboys reported that the Trust had introduced a weekly review of rosters. He said this would enable the bank office to meet with individual Wards to go through the roster. Mr Bostock asked if the rostering system covered the reconciliation of staff claims. Mr Mortiboys said that the rosters would be matched the requests that were sent in by staff. **ACTION: Ms Carroll to attend the December 23 Audit Committee meeting to provide an update on the timeline of the highlighted Rostering Actions.**

	Resolved: that the Follow up of Rostering including Bank and Agency Bookings report be received and noted.
051/23	**Healthcare Benchmarking Report**
	Resolved: that the Healthcare Benchmarking Report be received and noted.
	External Audit Reports, Approvals, Actions, Discussions
052/23	**External Audit Plan Progress Report**
	Mr Surridge asked that committee members receive the External Audit plan and the recommendations. He said there were 3 high and 6 medium internal control recommendations as well as 5 recommendations from the prior year not yet implemented. Mr Surridge advised that the Trust had been unable to conclude on accounting for Private Finance Initiatives (PFI) under International Financial Reporting Standard 16 Leases (IFRS 16) as part of the Month 9 close due to lack of staffing and long-term sickness. Mr Mortiboys reported that Walsall Healthcare NHS Trust (WHT) financial team was now fully staffed with substantive staff. He said work would continue with The Royal Wolverhampton NHS Trust (RWT) to develop the new WHT staff members skills. Mr Surridge advised that the Trust use the Month 9 close as a trial run for the year end timetable to test the robustness of arrangements in advance of the year end. Ms Martin asked if the Trust could track the recommendations required against a timeline. Mr Surridge advised that the recommendations would not be reviewed until there was evidence which would not be presented until after Month 9 or Month 12. Mr Wilshere said that if the recommendations were provided, the actions could be added to ibabs and tracked by the committee in the intervening period. **ACTION: Mr Surridge to confirm outstanding actions to Mr Wilshere.** Ms Martin asked if the cost overrun was the agreed position. Mr Stringer advised that this had not been agreed and Mr Mortiboys would continue to work on the agreed position. **ACTION: Mr Surridge to provide an update on the outcome of the Month 9 close and progress against the recommendations.** **Resolved: that the External Audit Plan Progress Report be received and noted.**
	Review of Governance Arrangements
053/23	**Group Director of Assurance – Regulatory Report**
	Mr Bostock advised that all reviews were up to date and action plans that were required were being monitored through Quality, Patient Experience and Safety (QPES) committee. Mr Bostock reported that the Human Tissue Authority had inspected the Trust on 27-29 July 23. He said 8 issues had been highlighted as actions for Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust. Mr Bostock advised that an action plan had been presented to the Human Tissue Authority and they had accepted the plan. **Resolved: that the Group Director of Assurance Regulatory Report be received and noted.**
054/23	**Data Security and Protection Toolkit (DSPT) – Final Submission and Improvement Plan**
	This agenda item was discussed earlier in the meeting under minute reference 047/23.
	Review and Approval of Relevant Policies and Registers (Section Heading)
055/23	**Review of Conflicts of Interest Policy Compliance and Registers**
	Mr Wilshere reported that a significant number of staff had not made a return or declaration and work would continue to follow-up on non-compliance throughout 2023/24. Mr Wilshere advised that the Trust had received the annual summary from the Association of the British Pharmaceutical Industry (ABPI) for 2022/23 of benefits received by staff identifying as

	working for the Trust. He said an initial check against the Trust register had indicated significant variances and this would be pursued by Counter-Fraud. He confirmed that this had been shared with Dr Shehmar, Medical Director. Mr Wilshere asked the committee to consider whether the Fit and Proper Persons Test (FPPT) should apply to other senior staff and this decision would be taken at Board level. **Resolved: that the Review of Conflicts of Interest Policy Compliance and Registers be received and noted.**
	Financial Reports, Approvals, Actions, Discussions
056/23	**Single Tender Actions**
	Resolved: that the Single Tender Actions Report be received and noted.
057/23	**Suspension Breaches – Verbal**
	Mr Mortiboys advised there were no suspension breaches. **Resolved: that the Suspension Breaches – Verbal be received and noted.**
058/23	**Review of Losses and Special Payments**
	Resolved: that the Review of Losses and Special Payments be received and noted.
	Any Other Matters
059/23	**Any Other Business**
	No Other Business Was Raised.
060/23	**Reflections on Meeting and Items for Inclusion on Chair's Report to Board**
	Ms Martin advised that the Mental Health Provision risk would be escalated to Trust Board members through the Audit Committee Chair's report. Ms Martin advised the internal audit progress report would be escalated to Trust Board members through the Audit Committee Chair's report. Ms Martin advised the Board regarding the scope of positions to be included under the fit and proper persons requirements to be confirmed by the Board.
061/23	**Date of Next Meeting**
	Date: Monday 11th December 2023 **Time:** 14:30-16:30PM **Venue:** MLCC Room 9 Walsall Manor Hospital