The Royal Wolverhampton NHS Trust

Bundle Public Trust Board 7 February 2023

0 Apologies for absence - none

Additional attendees
Dr Tina Vaz Senior Clinical Fellow, Critical Care Services Directorate, RWT
Lisa O'Brien Chief Reporter Express and Star

1 Nolan Principles

Nolan Principles of Public Life and Trust Values v4 020223.pdf

2 To receive declarations of interest from Directors and Officers

Declarations of Interests February 2023 v1.pdf

3 09:30 - Minutes of the meeting of the Board of Directors held on 6 December 2022

Action To approve
Lead Chair

RWT Public Trust Board Minutes 6 December 2022 v0.6 KW SB SE LN.doc

4 Matters arising and Board Action Points from the minutes of the meeting of the Board of Directors held on 6 December 2022

Action items -v1 February 2023.docx

4.1 09:35 - Update on actions in relation to Covid-19 National Inquiry

Lead and presenter - Kevin Bostock, Group Director of Assurance

RWT TB COVID19 Inquiry Update Report Front sheet.docx

Part 2 - Covid 19 Inquiry.pdf

5 09:40 - Patient Story

Lead Head of Communications Emily Smith
Action to note
https://www.youtube.com/watch?v=sUBkNFLUaDA
Attending Dr Habib Consultant Thoracic Surgeon RWT

6 10:00 - Chief Executive and TMC Reports - Section Heading

Lead Group Chief Executive Officer
Action to note

6.1 Chief Executive's Report

Lead - Prof. David Loughton, CEO

TB CEO Report to Board 7 February 2023.doc

6.2 Chief Executive's Report of the TMC held on 27 January 2023

Chairs Report TMC TB Summary 7 February 2023 for meeting on 27 January 2023.docx

7 Patient Safety, Quality and Experience - Section Heading

7.1 10:10 - Patient Experience (& Complaints Report)

Presenter Alison Dowling Head of Patient Experience
Lead Director of Nursing Debra Hickman
Action to note

TB patient experience bi monthly report Oct November 2022 06022023 v2 - combined.pdf

7.2 10:15 - Learning from Deaths Report

Lead Chief Medical Officer Dr McKaig
Action to note

Learning From Deaths - Trust Board February 2023.pdf

Learning from Deaths Update February 2023.pdf

7.3 10:20 - Quality Improvement Team Update

Lead Group Chief Strategy Officer Simon Evans
Action to note

RWT TB QI Rep 07-02-23 Merged.pdf

8 Governance, Risk and Regulatory - Section Heading

8.1 10:25 - Quality Governance Assurance Committee (QGAC) - Chair's Report

Lead Prof. Louise Toner
Action to note

QGAC Chairs Report - January 2023.docx

8.2 10:30 - Chief Nurse's Nursing Report

Lead Director of Nursing Debra Hickman
Action to note

Part 1 _TB_CNO Report - January 2023.pdf

Part 2 _TB_CNO Report - January 2023 - combined.pdf

8.3 10:35 - Integrated Quality and Performance Report

Lead Director of Nursing Debra Hickman/Chief Operating Officer Gwen Nuttall
Action to note

Trust Board IQPR December 2022.pdf

8.4 10:50 - Midwifery report including Maternity Incentive Scheme Year 4 Safety Action 4

Lead Director of Midwifery Tracy Palmer
Action to note

part 1 Midwifery Services report Feb 23 final Trust Board .pdf

Part 2_ Midwifery Services report Feb 2023 Final TB docx (002) - combined.pdf

8.5 10:55 - Break

8.6 11:05 - Pharmacy & Medicines Optimisation report

Presenter Angela Davis, Clinical Director of Pharmacy and Medicines Optimisation
Controlled Drugs Accountable Officer
Lead Chief Medical Officer Dr McKaig
Action to note

Trust Board Pharmacy and Medicines Optimisation Report January 2022_23 Final.docx

8.7 Director of Infection Prevention and Control Report (Including Infection Prevention BAF)

Presenters Jo Macve and Matt Reid
Lead Director of Nursing Debra Hickman
Action to note

IPC TB report Jan 2023 v2 - combined.pdf

8.8 11:10 - Trust Risk Register/Board Assurance Framework Heat Map

Lead Group Director of Assurance Kevin Bostock and Group Company Secretary Keith Wilshere
Action to note

TRR Trust_Board Report feb 2023 (003).docx

8_Trust BAF Heat Map 24.01.23 v3.5.pdf

8.9 11:15 - Mental Health Report

Presenter Jodie Owens-Kirby, Lead Nurse for Mental Health
Lead Chief Medical Officer, Dr McKaig
Action to note

Mental Health Report Trust Board RWT February 2023. v2docx.docx

8.10 11:20 - Audit Committee - Chair's Reports September and December

Lead Julie Jones
Action to note

AC 6 September 2022.docx

AC 13 December 2022.docx

8.11 Audit Committee Terms of Reference

Lead Julie Jones
Action for approval

Terms of Reference Audit Committee RWT.v 1.6 updated 12.1.23 (003).docx

8.12 11:25 - Workforce Safeguards - Nursing and Allied Health Professionals (AHP)

Lead Director of Nursing Debra Hickman
Action to note

Part 1_Workforce Safeguards Report TB _Feb2023.pdf

Part 2_Workforce Safeguards Report February 2023 TB.pdf

9 Performance and Finance - Section Heading

9.1 11:30 - Performance and Finance - Chair's Report

Lead John Dunn
Action to note

Report to Board - Chairs Report P+F Jan.pdf

9.2 11:35 - Report of the Chief Financial Officer - Month 7, 8 and 9

Lead Group Chief Finance Officer and Deputy Chief Executive Officer Kevin Stringer
Action to note

M07 Board Report.pdf

M08 Board Report.pdf

M09 Board Report.pdf

9.3 11:40 - Review of GI02, Financial Management Policy Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation

Lead Group Chief Financial Officer, Kevin Stringer and Group Company Secretary Keith Wilshere
Action to approve

GI02 Trust Board Front Sheet.docx

GI_02_Policy.docx

CLEAN GI_Appendix1_Standing_Orders version 9 January 2023 (002).docx

GI_Appendix2_Standing_Financial_Instructions.v2.docx

CLEAN GI_Appendix3_Scheme_of_Reservation_and_Delegation.v2.docx

GI_Appendix4_Budget_Management.pdf

GI_Standing_Financial_Instructions-Authorised_Limits.docx

10 Strategy, Business and Transformation - Section Heading

10.1 11:45 - Update from the Black Country Provider Collaboration Programme

Lead Group Chief Strategy Officer Simon Evans
Action to note

RWT TB Provider Collaboration Rep Feb merged 2023.pdf

10.2 11:50 - Sustainability Report

Lead Group Chief Strategy Officer Simon Evans
Action to note

RWT TB Sustainability Rep Feb 23 merged.pdf

11 People and Engagement - Section Heading

11.1 11:55 - People Organisational and Development Committee - Chair's Report

Lead Junior Hemans
Action to note

PODC Committee Chair Report Jan 2023.docx

11.2 12:00 - Executive Summary Workforce Report

Lead Group Chief People Officer Alan Duffell
Action to note

Exec Workforce Summary Report - TB Feb 2023.pdf

11.3 12:05 - The Royal Wolverhampton NHS Trust Equality Objectives 2023 - 2027

Lead Group Chief People Officer Alan Duffell
Action to approve

RWT Equality Objectives 2023 - 2027 Report to Trust Board.docx

11.4 12:10 - Update on Health and Inequalities (following an action from TB August 2022)

Lead Group Chief Medical Officer Dr Odum
Action to note

Health Inequalities - Front Sheet Trust Board Report February 2023 v2.pdf

Appendix A - Health Inequalities Update January 2023.pdf

12 12:15 - Items to Note

12.1 Approved Minutes from Committees in respect of which the Chair's report have already been submitted to the Board

12.1.1 Audit Committee Minutes dated 6 September 2022

Minutes of the Audit Committee 6.9.22 final.docx

12.1.2 Performance and Finance Minutes 23 November 2022 and 24 November 2022

3.2 Performance + Finance Investment Min 24.11.22.pdf

3.1 Performance + Finance Min 23.11.22.pdf

12.1.3 PODC Minutes 25 November 2022

PODC Mins 25th Nov 2022 .docx

12.1.4 Trust Management Committee minutes dated 25 November 2022

RWT Minutes Trust_Management_Committee_of_the_Board 25 Nov_2022 v1.4 MZ SB.docx

12.1.5 QGAC minutes 24 November 2022

Enc 1 - QGAC Minutes November 2022.docx

13	12:20 - Staff Voice - Capacity Team *Lead Group Chief People Officer Alan Duffell*
14	General Business
14.1	Any Other Business
14.2	Questions from members of the public and those in attendance
14.3	Date and time of the next meeting *Tuesday 4 April 2023 at 9:30 am*
14.4	To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudical to the public interest
15	For reading/information

Nolan Principles of Public Life & Trust Values

The Royal Wolverhampton NHS Trust

Committee on Standards in Public Life - Guidance

The Seven Principles of Public Life

Published 31 May 1995

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

Principle	*I will show this by*
1. Selflessness Holders of public office should act solely in terms of the public interest.	
2. Integrity Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.	
3. Objectivity Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.	
4. Accountability Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.	
5. Openness Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.	
6. Honesty Holders of public office should be truthful.	
7. Leadership Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.	

Excel in the delivery of Care

We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.

- We will embed a culture of learning and continuous improvement at all levels of the organisation
- We will prioritise the treatment of cancer patients, focused on improving the outcomes of those diagnosed with the disease
- We will deliver safe and responsive urgent and emergency care in the community and in hospital
- We will 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 communities and populations

Support our Colleagues

We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations.

- Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff
- Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing
- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged
- Deliver year on year improvement in Workforce Equality Standard performance

Improve the health of our Communities

We will positively contribute to the health and wellbeing of the communities we serve.

- Develop a strategy to understand and deliver action on health inequalities
- Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025
- Work together with PLACE based partners to deliver improvements to the health of our immediate communities

Effective Collaboration

We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.

- Work as part of the provider collaborative to improve population health outcomes
- Improve clinical service sustainability by implementing new models of care through the provider collaborative
- Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital
- Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes
- Facilitate research that establishes new knowledge and improves the quality of care of patients

RWT- Register of Declarations of Interest from Directors and Officers February 2023

Employee	Role	Interest Type	Provider	Interest Description (Abbreviated)
Alan Duffell	Group Chief People Officer	Loyalty Interests	UK and Ireland Healthcare Advisory Board for Allocate Software (Trust Supplier)	Member (unpaid)
Alan Duffell	Group Chief People Officer	Loyalty Interests	Chartered Management Institute	Member
Alan Duffell	Group Chief People Officer	Loyalty Interests	CIPD (Chartered Institute for Personnel and Develovement)	Member
Alan Duffell	Group Chief People Officer	Outside Employment	The Dudley Group NHS Foundation Trust	Interim Chief People Officer
Alan Duffell	Group Chief People Officer	Outside Employment	Walsall Healthcare NHS Trust	Group Chief People Officer
Alan Duffell	Group Chief People Officer	Outside Employment	Black Country Provider Collaborative	Provider Collaborative HR & OD Lead
Alan Duffell	Group Chief People Officer	Outside Employment	NHS Employers Policy Board	Member
Allison Heseltine	Associate Non Executive Director	Outside Employment	NHS England and Improvement	Associate Director of Nursing and Quality. Working in the COVID Outbreak Cell. 20 hours per week until 31/03/22, 15 hours per week from 01/04/22. Fixed term contract being extended from 1st

Allison Heseltine	Associate Non Executive Director	Loyalty Interests	Jason Ryall - Employee of KPMG.	Associate Director - Asset Management Advisory Sector, Infrastructure Advisory Group, KPMG.
Ann-Marie Cannaby	Group Chief Nurse	Loyalty Interests	Staffordshire University	Visiting Professor (unpaid Assignment)
Ann-Marie Cannaby	Group Chief Nurse	Loyalty Interests	Higher Education Academy	Teaching Fellow
Ann-Marie Cannaby	Group Chief Nurse	Loyalty Interests	Royal College of Nursing	Member
Ann-Marie Cannaby	Group Chief Nurse	Outside Employment	Birmingham City University	Visiting Nursing Professor
Ann-Marie Cannaby	Group Chief Nurse	Shareholdings and other ownership interests	Ann-Marie Cannaby Ltd	Director
Ann-Marie Cannaby	Group Chief Nurse	Outside Employment	British Telecom	Principal Clinical Advisor
Ann-Marie Cannaby	Group Chief Nurse	Outside Employment	Cavell (Charity)	Member of Cavell (Charity) Advisory Panel – this is a volunteer role with no payment being received and undertaken in own time
Ann-Marie Cannaby	Group Chief Nurse	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Nurse/Deputy Chief Executive

Ann-Marie Cannaby	Group Chief Nurse	Outside Employment	Charkos Global Ltd	Advisory Board Member for Charkos Global Ltd
Brian McKaig	Chief Medical Officer	Loyalty Interests	Rotha Abraham Trust	Trustee for the Rotha Abraham Trust which was set up to advance medical research and practice to benefit the population of Wolverhampton. Upaid role
David Loughton	Group Chief Executive	Outside Employment	West Midlands Cancer Alliance	Chair
David Loughton	Group Chief Executive	Loyalty Interests	National Institute for Health Research	Member of Advisory Board
David Loughton	Group Chief Executive	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Executive
Debra Hickman	Director of Nursing	Nil Declaration		
Gillian Pickavance	Associate Non Executive Director	Shareholdings and other ownership interests	Wolverhampton Total Health Limited	Director
Gillian Pickavance	Associate Non Executive Director	Outside Employment	Newbridge Surgery	Senior Partner at Newbridge Surgery Wolverhampton
Gillian Pickavance	Non Executive Director	Outside Employment	Tong Charities Committee	Unpaid member of the Committee

Gwen Nuttall	Chief Operating Officer	Loyalty Interests	Calabar Vision 2020 Link	Trustee
John Dunn	Non-Executive Director	Nil Declaration		
Jonathan Odum	Group Chief Medical Officer	Outside Employment	Wolverhampton Nuffield	Private out-patient consulting and general medical/hypertension and nephrological conditions at Wolverhampton Nuffield
Jonathan Odum	Group Chief Medical Officer	Outside Employment	Black Country and West Birmingham ICS Clinical Leaders Group	Chair
Jonathan Odum	Group Chief Medical Officer	Loyalty Interests	Royal College of Physicians	Fellow of the Royal College of Physicians
Jonathan Odum	Group Chief Medical Officer	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Medical Officer
Julie Jones	Associate Non Executive Director	Outside Employment	Heart of England Academy	Chief Finance Officer
Julie Jones	Associate Non Executive Director	Outside Employment	Academy Advisory	Associate Director
Julie Jones	Associate Non Executive Director	Outside Employment	Walsall Housing Group	Member of Audit & Risk Committee

Julie Jones	Associate Non Executive Director	Outside Employment	Solihull School Parents' Association	Trustee
Julie Jones	Associate Non Executive Director	Outside Employment	Cranmer Court Residents Wolverhampton Limited	Director of leasehold management company
Junior Hemans	Non Executive Director	Outside Employment	Wolverhampton University	Visiting Lecturer
Junior Hemans	Non Executive Director	Outside Employment	Kairos Experience Limited	Company Secretary
Junior Hemans	Non Executive Director	Outside Employment	Wolverhampton Cultural Resource Centre	Chair of the Board
Junior Hemans	Non Executive Director	Outside Employment	Tuntum Housing Assiciation (Nottingham)	Chair of the Board
Junior Hemans	Non Executive Director	Outside Employment	Libran Enterprises (2011) Ltd	Director
Junior Hemans	Non Executive Director	Loyalty Interests	Labour Party	Member
Junior Hemans	Non Executive Director	Loyalty Interests	Prince's Trust	Business Mentor

Junior Hemans	Non Executive Director	Loyalty Interests	Walsall Healthcare NHS Trust	Non-Executive Director
Junior Hemans	Non Executive Director	Loyalty Interests	wife	Wife works as a Therapist at The Royal Wolverhampton NHS Trust
Junior Hemans	Non Executive Director	Loyalty Interests	Second Cousin	Second Cousin works as a Pharmacist at The Royal Wolverhampton NHS Trust
Keith Wilshere	Group Company Secretary	Shareholdings and other ownership interests	Keith Wilshere Associates	Sole owner, sole trader
Keith Wilshere	Group Company Secretary	Loyalty Interests	Foundation for Professional in Services for Adolescents (FPSA)	Trustee, Director and Managing Committee member of this registered Charity and Limited Company since May 1988.
Keith Wilshere	Group Company Secretary	Outside Employment	Walsall Healthcare NHS Trust	Group Company Secretary
Kevin Bostock	Group Director of Assurance	Outside Employment	Oxford Health NHS Foundation Trust via Orange Genie Umberella Company	Continuance of previous employment supporting the Covid-19 Vaccination Programme as Senior Clinical Lead on an as and when required basis until October 2021.
Kevin Stringer	Group Chief Financial Officer	Outside Employment	Healthcare Financial Management Association	Treasurer West Midlands Branch
Kevin Stringer	Group Chief Financial Officer	Loyalty Interests	Midlands and Lancashire Commissioning Support Unit	Brother-in-law is the Managing Director

Kevin Stringer	Group Chief Financial Officer	Loyalty Interests	CIMA (Chartered Institute of Management Accounts)	Member
Kevin Stringer	Group Chief Financial Officer	Gifts	Veolia	Spade used for 'sod cutting'.
Kevin Stringer	Group Chief Financial Officer	Outside Employment	The Dudley Group NHS Foundation Trust	Interim Director of Finance for the Trust.
Kevin Stringer	Group Chief Financial Officer	Loyalty Interests	Amy Stringer	Daughter works on the administration bank of the Trust.
Kevin Stringer	Group Chief Financial Officer	Outside Employment	Walsall Healthcare NHS Trust	Group IT Director and SIRO
Kevin Stringer	Group Chief Financial Officer	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Financial Officer
Lisa Cowley	Non Executive Director	Outside Employment	Beacon Centre for the Blind	CEO
Lisa Cowley	Non Executive Director	Outside Employment	Beacon Centre for the Blind	Healthy Communities Together Project Sponsor
Louise Toner	Non Executive Director	Outside Employment	Walsall Healthcare NHS Trust	Non-Executive Director

Louise Toner	Non Executive Director	Outside Employment	Birmingham City University	Professional Advisor
Louise Toner	Non Executive Director	Outside Employment	Wound Care Alliance UK	Trustee
Louise Toner	Non Executive Director	Outside Employment	Birmingham Commonwealth Society	Trustee
Louise Toner	Non Executive Director	Outside Employment	Advance HE (Higher Education)	Teaching Fellow
Louise Toner	Non Executive Director	Loyalty Interests	Birmingham Commonwealth Association	Chair of Education Focus Group
Louise Toner	Non Executive Director	Loyalty Interests	Board of Directors Birmingham Commonwealth Association	Member
Louise Toner	Non Executive Director	Loyalty Interests	Greater Birmingham Chamber of Commerce Commonwealth Group	Member
Louise Toner	Non Executive Director	Loyalty Interests	BSol Education Partnerships Group	Member
Louise Toner	Non Executive Director	Loyalty Interests	Health Data Research UK	Member/Advisor

Louise Toner	Non Executive Director	Loyalty Interests	Royal College of Nursing	Member
Louise Toner	Non Executive Director	Loyalty Interests	Nursing and Midwifery Council	Required Registration to practice
Martin Levermore	Associate Non Executive Director	Shareholdings and other ownership interests	Medical Devices Technology International Ltd (MDTi)	Ordinary shares
Martin Levermore	Associate Non Executive Director	Outside Employment	Nehemiah United Churches Housing Association Ltd	Vice Chair of Board paid position by way of honorarium
Martin Levermore	Associate Non Executive Director	Outside Employment	Medilink Midlands	Chair non-paid of not for profit medical industry network organization/association
Martin Levermore	Associate Non Executive Director	Outside Employment	New Roots Limited Charity	Chair of Trustees non-paid homeless charity
Martin Levermore	Associate Non Executive Director	Outside Employment	Her Majesty's Home Office	Independent Adviser to Windrush Compensation Scheme paid
Martin Levermore	Associate Non Executive Director	Outside Employment	Birmingham Commonwealth Association Ltd	Chair of Trade and Business non-paid not for profit association
Martin Levermore	Associate Non Executive Director	Outside Employment	Medical Devices Technology International Ltd (MDTi)	Chief Executive Officer paid of private Medical Device company

Martin Levermore	Associate Non Executive Director	Outside Employment	Commonwealth Chamber of Commerce	Executive member non-paid
Sally Evans	Group Director of Communications and Stakeholder Engagement	Outside Employment	Walsall Healthcare NHS Trust	Group Director of Communications and Stakeholder Engagement
Simon Evans	Group Chief Strategy Officer	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Strategy Officer
Stephen Field	Chairman	Loyalty Interests	Nishkam Healthcare Trust Birmingham	Trustee
Stephen Field	Chairman	Loyalty Interests	EJC Associates	Director
Stephen Field	Chairman	Loyalty Interests	Walsall Healthcare NHS Trust	Chair
Stephen Field	Chairman	Loyalty Interests	University of Warwick	Honorary Professor
Stephen Field	Chairman	Loyalty Interests	University of Birmingham	Honorary Professor
Stephen Field	Chairman	Outside Employment	Makkah Health Cluster, Kingdom of Saudi Arabia	Advisor to Health Holding Company and Board Member of Makkah Health Cluster, Kingdom of Saudi Arabia

Susan Rawlings	Asscociate Non Executive Director	Outside Employment	Telford Christian Council Supported Housing (STAY)	Trustee and Director of Telford Christian Council Supported Housing (STAY), a charitable company.
Susan Rawlings	Associate Non Executive Director	Outside Employment	Telford Christian Council	Trustee and Director of Faith based Charity in Telford
Tracy Palmer	Director of Midwifery	Nil Declaration		
Angela Harding	Associate Non Executive Director	Outside Employment	General Dental Council	People and Organisational Development Director
Angela Harding	Associate Non Executive Director	Outside Employment	Naish Mews Management Company	Director
Umar Daraz	Associate Non Executive Director	Outside Employment	Getaria Enterprises Limited	
Umar Daraz	Associate Non Executive Director	Outside Employment	Birmingham City University	Director of Innovation
Patrick Carter	Specialist Advisor to the Board	Director	JKHC Ltd (business services)	Director
Patrick Carter	Specialist Advisor to the Board	Director	Glenholme Healthcare Group Ltd	Director
Patrick Carter	Specialist Advisor to the Board	Director	Glenholme Wrightcare Ltd (Residenial nursing care facilities)	Director

Patrick Carter	Specialist Advisor to the Board	Director	The Freehold Corporation Ltd (property; real estate)	Director
Patrick Carter	Specialist Advisor to the Board	Director	Primary Group Limited, Bermuda (Insurance & Re-Insurance)	Director
Patrick Carter	Specialist Advisor to the Board	Outside Employment	Primary Group Limited, Bermuda (Insurance & Re-Insurance)	Chair
Patrick Carter	Specialist Advisor to the Board	Outside Employment	NHS Improvement (Monitor)	Non Executive Director
Patrick Carter	Specialist Advisor to the Board	Outside Employment	Health Services Laboratories LLP	Chair
Patrick Carter	Specialist Advisor to the Board	Outside Employment	Scientific Advisory Board - Naitive Technologies Ltd (experimental development on natural sciences and engineering	Member
Patrick Carter	Specialist Advisor to the Board	Outside Employment	Bain & Co UK	Advisor
Patrick Carter	Specialist Advisor to the Board	Outside Employment	JKHC Ltd (business services)	Business Services
Patrick Carter	Specialist Advisor to the Board	Outside Employment	Cafao Ltd	Management consultancy activities other than financial management)
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Cafao Ltd	Shareholder

Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	The Freehold Corporation Ltd (property; real estate)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	JKHC Ltd (business services)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	The Glenholme Healthcare Group Ltd (care and rehabilitation centres)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	The Freehold Investment Corporation 1A Ltd	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	The Freehold Investment Corporation 1B Ltd	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	The Freehold Investment Corporation 2A Ltd	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	The Freehold Investment Corporation 2B Ltd	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Adobe Inc (technology)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	AIA Group Ltd (insurance)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Alibaba Group Holding Ltd (retail)	Shareholder

Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Alphabet Inc (multinational conglomerate)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Amazon.com Inc (retail)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	American Tower (manufacturing)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Amphenol Corp (manufacturing)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Apple Inc (technology)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	ASML Holding NV (manufacturing)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Berkshire Hathaway Inc (financial)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Broadridge Financial Solutions Inc (financial)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Canadian Pacific Kansas City Ltd	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Colgate Palmolive Co	Shareholder

Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Constellation Software Inc (software)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Croda International Plc	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	CSL Ltd (technology)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Danaher Corp (science and tech)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Discover Financial Services (financial)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Ecolab Inc (health)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Essilor International (health)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	First Republic Bank/CA (financial)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Halma plc (tech)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	HDFC Bank Ltd (financial)	Shareholder

Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Hexagon AB-B SHS (tech)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	IDEX Corp (manufacturing)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Intuit Inc (science and tech)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Johnson & Johnson (retail)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	London Stock Exchange	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	L'Oreal SA (manufacturing and retail)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Meta Platforms Inc A	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Mettler Toledo (manufacturer of scales and analytical instruments)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Microsoft Corp (tech)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Netflix Inc (technology)	Shareholder

Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Nike Inc (retail)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Roper Technologies Inc (manufacturing)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	ServiceNow Inc (technology)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	SG WOF Phoenix Plus Note (financial)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Sherwin Williams Co/The	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Taiwan Semiconductor Manufacturing Company Limited (science and tech)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Tencent Holdings Ltd (science and tech)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Thermo Fisher Scientific Inc (biotechnology)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Topicus.com Inc	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	UnitedHealth Group Inc (health)	Shareholder

Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Visa Inc (financial)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Shareholdings and other ownership interests	Wisdomtree Physical Swiss Gold (commodity)	Shareholder
Patrick Carter	Specialist Advisor to the Board	Land/Property Owner	Villa in France	Owner
Patrick Carter	Specialist Advisor to the Board	Land/Property Owner	Farms, farmland, residential and tourist activities in Hertfordshire	Owner
Patrick Carter	Specialist Advisor to the Board	Non-financial interests - unremunerated directorships	CAFAO Ltd	Director (Member's own company which takes care of his family office matters)
Patrick Carter	Specialist Advisor to the Board	Non-financial interests - unremunerated directorships	The Freehold Acquisition Corporation Ltd (property; real estate)	Director
Patrick Carter	Specialist Advisor to the Board	Non-financial interests - unremunerated directorships	The Freehold Financing Corporation Ltd (property, real estate)	Director
Patrick Carter	Specialist Advisor to the Board	Non-financial interests - unremunerated directorships	Glenholme Senior Living (Bishpam Gardens) Ltd (nursing home	Director

The Royal Wolverhampton NHS Trust (RWT)

Minutes of the meeting of the Board of Directors held on Tuesday 6 December 2022 at 9:30 am from Conference Room C27 Hollybush House, New Cross Hospital, Wednesfield, Wolverhampton and virtually via Microsoft Teams (MT)

PRESENT:

Prof. S Field CBE	Chair, in person
Prof. D Loughton (v) CBE	Group Chief Executive Officer,
Mr S Evans	Group Chief Strategy Officer,
Mr A Duffell	Group Chief People Officer,
Mr J Hemans	Non-Executive Director,
Dr B McKaig (v)*	Chief Medical Officer,
Prof. L Toner	Non-Executive Director,
Ms S Rawlings	Associate Non-Executive Director, in person
Mr K Stringer (v)	Group Chief Financial Officer/Deputy Chief Executive,
Ms G Nuttall (v)	Chief Operating Officer,
Ms L Cowley	Non-Executive Director,
Ms J Jones (v)	Associate Non-Executive Director,
Ms T Palmer	Director of Midwifery,
Ms D Hickman	Director of Nursing, RWT
Ms S Evans	Group Director of Communications and Stakeholder Engagement, RWT
Prof. A-M Cannaby (v)	Group Chief Nursing Officer,
Mr M Levermore (v)	Associate Non-Executive Director, RWT
Mr K Bostock	Group Director of Assurance, RWT
Mr J Dunn	Non-Executive Director, RWT
Dr J Odum (v)*	Group Chief Medical Officer, RWT
Dr G Pickavance	Associate Non-Executive Director
Ms P Boyle	Group Managing Director of Research and Development, RWT

*(v) denotes voting Executive Directors, * denotes shared single vote*

IN ATTENDANCE:

Mr K Wilshere	Group Company Secretary, RWT, in person
Ms S Banga	Operations Coordinator for the Company Secretary, RWT,
Ms M Zajac	Senior administrator for the Company Secretary, RWT,
Dr J Macve	Infection Prevention, RWT for Infection Prevention item,
Mr M Reid	Infection Prevention, RWT for Infection Prevention item,
Ms A Dowling	Head of Patient Experience and Public Involvement, RWT for Patient Experience item,
Ms S Winter	Interim Matron for Trauma, RWT for Patient Story
Ms A Sykes	Freedom to Speak up Guardian, RWT for Freedom to Speak up Guardian item
Ms L Nickell	Group Director of Education and Training, RWT, for Schwartz Rounds annual update Item, and Education and Training report item
Mr M Greene	Deputy Chief Finance Officer, RWT for Staff Voice item
Ms N Skov	Accounts Payable Manager, RWT for Staff Voice item
Mr T Otufowora	Capital Accountant, RWT for Staff Voice item
Mr J Lawley	Senior Management Accountant (BCPS), RWT for Staff Voice Item
Ms E Parkes	Income Accountant, RWT for Staff Voice item
Ms D Black	Division 1 Head of Nursing, RWT
Ms D Johnson	Group Patient Safety Specialist, RWT
Mr T Parkes	Wolverhampton Express and Star
Ms S Stephenson	Deloittes
Mr M Podier	Business Development Associate, Acacium Group

APOLOGIES:
Ms A Heseltine Associate Non-Executive Director

Part 1 – Open to the public
Prof. Field welcomed all to the public meeting.

TB.8961: Nolan Principles
Prof. Field reminded all that it was important when working for the NHS that the Board adhered to the Nolan Principles and lived them especially in the Board meeting.

TB.8962: Apologies for absence
Prof. Field noted apologies of absence from Ms Heseltine. Prof. Field said Prof. Loughton would be late due to local road closures.

TB.8963: To receive declarations of interest from Directors and Officers
Prof. Field asked whether there were any new or changed declarations to be made. Prof. Toner said she would liaise with Ms Banga after the meeting with amendments to her declarations. She said there was nothing substantive or anything that would conflict with her position at the Trust or with any items on the agenda for this meeting.
Action: Prof. Toner to update declarations.

TB.8964: Minutes of the meeting of the Board of Directors held on 4 October 2022
Prof. Field went through the minutes of the Board of Directors held 4 October 2022 amendments were made as follows

TB:8918
Page number 7
Chief Nurse's Nursing (CNO) Report
Fourth paragraph
Ms Hickman mentioned the word "decamp" be removed and replaced with "decant"

TB:8918
Page number 8
Sixth paragraph
Chief Nurse's Nursing (CNO) Report
Prof. Toner mentioned the words "City Birmingham University" be removed and replaced with "Birmingham City University (BCU)"

Resolved: that the Minutes of the Board of Directors held on 4 October 2022 be approved as a true record subject to the amendments noted.

TB.8965: Matters arising from the minutes of the meeting of the Board of Directors held on 4 October 2022– Action Points

4 October 2022/TB 8912
Trusts Strategy and Objectives
"Ms Evans to report back to the December Board meeting with feedback on progress with communicating the new Joint Trust Strategy."

Ms Evans said a document had been circulated detailing activity to date and the next steps involved including engagement sessions on hold to the New Year.
Action: it was agreed the action be closed.

2 August 2022/TB.8864
RWT Equality, Diversity and Inclusion Report 2021 – 2022
"Dr Odum to prepare an update on Health and Inequalities to the next Board meeting."
Mr Wilshere said Dr Odum had requested the item to be deferred to February 2023 Board meeting.
Action: it was agreed the action be moved to February Board meeting – action due date to be updated.

4 October 2022/TB 8909
Sustainability Report
"Mr Evans to feedback to the Sustainability Group the comment from Dr Pickavance on recycling wider equipment - i.e crutches."
Mr Evans said the action was complete and included in more detail in the report.
Action: it was agreed the action be closed.

4 October 2022/TB 8921
Midwifery report
"Prof. Loughton asked Ms Palmer to draft an email he could forward to Diane Wake about the Badgernet System."
Ms Palmer provided a description of the Badgernet System and confirmed a draft email was sent to Prof. Loughton on 4 October 2022.
Action: it was agreed the action be closed.

TB.8966: Patient Story
Ms Smith introduced the Patient Story - a Patient who had suffered a fall at home, broken her hip and had received treatment at the Trust. She said the Patient had raised concerns during her stay. Ms Winter, Trauma Matron reviewed the concerns raised as they had felt isolated after having been placed into a side room due to contracting Covid 19. She mentioned there had been issues regarding communication and diet as the Patient had celiac and required a gluten free diet. She said discussions had taken place with catering services and an increased range of gluten free snacks had been introduced, along with a training program for staff ordering out of hours gluten free food. She said the concerns raised had been shared with staff across wards and the number of Senior staff had been increased on night shifts as the issues mentioned had occurred elsewhere during the same period. She said the Trust recognised the communication issues and the Practice Education Facilitator was working with teams in making improvements. She said the Patient story had also been shared in Governance and Matrons meetings to raise staff awareness of these issues.

Ms Rawlings asked how staff had responded to the Patient story and whether there had been a recognition that things had not been done correctly such as understanding processes particularly in relation to gluten free diets. Ms Winter said the staff involved had attended training and had acknowledged the isolation felt by the patient from being placed into a side room and issues relating to access to the correct diet.

Ms Jones said it appeared from the story that nursing staff on duty had prioritised answering external calls to dealing with the patient calls. She asked whether that was something they were required to do, was there a particular timeframe in which staff were required to answer external calls. She asked whether this was widespread. Ms Winter said patient buzzer calls were always the priority for staff to answer. She said the Patient's stay at the hospital was during the Covid outbreak where there had been an exceptional number of calls to the Ward.

Prof. Cannaby asked whether the story and gluten free issues had been shared at the Matrons meetings to ensure the issues were highlighted wider for staff in the Trust. Ms Winter said she would add this as an action to share at the wider Matrons meetings. Prof. Cannaby asked whether Ms Winter and Senior staff were working on the wards as part of the "back to floor Fridays" initiative for senior staff, so checks could be undertaken to see whether improvements were required. Ms Winter confirmed she and her senior colleagues had been participating in the initiative.

Ms Hickman said the learning had been shared across wards as was likely to not be an isolated incident. She said the Trust needed to ensure support and training was in place for new staff. She said the Director of Nursing (DoN) report would include feedback from the internal mealtime audits reported from the Nutrition Steering Group to Quality Governance Assurance Committee (QGAC) to illustrate the evidence, assurance and monitoring.

Ms Dowling said she had spoken at length with the Patient and had offered to be her point of contact should she come back to the Trust to build her confidence in the Trust's services in future. She said the Trust was continuing in supporting the patient with additional needs regarding mobility at her home with physiotherapy.

Prof. Field thanked all involved and said it was important it was shown that the lessons had been learnt to improve the quality of care for patients provided by staff.

Resolved: that the Patient Story be received and noted.

Chief Executive and TMC Reports

TB.8967: Chief Executive's Report

Prof. Field said the Chief Executive's Report had been discussed with the Non-Executive Directors (NEDs) and asked that any issues be raised as part of the agenda items.

Resolved: that the Chief Executive's report be received and noted

TB.8968: Chief Executive's Report of the TMC held on 23 September 2022

Resolved: that the Chief Executive's Report of the TMC held on 23 September 2022 reports be received and noted

TB: 8969: Trust Management Committee (TMC) Terms of Reference

Prof. Field confirmed that the terms of reference was approved.

Resolved: that the TMC Terms of Reference be approved

People and Engagement

TB.8970: People & Organisational Development (PODC) Committee – Chair's Reports October and November

Mr Hemans highlighted a 'deep dive' detailed review undertaken into the staffing requirements at the Black Country and Pathology Services (BCPS). He said staff had continued to work remotely and there had been challenges in developing a new single culture when bringing staff together from across the Black Country whilst working remotely prior to returning onsite. He said the Trust was to provide further organisational development support.

Mr Hemans said the Committee had recognised the challenges with appraisals and operational pressures faced by staff, including recruitment and retention. He said there had been positive recruitment of international nurses. He added that there was now a Board Assurance Framework (BAF) Risk in respect of addressing Equality, Diversity and Inclusion (EDI) issues that was being monitored. He also referred to a review of retention and turnover that had remained above target with recognition that there was an increase in staff retiring and returning to work at the Trust. He said a review had also taken place in respect of Allied Health Professionals (AHPs) staffing with hotspot recruitment and retention issues in Chiropody, Podiatry, Theatre staff (ODP's) and Occupational Therapy (OT). He mentioned apprenticeships arrangements had been put in place for Physiotherapy and Occupational Therapy and the Trust continued to promote these to young people looking for work.

Resolved: that the People & Organisational Development (POD) Committee – Chair's Reports for October and November be received and noted

TB.8971: Executive Summary Workforce Report

Mr Duffell introduced the report and highlighted recruitment, and retention as key areas of focus. He said 'deep dives' *(detailed reviews and actions)* had been undertaken looking into the possible root causes were and he highlighted that it might lead to a new BAF risk. He said there was a focus on completing appraisals as they were linked to staff retention. He highlighted the potential role of 'stay' conversations as part of appraisals in identifying those planning to leave and what might be done for them to stay in respect of, for example, work-life balance, flexibility, different roles, and reduced hours if required. He said the Trust wide vacancy rate remained positive and more new staff had been commenced than those leaving but that it was a fine balance. He said that as of November 2022, the Trust's staff head count had passed 11,000, not including bank staff.

Mr Duffell spoke about the recent ballots by some staff side organisations regarding possible strike action, particularly Unison and the Royal College of Nursing (RCN). He said RCN vote had not met the threshold for industrial action and Unison had also fallen short. He said this did not mean the Trust would not be impacted in some way or at a future point.

Ms Nuttall added that a group specifically looking at the potential impacts had been formed that was working on mitigations and contingencies. She added that the outcome of the Midwives ballot was awaited. She said the risks to Trust services from the strikes scheduled for the 15 and 20 December 2022 should be minimal, however annual leave requests and sickness levels were being monitored as the Trust was being open and transparent in this so it could continue to run services. She said the GMB Union had a mandate for strike action and that West Midlands Ambulance Service (WMAS) had significant numbers of members in the GMB. She said the Trust had been working with WMBS regarding any impact on strike dates and that the results of ballots for Midwives, Physiotherapists, and junior doctors were expected. Prof. Field said the Trust would ensure communication was circulated to Executive Directors and NEDs during the Christmas Period regarding any impacts.

Mr Dunn said the Performance and Finance Committee (P&FC) saw staffing as a key enabler when addressing the winter plan and pressures. He said there was concern in any delays in recruits, such as the international recruits, to being work and ward ready and he asked whether this could be accelerated to assist with winter pressures, and whether there was sufficient staffing for the ambulance reception centre (ARC) and as to any being taken if key staff should be lost.

Mr Duffell said international recruitment was progressing well, with some delays in obtaining visas and nationally, an increased number of people taking more attempts to pass their objective structured clinical examination (OSCE), the exam required to registered as a nurse.

He said several organisations had experienced the same issues and Ms Hickman said had been picked up with educational support as international nurses arrived in preparation for the OSCE and preparation for clinical areas. She said there had been significant changes to the standards to obtain the OSCE which had adversely affected the first-time passing rates.

Prof. Cannaby said she was aware that the changes to the OSCE was a national issue. She said that as the Trust had recruited hundreds of international nurses this had an impact, and that there was fixed capacity in the team recruiting and supporting the new entrants. Mr Hemans said whilst the Trust was recruiting the overseas nurses, there was also a housing issue that had been discussed with registered housing providers across the Black Country together with the National Housing Federation to see if they could assist in finding suitable and appropriate accommodation for the new staff.

Dr Pickavance said she was aware when new staff were introduced this could put a strain on existing staff and asked whether there was a risk of losing staff due to the number of new international recruits they had to supervise. Mr Duffell said that he had not seen any indication that this had occurred and that in the main staff were keen to see the international recruits join them. Ms Hickman referred to the importance of the legacy mentor role and the Practice Education Facilitators in preparing new staff for transitions and she was aware of the scale of the challenge in supporting many new people into clinical areas. Prof. Cannaby said there was a period of transition to settle into their new roles and the existing staff accepted that period of transition.

Prof. Toner felt the Trust was in a much better position because of the work done over several years and she asked how the Trust was managing staffing during the winter. Mr Levermore asked about staff churn ratios and the impact of new areas and any assessment on workload lift for existing staff from staff churn. Mr Duffell said churn was measured at 12, 18 and 24 months and the Trust looked at individual areas staff lengths of service before moving on. He said those areas were monitored in relation to whether it was a potential BAF risk, and the decision would be made in the New Year if there was still concern over retention levels. He said numbers varied depending on service, division and speciality and the impact was best understand by area.

Resolved: that the Executive Workforce Summary report be received and noted.

TB.8972: Freedom to Speak Up Report

Prof. Field welcomed the well-written report for noting. Ms Jones referred to the reduction in contacts in the second quarter compared to the first and asked whether this showed an issue for staff wishing to speak up and what was being done to ensure staff did not feel a detriment because of speaking up.

Ms Sykes said the regional Guardians network had produced guidelines on detriment and the Trust had introduced a resource section on the staff intranet with guidelines for assessing and appreciating detriment for managers and staff. Ms Jones asked whether there was more detail on the type of detriment that had occurred. Ms Sykes said that the categories were subjective, for example it could be a feeling of being passed over or not offered progression opportunities compared to others, the most common perception in such cases. She said the Trust was trying to raise the profile of speaking up and had speak up champions across different departments to assist.

Resolved: that the Freedom to Speak Up Report be received and noted

TB.8973: Schwartz Rounds Annual Update

Ms Nickell introduced the report and explained that the Schwartz Round was an intervention where staff could confidentially talk about things that affected them in their daily work of caring for patients and each other. She said over the last year the Trust had held 10 rounds with an average attendance of 38 staff at each round with positive evaluation data with over 97% of people attending that would recommend them to colleagues. Prof. Toner mentioned Health Education England (HEE) had allocated monies to higher Educational Institutes who were delivering pre-qualifying related programmes.

Dr Pickavance asked who chose topics for the Schwartz Rounds. Ms Nickell said this was managed by a Steering Group who looked at the evaluation and chose the future topics, working closely with the Health and Well Being Team to reflect topics important to staff. Ms Rawlings asked whether attendees were the same each month. Ms Nickell said this was varied and each month there were at least 10 new attendees.

Resolved: that the Schwartz Rounds Annual Update be received and noted

TB.8974: Education and Training

Ms Nickell highlighted the Trust had been awarded excellence by the General Medical Council (GMC) National Training Survey (NTS) for Post Graduate Education. She said the Trust had undertaken several internal visits which the Deanery had recognised as excellent practice in self-analysis for quality improvement. She said the Trust had received two further awards - one for the certificate of recognition for Sustainable and Innovative Post Graduate Medical Education, and the second by the Paediatrics team awarded a Paediatric Award for Training Achievements (PAFTA) for being the best training unit. She said that in Undergraduate Medical Education there had been an increase in the Aston Medical Students (AMS) Students joining the Trust. She said the Trust had been awarded £265k that supported bids by departments to add to the two new High Fidelity Simulation kits. She said that for people development the Trust had introduced new courses in Learnt Optimism and Compassionate Leadership.

Ms Nickell said there were 22 Physician Associates (PA) at the Trust but that the University of Wolverhampton programme had closed to PhD Students and the Trust had taken PA Students from Birmingham City University (BCU) and Keele University instead. She said the Trust had 68 work experience paid placements in the last 12 months, 32 of whom had gained paid employment at the Trust. She said the Work Experience Team had received a gold award for quality from HEE, one of only three organisations in the UK. Prof. Field congratulated Ms Nickell and her team as he felt the Trust had one of the best learning organisations in the country and it was important for the Black Country economy to get local people into local jobs. He said the economic benefit of people in work and having career opportunities was very important and felt more publicity was required on this. Ms Nickell said she would liaise with Ms Evans.

Action: Ms Nickell and Ms Evans to review the future promotional potential of the work experience programme.

Mr Hemans said this positive story should be shared with Wolverhampton Place as it was an important factor for the local economy and population health and well-being. Dr Odum said the work of the Education Academy was fantastic and had expanded significantly in scope and that having students from BCU and Aston was very positive. He said an education awards ceremony had taken place that included both RWT and WHT. Ms Rawlings asked how the PA were led. Ms Nickell said a lead was already in place across both Trusts sharing clinical competencies, education support and programme of work.

Resolved: that the Education and Training be received and noted

TB.8975: People and Organisational Development Committee Terms of Reference (TOR)
Prof. Field asked that the TORs were approved.

Resolved: that the People and Organisational Development Committee Terms of Reference be approved

Patient Safety, Quality and Experience

TB.8976: Patient Experience (& Complaints Report)
Ms Dowling introduced the report and said the Trust received 325 complaints during the reporting period. She said there had been a decrease in the number of complaints regarding the Emergency, and obstetrics and gynaecology departments. She said during the period 5 cases had received full ombudsman investigations of which 4 had not been upheld. She said there was a case for elderly medicine partly upheld with no financial redress but a letter of apology and action plan to address the agreed identified service failures that related to communication. She said the Trust had adopted the new Ombudsman standards for complaint handling and policies at the Trust had been amended to reflect these. She mentioned the Trust had recruited a further 140 volunteers during the period.

Mr Dunn asked how easy it was for people to complain if they were not happy with something. Ms Dowling said the Trust made it as easy and as accessible as possible for people to raise complaints by telephone or an online form with promotional videos in other languages to seek feedback and some outreach work with the community groups with the assistance of the Diversity and Equality Officer.

Ms Rawlings referred to page 11 of the report and one of the questions from the Care Quality Commission (CQC) regarding staff education and any proactive work to let people know that they could give their views. Ms Dowling said the Trust tried to promote this as much as possible, including workshops for receptionists in seeking feedback, and the Trust was also trialling an initiative (already operating at WHT) of 'mystery patient' feedback. She said the Trust was producing more posters for patient's lockers with QR code links.

Ms Cowley referred to page 12, that notice on leaving hospital had deteriorated and whether that cross referenced to complaints relating to discharge. Ms Dowling said from a Patient Experience Liaisons (PALS) perspective this was not specifically about the waiting for notice period for discharge but more about what and how information was communicated and delivered when discharge occurred. She said this had been picked up by the relevant matron groups.

Resolved: that the Patient Experience (& Complaints Report) be received and noted

TB.8977: Quality Improvement Team Update
Mr Evans introduced the report that detailed the progress the Trust was making as part of its 'group' approach. He said the integrated teams would be known as the 'Quality Improvement Team' and that the focus was now to build improvement capacity and capability with a new improvement plan presented to the new (Joint Committee) Innovation Improvement and Research Sub-Group that was to oversee progress, with the ambition of increased capacity and capability for both organisations focussing on where the biggest impact could be achieved, with the Team working on 17 projects specifically related to patient flow.

Ms Jones asked about the ambitious plan to train 1000 staff over the next 3 years and was there a trajectory to show that was achievable. She also asked about the alert section reference to limited opportunity for sharing learning and asked for clarification of this, and how the Board might ensure an improvement in such opportunities. Mr Evans said when the Trust initially signed up to the Quality Service Improvement & Redesign (QSIR), it had developed a training programme pre-Covid where the target could be achieved. He said the ability of teams to share learning opportunities in their day-to-day jobs was being explored by a working group as to how this could be done during times of operational pressure and maintain clinically safe services. Ms Jones said the report had an element for the Board to address, according to the action plan. She asked what was required of the Board. Mr Evans said this related to options for dedicated learning time and the Associate Medical Director was speaking to senior clinicians across the organisation about the best possible way to make that happen depending on individual teams' circumstances and the Board was asked to support this.

Resolved: that the Quality Improvement Team Update be received and noted, and the approach outlined be supported.

TB.8978: Emergency Preparedness, Response & Resilience (EPRR) Annual Assurance 2022 – 2023

Ms Nuttall introduced the report as there was an annual requirement that all organisations were assessed against the national Civil Contingencies Act. She said previously the Trust scored highly with substantial assurance however this had changed for all organisations and as a result this year had received partial assurance with regards to the action plans and 5 of the metrics linked to changed NHS structures and revised national guidance issued in November 2022 when the Trust had to undertake the assessment in September 2022. She said those metrics required external factors linked to the Integrated Care Boards (ICBs) who were establishing their emergency plans. She felt that this position did not pose a risk to the Trust addressing a major incident or business continuity crisis.

Resolved: that the Emergency Preparedness, Response & Resilience (EPRR) Annual Assurance 2022 – 2023 be received and noted.

There was a break from 11:00 – 11:10am

Governance, Risk and Regulatory

TB.8979: Quality Governance Assurance Committee (QGAC) Chair's Reports October and November

Prof. Toner highlighted the challenges in the Cancer Improvement Plan with concern about renal services where mutual aid was not available nationally or locally, staffing issues in dermatology, and in melanoma management. She said measures were in place that addressed pathology turnaround times that had not improved to the degree desired.
She recognised improvement in scanning, but ultrasound scanning remained challenged as elsewhere. She said ambulance waits and Emergency Department ED breaches continued to be a challenge with the ARC opened to assist. She said there was discussion about a new model 'Push' looking at the flow of patients through the system.

Prof. Toner recognised the work regarding improving medicines management storage and policy compliance. She added that monies had been made available to social care services to assist patients medically fit for discharge into the community although home care and care homes remained vulnerable in relation to vacancies. She said there was a challenge with observations on time and targeted work was being undertaken in the areas that were not achieving the targets.

She also referred to the 'Back to Floor Fridays' initiative recommenced to assist with education and training. She said the Infection Prevention Control Report had been discussed in detail including the potential for a Patient Equipment Cleaning Centre. She said the Committee felt it was a good document with clear outcome measures. She also referred to the newly formed Patient Safety Incident Reporting Framework Group.

Resolved: that the Quality Governance Assurance Committee (QGAC) Chair's reports for October and November be received and noted.

TB.8980: Director of Nursing (DoN) Report

Ms Hickman introduced the report and referred to the Undergraduate Programme as it had been seen that some students were not transitioning into qualified posts. She said that positive conversations had taken place with the local Health Education Providers on how they could support the Trust in taking students when they were ready instead of at fixed times. She mentioned the Gap Analysis for the Winter Staffing Plan had been received with the regulatory letter that formed part of supportive conversations with staff. She recognised the deterioration in observations on time and referred to collaborative work with Walsall Healthcare NHS Trust (WHT) and the Quality Improvement Programme in place. She said there were 9 cases of *C-Difficile* at the Trust, 2 with transmissions. She said the Trust had requested a Peer Review of systems, processes and environment from the Regional Lead who was to attend the Trust on the 28 December. She also mentioned that the decant facility had recommenced.

Resolved: that the Chief Nurse's Nursing Report be received and noted.

TB.8981: Integrated Quality and Performance Report

Ms Nuttall highlighted the key challenges in achieving timely Ambulance Handovers and as a result. She said the Trust had developed and opened the ARC to assist as a receiving Centre for the Ambulance staff to book into as well as increased offload capacity in ED. She said that when there was significant pressure across the NHS system the Trust had seen an improvement in Handover times and that performance was monitored daily. She said the ARC worked if there was flow within the organisation from the Emergency Department and Prof. Toner had highlighted the challenges in Local Authority and third sector partners in achieving safe and timely discharges. She mentioned the Social Care Discharge Fund allocation of £1m in Wolverhampton but that it was a challenge to ensure the necessary resources and schemes in place to improve patients discharge. She said cancer referrals had increased to 30% above pre-Covid levels with the greatest pressures in Colorectal and Breast Cancer from the national screening programmes. She said the histopathology turnaround times affected the performance across the Black Country for the Black Country Pathology Service (BCPS). Prof. Field said the information in the report was very clear and the reports had been challenged in QGAC.

Resolved: that the Integrated Quality and Performance Report be received and noted.

TB.8982: Midwifery Service Report

Ms Palmer introduced the report including a letter from NHS England on the changes to the transformation programme regarding the Continuity of Care Models. She said the national challenges with the Midwifery workforce recruitment and retention, the Directors of Midwifery had raised their concerns about achieving the transformation of workforce, the trajectories and timescales for the delivery of Continuity of Care Models. She said the Trust was refraining from introducing any further Continuity of Care Models until workforce was stable. She said vacancy levels and maternity leave had had an impact on Trust services. She referred to the CQC inspection in October 2022 and that the draft report had been received and the factual inaccuracies corrected.

Ms Palmer referred to the impending requirement for Board approval of the declaration for the Maternity CNST Incentive scheme including the now achieved training element. She said she would report back to the Board on where the Trust was with the 10 safety actions in due course. She asked whether, due to the timing of the next Board meeting, for delegation of the declaration sign-off on behalf of the Board to the next QGAC meeting. Prof. Field confirmed the Board delegation.

Resolved: that the approval of the CNST Maternity Incentive Scheme (CNST) declaration be delegated to QGAC on behalf of the Board.

Prof. Toner said she had done a 'walkabout' at the maternity unit and could see changes in triage that had been implemented. She asked whether the change in oversight from NHSE to the Black Country LMNS was positive. Ms Palmer said the delegated responsibility was with the LMNS. Prof. Toner also asked about the under 27-week pathway and the Trust's involvement. Ms Palmer said work was in progress to get the pathway correct as a priority, working closely with WHT. She said there were multifactorial issues as to how that was done, and she was confident that positive progress was being made.

Resolved: that the Midwifery Service Report be received and noted.

TB.8983: Infection Prevention & Control (IPC) and Infection Prevention Board Assurance Framework (BAF) report

Dr Macve highlighted an increase in *C-Difficile* cases with the Trust above the external trajectory. She mentioned the change in *C.Difficile* testing that had affected all 4 Black Country Trusts, where the algorithm had been amended and a different screening test had been used which enabled results to be turned around quicker. She said the Trust was above target for device related bacteraemia's. She said there was one Carbapenemase-Producing Enterobacteriaceae (CPE) at the Trust and the Trust was seeing an increase in the number of patients with action being taken to prevent spread between patients. She said the Trust had a point of care testing for flu in the Emergency and Accident (ED) department and had 100 flu positives in November 2022, of which 62 were in the last week, an increase in line with what was being seen across the Country. Mr Reid said the revised key lines of enquiry were revised in September 2022 for the IP BAF reduced from 124 to 97. He said there had been an increase in Covid 19 cases at the Trust.

Ms Jones asked about the issues with estates regarding returning rooms ready for care and she asked what the timeline was to resolve this, and whether there was there anything the Board could do to assist. Mr Reid said he did not have a timeline but the Environment Group Meeting reporting to the Infection Prevention Control Group (IPCG), were working on a solution. Prof. Field asked for feedback and the item be on the matters arising section for next Board meeting.

Action: an update on the resolution of turn-around of rooms for care with estates be reported as a matter arising at the next Board meeting in February 2023.

Resolved: that the Infection Prevention & Control and Infection Prevention Board Assurance Framework (BAF) report be received and noted.

TB.8984: Trust Risk Register (TRR)/Board Assurance Framework (BAF) Heat Map

Mr Bostock highlighted the 22 risks on the TRR, 6 of which had been there for more than 3 years, that no new risks had been added in November 2022, that there remained 8 red open risks, 6 of which had been identified for specific attention and were being reviewed by the Responsible Risk Owners. He said all risks were monitored with a monthly review process undertaken. Mr Wilshere mentioned there was one amendment on the BAF following

discussion at P&F related to risk SR15 score increased to 5x4=20 from 5x3=15.
Mr Levermore asked whether there were any correlations between the red risks 4472 and 4596, owned by the Chief Operating Officer, relating to delays in timely assessment and training at ED and gallstone disease. Ms Nuttall said the delay times in ED had already been discussed and she would feedback to him and the next Board. (N.B. Ms Nuttall provided the feedback at the end of the meeting – see minute 8998)

Resolved: that the Trust Risk Register/Board Assurance Framework Heat Map Report be received and noted.

TB.8985: Patient Safety Incident Response Framework (PSIRF) – Preparation

Mr Bostock introduced the report, an update on progress for implementation of the PSIRF national requirement. He said the PSIRF replaced the Serious Incident Framework from NHS England of 2015 in April 2023 and work was underway by the Trust to adopt the framework.

Resolved: that the Patient Safety Incident Response Framework – Preparation be received and noted.

Performance and Finance

TB. 8986: Performance and Finance (P&F) - Chair's Reports October and November

Mr Dunn introduced the report and pointed to the positive correlation between people issues and quality issues which were the main concerns. He alerted the Board to the predicted £12m deficit and work underway on the Financial Out Turn Plan. He said the Committee undertook a 'deep dive' (detailed review) at the November 2022 meeting looking at the predicted financial out turn and any possible mitigation actions. He said the Committee also looked in depth at the winter plan resourcing and Key Performance Indications and that the Committee would continue to review these monthly. He said the Committee also looked at Elective Recovery key issues including the increased referral rates and the ability to create capacity to meet the targets. He said a new BAF risk was being developed regarding concerns about Cyber-attacks.

Resolved: that the Performance and Finance Chair's reports for October and November 2022 be received and noted.

TB.8987: Report of the Chief Financial Officer – Months 6&7

Mr Stringer highlighted the £12.8m deficit driven mainly by pay overspend and Cost Improvement Plan (CIP) challenges. He said there was the potential that if the Trust and system forecast a deficit that the national protocol would be activated which had been shared with the Board, that included increased sign off at a system level of spends over £50k and £100k. He said meetings had taken place with the Acute Collaboration and system exploring any potential for breakeven and that there were significant challenges in doing so and that a plan involving using balance sheet flexibility at the system level offsetting deficits to try and achieve break-even by 31 March 2023.

Mr Hemans asked if the potential strike action resulted in a pay increase, whether it was likely to be fully funded. Prof. Loughton said Mr Stringer would discuss this further with Mr Hemans after the meeting

Resolved: that the Report of the Chief Financial Officer – Months 6 & 7 reports be received and noted.

TB.8988: Performance and Finance Committee Terms of Reference
The Terms of Reference were approved.

Resolved: that the Report of the Performance and Finance Committee Terms of Reference be approved

Strategy, Business and Transformation

TB: 8989: Sustainability Report
Mr Evans highlighted in relation to the action mentioned at the beginning of the meeting, since 17 October the Trust had commenced the Walking Aids scheme where 507 individual pieces of equipment had been returned for recycling of which over 50% could be reused which was positive news. He said in relation to the Trust's Carbon Reduction Programme there were a number of schemes that would require capital investment. He believed nationally the NHS was aware as the ambition to be the first health system in the world to become carbon neutral would require a degree of investment. He said the Trust was working on what the financial implications were on its plan which would be ready next year.

Resolved: that the Sustainability Report be received and noted.

TB: 8990: Black Country ICS Update
Mr Evans introduced the report and the operating model that showed all the information required and included the Provider Collaborative update and Place based working arrangements. He said the appendices included the operating framework detail of how the parts worked together and were governed including the joint committees and the strategic programme Boards. He said several Board members were members of the work programmes. He reassured the Board that any work undertaken with an impact on the scope of services provided was with the Integrated Care Board (ICB) and any and/or all the proposals would come back to the Trust Board for consideration and approval. Prof. Field said that as a sovereign Board, each Trust would need to approve of any changes proposed and Mr Evans confirmed this.

Resolved: that the Black Country ICS Update be received and noted.

TB: 8991: Update from the Black Country Provider Collaboration Programme Board
Mr Evans introduced the report and provided the updates for October and November Executive Meetings of the collaborative. He said the key actions were the proposed scheme of delegation, which was being worked on, and linked to the clinical workstreams underway. He said what was being considered was that all 4 organisations within the Provider Collaborative aligned within the clinical workstreams. He said it was unlikely that any of the delegated authority would be sought or released to the Provider Collaborative until 2023/2024 at the earliest. He said the case for change was on 'pause' pending the output from the broader ICB development of the system Clinical Strategy. He said a Vision had been agreed by the Provider Collaborative and work was to commence to develop a website to support the Provider Collaborative work. Prof. Field said that for any schemes of delegation, approval would have to be sought from the RWT Board. Mr Evans confirmed that no delegation to the collaborative could occur until approved by each and all of the 4 Boards.

Prof. Field asked whether the clinical pathways included any movement of funds based on mutual aid and activity. Mr Evans said the pathways currently were based purely on clinical standardisation and work would have to follow on how payment was to be likewise

standardised.

Ms Cowley said she was a member of the Ophthalmology Transformation Group for the Acute Provider Collaborative that included looking at payment models from commissioners and for providers. She said this included potential to standardise rates of pay for staff. She said this had positive potential coming from work at RWT on the glaucoma pathway and cataract pathway. She said this included positive work on workforce development. Prof. Field said the work should include the potential role of the private sector and that it was a complex piece of work and should be monitored. Ms Cowley said there had been discussion about moving some activity to Private providers but them being unable to maintain the required competencies.

Resolved: that the Update from the Black Country Provider Collaboration Programme Board be received and noted.

TB: 8992: Charity Committee Chair's Report

Ms Rawlings introduced the report. She confirmed that the Trust had launched its Christmas Appeal alongside a Christmas Fayre and a Winter Fashion show, and she thanked all the staff involved in these. She confirmed that the Charity was granted £220k from NHS Charities Together in partnership with Wolverhampton Voluntary Sector Council to support a 2-year project to reduce social isolation. She referred to the Charities action plan and Key Performance Indicators (KPIs) had been reviewed. She said the Trust had appointed an Arts and Heritage Officer and was looking to develop detailed fund adviser's guidance and Trustee training and Board development.

Resolved: that the Charity Committee Chair's Report be received and noted.

TB: 8993: Charity Committee Terms of Reference

Prof. Field sought and gained confirmation that the Terms of Reference were approved.

Resolved: that the Charity Committee Terms of Reference be approved.

TB. 8994: The Royal Wolverhampton NHS Trust Charity Annual Report and Accounts 2021-22

Ms Rawlings asked for approval. Mr Stringer said the Accounts had been fully audited and followed the Charites reporting requirements.

Resolved: that The Royal Wolverhampton NHS Trust Charity Annual Report and Accounts 2021-22 be approved.

TB.8995: Approved Minutes from Committees in respect of which the Chair's report have already been submitted to the Board

Resolved: that the Performance and Finance Committee minutes 29 September 2022 and 26 October, Trust Management Committee minutes 23 September 2022 and 28 October 2022, People and Organisational Committee minutes 23 September 2022 and 28 October 2022, Charity Committee minutes 30 August 2022 and QGAC minutes 1 October 2022 be received and noted

TB: 8996: Staff Voice – Finance Team

Mr Duffell introduced the Finance Team and referred to the increased focus on finance towards the end of the financial year, it was just as important that the role and contribution of corporate

staff was recognised and heard at Board.

Mr Stringer said they were an incredible team who had worked hard under difficult circumstance throughout Covid and had ensured everything was paid including staff were paid.

Mr Duffell asked what it was like to work at RWT and what were the key challenges they faced. Ms Skov said coming from a corporate background she had very supportive management team, she was hybrid working and was glad the Trust had been open to accommodate this for and with staff and was working well.

Mr Lawley said he joined the Trust during the Covid lockdown and had not seen the team face to face until about 12 months into his role. He said this year the team were doing more face-to-face work and that the mixture was useful for wider learning and that hybrid working was positive.

Mr Duffell asked what challenges the team faced. Ms Parkes said within the income team the biggest challenge had been the increase in commissioning drug queries and the complexity of those queries and details commissioners asked for, alongside dealing with, and keeping on top of the many different schemes to make best use of non-recurrent funding opportunities. Ms Otufowora said there had been an increase in work regarding capital requirements and less time for personal development for staff which was challenging but they were coping well. Mr Dunn said he had found the finance team very responsible, professional, and helpful and thanked them all.

Ms Jones asked if Mr Stringer gave them an unlimited budget, what would they invest in to make their jobs more straightforward. Mr Greene said there were issues across systems in the ICB and a lack of consistency and continuity. He said the team were seeing more activity and therefore he would invest in additional staff in key areas.

Dr McKaig asked whether it would benefit the team if they had access to clinical information to assist gaining information that was required by them. Mr Greene said there were already forums for clinical information and a system that integrated with operational performance and divisional managers. He said he would like to improve the Trust's underlying costing systems and understanding better productivity and integrated performance. Mr Stringer said given the context of the NHS, it was going to be a difficult few years and that regionally and nationally there was talk about productivity, the Get it Right First Time (GIRFT) information and the interrelationship between clinical practice, operational and performance management, and finance to find ways to improve the value gained from every pound spent.

Mr Duffell asked how well supported the staff had felt during the last 2 to 3 years. Mr Lawley said it had been a difficult couple of years as he was redeployed into distribution. He said that had been eye opening and gave him a better appreciation of what the nurses, consultants, doctors, and clinical staff did. He said managers had been very supportive. He said also with remote working people could get isolated and the team had supported each other during this time.

Mr Duffell asked whether the team wanted to highlight anything with the Board. Ms Otufowora said she felt happy as the team were well supported. She said RWT was a great place to work as staff were provided with the balance between work and family life with agile working. Prof. Field thanked all the team on behalf of the team for all their work. He said organisations like the Trust cannot provide great without the support of teams like the finance team.

Resolved: that the Staff Voice of the Patient Services Team be noted

General Business

TB:8997: Any other business

Ms Nuttall provided a response to Mr Levermore and said of the 2 risks Mr Levermore highlighted, one was about surgical waiting times for laparoscopic cholecystostomy, and the ED waiting times and she confirmed there was no correlation between those two risks. Prof. Loughton said it had been confirmed that the Ambulance workers strike was to take place on the 21 and 28 December 2022 and that the 28 December was normally the busiest day in the period. He added that staff morale was not high due to work and financial pressures and difficulties due to the rising cost of living and that the Trust would look at what else could be done for staff wellbeing and to support staff. Prof. Field thanked all staff at the Trust for their hard work and commitment.

TB.8998: Questions from the public, TB.8999: Date and time of next meeting:

Mr Wilshere confirmed no questions had been received. Prof. Field reiterated that anyone observing who had questions could email them after the meeting to the Trust Board or Company Secretary email addresses on the Trust web site. Prof. Field confirmed that the next meeting was to take place on Tuesday 7 February 2023 via MS Teams.

TB.9000: To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudicial to the public interest

Resolved; that the resolution be approved.

The meeting closed at 12:35 pm

The Royal Wolverhampton NHS Trust

1 February 2023 16:11

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 06/12/2022 9.6 Infection Prevention & Control and Infection Prevention Board Assurance Framework (BAF) report				
1058.	Infection Prevention & Control (IPC) and Infection Prevention Board Assurance Framework (BAF) report	Hickman, Debra	02/02/2023	Pending
	Explanation action item An update on the resolution of turn-around of rooms for care with estates be reported as a matter arising at the next Board meeting in February 2023			
Public Trust Board 06/12/2022 2 To receive declarations of interest from Directors and Officers				
1056.	Declarations of interest	Toner, Louise	31/01/2023	Completed
	Explanation action item Prof Toner to update her declarations UPDATE: 28.01.23 declarations have been updated			
Public Trust Board 06/12/2022 7.6 Education and Training				
1057.	Education and Training - Work Experience Programme	Evans, Sally Nickell, Louise	02/02/2023	Completed
	Explanation action item Ms Nickell and Ms Evans to review the future promotional potential of the work experience programme.			

	UPDATE: 29.02.23 Ms Evans confirmed communication had been circulated			
Agenda item		**Assigned to**	**Deadline**	**Status**
Public Trust Board 02/08/2022 7.4 RWT Equality, Diversity and Inclusion report 2021 - 2022				
887.	Health and Inequalities	Odum, Jonathan	05/12/2022	Completed
	Explanation action item Dr Odum to prepare and update on Health and Inequalities to the next Board meeting. UPDATE: 29.09.22. The paper on Health & Inequalities was presented to Quality Governance Assurance Committee (QGAC) on 28th September 2022. Terms of Reference and action plan noted. Further update to be provided at the December public Trust Board UPDATE: 20.11.22. Dr Odum mentioned the presentation was in the process of being completed and requested the item to be deferred to February 2023 Board meeting. UPDATE: 31.01.23 The item is scheduled on the agenda for the February Board meeting			

The Royal Wolverhampton NHS Trust

MEETING OF TRUST BOARD AND ANY APPROPRIATE ASSOCIATED COMMITTEES		
Meeting Date:	7 February 2023	
Title of Report	Covid – 19 National Inquiry Update	
Action Requested:	Inform and Assure For information only, not discussion	
For the attention of the Board		
Assure	• (Members of the Trust Board are asked to note the progress to date in participation in the National Inquiry into Covid-19. Specifically Module 3 – '*The impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland*'.	
Advise	• The National Inquiry was established on 28 June 2022 to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future. • Module 3 relates to the specific impact on healthcare systems and commenced on 8 November 2022.	
Alert	• The Trust has complied with the Inquiry's requirement to notify all staff of their legal duty in relation to record-keeping to support the Trust's preparation for the Inquiry. This is called a 'STOP Notice' and the requirement is for colleagues to ensure that all records are saved, whether they are/were working directly on Covid-19 recovery, or as part of business-as-usual activities.	
Author and Responsible Director Contact Details:	Kevin Bostock Group Director of Assurance	Steph Poulter Assurance Team Support
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care
Resource Implications:	People and technology to deliver against the inquiry will be utilised from current teams and technology.	
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**	
Equality and Diversity Impact	There are no legal or equality & diversity implications associated with this paper.	
Risks: BAF/ TRR		
Risk: Appetite		
Public or Private:	Public	
Other formal bodies involved:		
References	National Inquiry	
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences	

	• Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	**Covid-19 National Inquiry Update**
Item/paragraph 1. **PURPOSE OF REPORT**	The purpose of this report is to inform the Trust Board and its associated committees that all appropriate and necessary steps have been taken in preparation for Walsall Healthcare NHS Trusts (WHT) and Royal Wolverhampton NHS Trusts (RWT) participation in the Covid-19 National Inquiry which opened in June 2022 and is due to complete by June 2024. The Inquiry will hold its first preliminary hearing for its third investigation – Module 3 '*looking at the impact of the pandemic on healthcare'*, on Tuesday 28 February 2023.
2. BACKGROUND	On 28th June 2022 the Rt. Hon Baroness Heather Hallet DBE PC, was appointed Chair of the Covid-19 National Inquiry, which was established to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future. In support of this a Terms of Reference for the Inquiry was published which set out the high level scope, aims, the overall response expected of the health and care sector, the economic response and impact and the overall lessons learned. Attached at appendix 1. The approach Baroness Hallet has taken is modular and in October 2022 a preliminary hearing was held on '*Module 1- Government Planning and Preparedness'*. The group is scheduled to meet again on 14 February 2023 with '*Module 2 – Political and Administrative Decision Making'* meeting on 1 March 2023 and '*Module 3 - looking at the impact of the pandemic on healthcare'* on Tuesday 28 February 2023. In preparation for each of the preliminary hearings an information gathering exercise needs to take place. For Module 3 this resulted in a letter from the appointed Lead Solicitor for Module 3 to Trusts, ICBs and range of organisations across the health system to voluntarily answer a range of questions against the provisional outline of scope attached at appendix 2 with the questionnaire attached at appendix 3 and RWTs response attached at appendix 4. No further detail will be released until after the Module -3 Preliminary Hearing on 28 February 2023 and therefore it is unclear whether WHT/RWT will be asked to submit anything further or be involved in detail with the Inquiry as it progresses. However, WHT/RWT needs to be prepared to respond to the Inquiry in any way considered appropriate.

3. **PREPARING FOR THE INQUIRY**	The Wolverhampton/Walsall NHS Hospitals Group is taking a proactive approach to preparing for the requirements of the National Inquiry. Therefore, both trusts have complied with the Inquiry's requirement to notify all staff of their legal duty in relation to record-keeping to support preparation for the Inquiry. This is called a STOP Notice and requires colleagues to save all records, whether they are/were working directly on Covid-19 recovery, or as part of business-as-usual activities. In addition, WHT/RWT have set up a comprehensive Group-Wide Covid-19 National Enquiry Project Team for which Kevin Bostock - Group Director of Assurance is the Chair/Lead Executive and named Single Point of Contact for the Inquiry. The Group held its inaugural meeting on 19th January 2023 and set out an agenda aimed at ensuring proportionate preparedness to respond to any information required by the Inquiry including the creation of a centralised, group accessible, file repository on SharePoint which all members of the group and their invited guests can directly file relevant information into, in order to meet the likely data and information requirements for records, whether they are/were working directly on Covid-19, recovery, or as part of business-as-usual activities. The Project Team will meet monthly in the first instance and will respond accordingly to further information requests from the Inquiry Team.
4. **RECOMMENDATIONS**	Trust Board members are requested to note the content of the report and its appendices:- Appendix 1 – Covid – 19 National Inquiry Terms of Reference Appendix 2 – Module 3 Provisional Scope Appendix 3 -- Questionnaire Appendix 4 – RWT Response to the questionnaire.

Covid-19 Inquiry Terms of Reference

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

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

In meeting its aims, the Inquiry will:

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

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

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

d) have reasonable regard to relevant international comparisons; and

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

The aims of the Inquiry are to:

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

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

   i) preparedness and resilience;

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

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

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

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

vi) legislative and regulatory control and enforcement;

vii) shielding and the protection of the clinically vulnerable;

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

ix) testing and contact tracing, and isolation;

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

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

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

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

xiv) education and early years provision;

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

xvi) housing and homelessness;

xvii) safeguarding and support for victims of domestic abuse;

xviii) prisons and other places of detention;

xix) the justice system;

xx) immigration and asylum;

xxi) travel and borders; and

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

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

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

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

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

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

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

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

vii) antenatal and postnatal care;

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

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

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

xi) provision for those experiencing long-COVID.

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

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

ii) additional funding for relevant public services;

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

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

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

UK Covid-19 Inquiry

Module 3

November 2022

Module 3 Provisional Scope

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

In particular, this module will examine:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FREEPOST

UK Covid-19 Public Inquiry

FAO: Chief Executive

28 November 2022

Dear Madam or Sir

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

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

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

Module 3

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

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

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

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

How your organisation can help the Inquiry - information gathering

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

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

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

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

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

Next Steps

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

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

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

In summary

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

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

Yours sincerely

Abigail Scholefield

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

Annex A

Questionnaire

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Form to be completed in response to Annex A questionnaire

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

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

Name of organisation completing this questionnaire:

The Royal Wolverhampton NHS Trust.

Question 1

Royal Wolverhampton NHS Trust is one of the largest providers of healthcare in the West Midlands, covering acute, community and primary care services. The Trust's services cover the population of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire, and Shropshire. The Trust acts as a specialist centre for a number of different services including, but not limited to, cancer, stroke and heart and lung services. In addition to this, it acts as a host for the Black Country Pathology Services (BCPS) – a single pathology service run by The Dudley Group NHS Foundation Trust, Sandwell & West Birmingham Hospitals NHS Trust, Walsall Healthcare NHS Trust, and The Royal Wolverhampton NHS Trust. We are the largest teaching hospital in the Black Country providing teaching and training to more than 130 medical students on rotation from the University of Birmingham Medical School. We also provide training for nurses, midwives, and Allied Health Professionals (AHPs) through well-established links with the University of Wolverhampton. During 2014 the Trust was established as the host for the Clinical Research Network West Midlands.

Question 2A

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

What Went Well

- Establishment of command and control processes early, at the start of COVID-19 being declared; establishment of Incident Control Centre, initially it was face to face, in line with the evolving pandemic it moved to being held virtual which helped to maintain the safety of staff along with having the opportunity to link in with external and wider partners and key Trust colleagues.
- Designation of key COVID-19 ward areas, to isolate the virus as much as possible thus maintaining the maximum amount of operational capacity, adopting a red and green system for bed capacity.
- The nature of community work changed with a switch from regular routine to greater support to care homes, end of life planning and a reduction in both routine

demand and activity. The intention was to support care homes with outbreak management, focusing on end-of-life care planning and to avoid the need to travel to hospital.
- Use of impact assessments in non clinical areas to prioritise workstreams and inform reallocation of resource.
- Establishment of a redeployment pool to support operational teams in caring for COVID-19 patients.
- Introduce ward orientation training programmes for non-clinical and clinical staff in back office/corporate services.
- Establishment of home working for back-office functions, which still continues today.
- To support the wellbeing of staff 'Wobble rooms/spaces' were established and continue to be in place, along with the establishment of a health wellbeing team providing regular support and updates along with an array of information, tools, and resources that aim to support staff health and wellbeing.
- Communications: frequent COVID-19 bulletin emails for all staff, information on staff intranet and external internet, along with regular social media posts and weekly MS teams updates from executive team with senior managers, to keep staff confident, informed, and safe.
- COVID-19 email inbox established for managing flow of information, monitored by Emergency Planning Team, which today is still in situ.
- Rapid deployment of IT technology with over 800 laptops to support agile / remote working for corporate non-clinical staff and over 70 webcams for Trust desktops to facilitate remote patient consultations.
- To support patients over 100 iPAD devices were built and deployed to wards with free to use access for Skype, Zoom and FaceTime so that our patients could keep in touch with family during hospital admissions where visiting was not permitted.

Areas identified for Improvement

- At the start of the pandemic, testing patients and staff was a key issue; submission of COVID-19 examples were having to be sent to other labs outside of catchment area, as the Trust did not have the ability at that time to do this, this created tremendous delays in the system to identify and treat the COVID-19 patients. It is now possible with the development of the Black Country Pathology service; the Trust and other Trusts in the Black Country are now able to test the samples locally.
- In the early days of the pandemic availability of PPE was a real challenge and risk for staff and patients.

What we are most Proud of

- Development of the Trust data warehouse, which has been continuing to evolve at pace as a decision tool for managers. This was fundamental in the monitoring and management of performance; prior to this development lots of manual processes

were in place.

- Establishment of internal team producing visors to assist with patient and staff safety.
- Early pandemic as supplies were limited in shops / supermarkets, the establishment of internal shop supplying staff with essentials of bread / milk etc was well received and appreciated by staff.

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Question 2B

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

Command & Control in response to the pandemic

At the start of the pandemic the Trust operated its usual preparedness and response to the different types of emergencies, using its existing command and control structure responding as part of the multi-agency group with the CCG, Local Authority, and local public health organisations. The Trust established a response structure which consisted of:

- Making key decisions on how to operationalise national guidance for local response
- Planning and advising on Trust business continuity arrangements including what happens in the event of mass admissions.
- Advising on PPE requirements for COVID-19, a separate specific PPE group was established and chaired by Medical Director, which met daily and then twice weekly.
- In conjunction with infection control considered and advised on steps needed to treat infected patients safely.
- Ensuring regular communications were sent out internally across the Trust and externally to keep staff and partners aware of what was happening.
- Consistently review the impact on staffing levels and welfare of staff.
- Monitored and maintained performance, daily 7/7 meetings to review capacity/ demand on all services.
- Effectiveness of infection prevention measures.

Governance Framework adopted.

- Regular reporting to the CEO who had overall responsibility and accountability to the Board for ensuring that the Trust developed and implemented robust arrangements to meet its legal duties in responding to COVID-19.
- Strategic & Tactical leadership and direction to the Trust.
- Provided a forum for developing and implementing plans to enable the Trust to respond and recover from mass admissions/staffing shortages as a result of COVID-19.
- Provided a forum for raising concerns/risks which were escalated to Strategic command consistently and ensure plans reflected the most concerning risks and any emerging risks were put in place.
- Took part in multi-agency response.

The Trust Incident Command Group (Tactical) had accountability and delegated responsibility to various service areas through Task & Finish Groups in terms of responding to this type of incident, community services, inpatient operational management group, outpatient group (as required), paediatrics and communications department,

occupational health / COVID-19 advice for staff.

The incident control groups met daily, which also involved multi-agency partners, LA, CCG, Public Health. There was a standard core agenda which all partners participated in, with minutes & actions being required.

The generic core Agenda was used:

Agenda

- Current Position (including international/national and local position)
- Patient status update & current numbers
- Changes in current national advice/guidance
- Workforce
- Current concerns
- Current risks/threats to Trust performance
- External feedback from Public Health and Social Care
- Communications
- Actions requiring escalation to Strategic Command

The Chair of the Tactical Group was a nominated director, strategic command was chaired by Chief Executive or an Exec Directors for discussion and agreement. The existing on call rota for Directors & Trust on call managers was updated to include nominated Tactical Commanders for the pandemic response identified during this period, this additional role was stood down in June 2022.

The Trust, in line with other organisations at the start of the pandemic established a COVID-19 email box, which is still monitored on a daily basis as the main communication link internally and externally. Lots of information/communications came through this box.

Mutual Aid Support

This was undertaken in line with requests made through the COVID-19 regional group – MIDSROC, being made through the Trust's designated COVID-19 email box, which the Trust discussed and shared if available. The Trust has since set up a mutual aid agreement process, working in partnership with Walsall Manor Hospital, and linking to the ICB.

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Question 2C

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

- The Trust instigated a 'lockdown process' at the start of the pandemic response, to keep patients fit and well at that time, above and beyond what would normally happen.
- This meant in line with IPC standards, inpatients were tested on admission and treated as positive until the results were received, they were isolated/placed in identified designated areas/wards. For patient safety the Trust adopted the principles of having red and green wards/areas in terms of keeping patients safe from COVID-19. There was also guidance issued for staff in high-risk areas where there were procedures being undertaken that were deemed aerosol generating.
- Visiting a patient was prohibited, a visiting system was implemented later during the pandemic, where family members were required to book a slot on the day if they wished to visit.
- Social distancing and mask wearing was instigated from the start of pandemic for all staff to follow, regardless of the area of work area whether it be clinical or non-clinical; for clinical areas, this practice is still in place.
- In order to meet IPC standards patients attending ED and inpatient services were tested on admission and treated as positive until the result was received to protect fellow patients and staff. This meant that until results were received, they were isolated in a single room or placed in a designated area or ward. This meant patients already feeling very unwell were not allowed to mix in a normal way which was found to be challenging for some of the service users. This is where the red and green bed capacity system was implemented.
- Personal Protective Equipment (PPE) – The Trust took steps to ensure staff were protected while caring for patients with suspected and / or confirmed cases of coronavirus, through masks, aprons etc.
- Strict rules were implemented for staff to follow in relation to hand hygiene, along with the wearing masks.
- Socially distancing rules were instigated across the Trust.
- Corporate non-clinical staff were encouraged to work from home where possible, Agile working was enabled through Digital enablement for our workforce where over 800 laptops were issued across the staffing base. Demand for remote connectivity saw the need to implement increased telephony bandwidth across the Trust. Disaster recovery Switchboard facilities were developed and the Trusts inbound / outbound telephony lines, along with mobile GSM Gateway was strengthened significantly.

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Question 2D

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

- The Trust instigated a risk assessment process for all staff including those at risk and for BAME staff, through their line managers. Adjustments / actions to minimise risk where relevant and appropriate to do so were undertaken, to ensure staff feel they are working in a safe environment to be able to confidently delivery care to patients and work with colleagues.

- The Trust has now established a Black, Asian, and Minority Ethnic (BAME) Employee Voice Group to help create an inclusive and supportive culture at RWT and shape a better place to work for BAME colleagues.

Question 3

Brief Summary of any key lessons learned

In line with the EPRR framework and the Civil Contingencies Act, which the Trust is governed by, the Trust operates a 24/7 on call Director & Trust on Call rota system, as part of its resilience to respond to the different types of incidents which may occur, a Major/Mass Casualty Incident, Critical or Business Continuity incident, along with having an alert cascade system which can easily be instigated in the event of future incidents.

Key lessons learned and changes as a result of COVID-19

- Surge in ICCU capacity
- Surge in community services
- Use of the independent sector
- Mortuary capacity
- Separation of elective and non-elective capacity to ensure can continue with treatments for patients with cancer / cardiac diagnosis.

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

Categories of document or key document produced by your organisation including document title and date (with link if publicly available)	**Brief description**	**Why it is particularly relevant**
Command Meeting Decision Logs	*Logs of all actions, decisions made and rationale behind decisions*	*Provides a clear understanding of decisions made to provide effective healthcare arrangements during the pandemic*
Command & Control decision logs	Minutes of daily meetings were recorded, along with actions/decisions required to be undertaken.	To record the actions & decisions required to be undertaken.
OP04 COVID-19 Pandemic Support and Guidance v1.81 –policy is regularly updated.	This policy was produced to provide staff with collective guidance specifically in relation to the COVID-19 pandemic – ranging from several different topics.	To ensure staff looking for information related to COVID-19 can access the most recent guidance, instructions etc Providing: Advice, Arrangements, Guidance Instruction, and Procedures.
PPE required for when dealing with suspected or confirmed COVID-19.	Staff who were required to deliver clinical care to affected patients were given the guidance, **NHS UK – How to Wash Your Hands**, along with a helpful **video** reminding. PPE for the different scenarios for Hospital and primary care/community settings, **Personal Protective Equipment (PPE) guidance for hospital clinical settings (PDF, 112Kb)**	PPE required for when dealing with suspected or confirmed COVID-19, and the PPE for the different scenarios for Hospital and primary care/community settings,

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

Document title and date (with link if publicly available)	**Brief description**	**Why it is particularly relevant**
Key articles or reports published with a link	Trust Board minutes	To give the Board assurance that plans are in place to respond to the pandemic.
Silver and Gold Meetings – minutes available.	Summary available at trust Board	As above

Question 6

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

- Main concern was availability of PPE

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

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7 February 2023
Title:	Chief Executive's Report
Action Requested:	**Receive and note**
For the attention of the Board	
Assure	• Assurance relating to the appropriate activity of the Chief Executive Officer.
Advise	• None in this report.
Alert	• None in this report.
Author + Contact Details:	Tel 01902 695950 Email gayle.nightingale@nhs.net
Links to Trust Strategic Objectives	• 1. To have an effective and well integrated health and care system that operates efficiently • 2. Seek opportunities to develop our services through digital technology and innovation • 3. Attract, retain and develop our staff, and improve employee engagement • 4. Deliver a safe and high-quality service • 5. Operationally manage the recovery from Coronavirus to achieve national standards • 6. Maintain financial health – appropriate investment to patient services
Resource Implications:	None
CQC Domains	**Responsive: Well-led:**
Equality and Diversity Impact	None in this report.
Risks: BAF/ TRR	None in this report.
Public or Private:	Public
Other formal bodies involved:	As detailed in the report.
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Chief Executive Report to Board	
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 five Consultant Appointments since I last reported: **Upper Gastrointestinal (UGI)/ Hepato-biliary (HPB) Surgery** Dr Simon Fisher **Haematology** Dr Erum Mazhar Dr Hyacynth De Silva Dr Harheen Karim **Bariatric Surgery** Dr Mitesh Sharma
3.0	**Policies and Strategies**
	Policies for December 2022 and January 2023 • Policies, Procedures, Guidelines and Strategies Update for December 2022 and January 2023 Reports • Trust Policy Group Terms of Reference • CP62 - Organ Donation Policy • CP66 - Care of Patients Requiring Enhanced Care Policy • CP68 - Management of Dysphagia Policy • G102 - Financial Management - Standing Financial Orders Policy • HR06 - Dispute Resolution in the Workplace Policy • HS05 - Ionizing Radiation Policy • MP11 - Covid-19 Vaccine Handling and Management Policy • OP18 - Patients' Property Policy • OP92 – Clinical Coding Policy • OP106 - Safeguarding Children Supervision Policy • Ward Huddle - 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 Monday 27 March 2020 I have participated in the following virtual calls: • Since Friday 27 March 2020 I have participated in weekly calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • Since 24 April 2020 I have held monthly with the Chair, Vice Chair and Scrutiny Officer of the Health Scrutiny Panel Committee meetings virtually • 21 November 2022 – attended the NHS England - Amanda Pritchard, Chief Executive and Julian Kelly, Chief Financial Officer Autumn Statement – virtual webinar • 22 November 2022 – participated in the virtual Charitable Funds Committee • 23 November 2022 – participated in the virtual Local Medical School Liaison Committee with Health Education England (HEE) and Birmingham Medical School • 25 November 2022 – chaired the virtual Trust Management Committee (TMC) • 29 November 2022 – participated in the NHS Providers – NHS England (NHS): Provider Collaborative Innovators Scheme virtual webinar • 30 November 2022 – attended the Cancer Alliance Leadership Forum • 2 December 2022 – participated in the virtual NHS Black Country Quarterly System Review meeting and met with Mark Ondrak – Unison representative • 5 December 2022 - participated in a virtual Black Country Collaborative Executive Committee • 9 December 2022 - met virtually with Mark Axcell, Chief Executive – Black Country

	Integrated Care System (ICS) and undertook a site visit at West Park Hospital • 12 December 2022 – participated in the City of Wolverhampton Health Scrutiny Panel Committee • 14 December 2022 – presented at the virtual Finance Leaders Network 'In Conversation with... David Loughton' – expectations of a Director of Finance • 15 December 2022 -), chaired a Joint Walsall and Wolverhampton Staff Briefing and participated in a virtual Black Country Collaborative Board • 16 December 2022 - virtually met with Becky Wilkinson, Director of Adult Services – City of Wolverhampton Council and participated in a virtual Senior Medical Staff Committee • 4 January 2023 - virtual met with Becky Wilkinson, Director of Adult Services – City of Wolverhampton Council • 6 January 2023 – met with Amy Sykes, Freedom to Speak-up Guardian, met with Mark Ondrak – Unison representative and met with Tim Johnson, Chief Executive – City of Wolverhampton Council • 17 January 2023 - chaired the virtual West Midlands Cancer Alliance Board • 18 January 2023 - participated a virtual in the Regional Cancer Board • 19 January 2023 - chaired the virtual Staff Briefing
5.0	**Board Matters**
	There were no Board Matters to report on.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7 February 2023
Title:	Chair's report of the Trust Management Committee (TMC) held on 27 January 2023 – to note this was a virtual meeting
Action Requested:	**Receive and note**
For the attention of the Board	
Assure	None in this report
Advise	Matters discussed and reviewed at the most recent TMC
Alert	None in this report
Author + Contact Details:	Tel 01902 695950 Email gayle.nightingale@nhs.net
Links to Trust Strategic Objectives	• 1. To have an effective and well integrated health and care system that operates efficiently • 2. Seek opportunities to develop our services through digital technology and innovation • 3. Attract, retain and develop our staff, and improve employee engagement • 4. Deliver a safe and high quality service • 5. Operationally manage the recovery from Coronavirus to achieve national standards • 6. Maintain financial health – appropriate investment to patient services
Resource Implications:	As per Agenda Item
Report Data Caveats	The meeting reviews standard reports that use the previous month's data. This data may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	None identified
Risks: BAF/ TRR	None identified
Public or Private:	Public
Other formal bodies involved:	Directors Meeting, Senior Managers Briefing
References	As per item.
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
1	**Key Current Issues/Topic Areas/ Innovation Items:** • Elective Care Recovery
2	**Exception Reports** • None this month.
3	**Items to Note – all of the following reports were reviewed and noted in the meeting** • Integrated Quality and Performance Report • Division 1 Quality, Governance and Nursing Report • Division 2 Quality, Governance and Nursing Report • Division 3 Quality, Governance and Nursing Report • Executive Workforce Summary Report • Chief Nursing Officer (CNO) Report • Finance Position Report – Months 8 and 9 • Financial Recovery Board Update Report • Capital Programme Update Report • Operational Group Minutes • Acute Collaboration Verbal 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. • Trust Risk Register (TRR)/ Board Assurance Framework (BAF) Report • Learning from Deaths Report • Wolverhampton Place Report • Integrated Care System (ICS) Report • Midwifery Services Report • Sustainability Report • Pharmacy and Medicine Optimisation Quarterly Report • Contracting and Business Development Report • Quality Improvement Team Report • OneWolverhampton - Draft Partnership Agreement • IM and T Strategy Report • Freedom to Speak-up Guardian Report • Care Quality Commission (CQC) Fundamental Standards of Care Compliance Report • Mental Health Report • Health and Safety Report • Standing Financial Orders Report • Infection Prevention including BAF Report • Patient Experience Report • Implementation of Trust Information Asset Risk Process Report • Annual Planning Guidance 2023/ 24 Report • Workforce Safeguards - Nursing and Allied Health Professionals (AHP) Report
5	**Business Cases approved - Division 1** • There were none this month.
6	**Business Cases approved - Division 2** • Business Case TA632 Trastuzumab Emtansine for the treatment of Positive Early Breast Cancer • Business Case TA649 Polatuzumab for the treatment of Relapsed or Refractory Diffuse Large B-Cell Lymphoma • Business Case TA689 Acalabrutinib for the treatment of Chronic Lymphocytic Leukaemia • Business Case TA695 Carfilzomib Lenalidomide Dexametheasone for the treatment of for Previously Treated Multiple Myeloma • Business Case TA713 Nivolumab for the treatment of Advanced Non-Squamous Non-Small Cell Lung Cancer after Chemotherapy

	• Business Case TA716 Nivolumab with Ipilimumab for the treatment of Previously Treated Metastatic Colorectal Cancer • Business Case TA722 Pemigatinib for the treatment of Relapsed or Refractory Advanced Cholangiocarcinoma • Business Case TA728 Midostaurin for the treatment of Advanced Systemic Mastocytosis • Business Case TA736 Nivolumab for the treatment of Recurrent or Metastatic Squamous Cell Carcinoma of the Head and Neck After Platinum Based Chemotherapy • Business Case TA737 Pembrolizumabfor the treatment of Previously Untreated Advanced Oesophageal and Gastro-Oesophageal Junction Cancer • Business Case TA739 Atezolizumab for the treatment of Untreated PD-L1 Positive Advanced Urothelial Cancer When Cisplatin is Unsuitable • Business Case TA742 Selpercatinib for the treatment of Advanced Thyroid Cancer • Business Case TA743 Crizanlizumab for the treatment of Preventing Sickle Cell Crises in Sickle Cell Disease • Business Case TA746 Nivolumab for adjuvant treatment of Resected Oesophageal or Gasto-Oesophageal Junction Cancer • Business Case TA756 Fedratinib for the treatment of Disease Related Splenomegaly or Symptoms in Myelofibrosis
7	**Business Cases approved - Division 3** • Business Case TA757 Cabotegravir with Rilpivirine for the treatment of HIV-1
8	**Business Cases – Corporate** • There were none this month.
9	**Outline/proposals for change** • There were none this month.
10	**Policies approved** • Policies, Procedures, Guidelines and Strategies Update for December 2022 and January 2023 Reports • Trust Policy Group Terms of Reference • CP62 - Organ Donation Policy • CP66 - Care of Patients Requiring Enhanced Care Policy • CP68 - Management of Dysphagia Policy • G102 - Financial Management - Standing Financial Orders Policy • HR06 - Dispute Resolution in the Workplace Policy • HS05 - Ionizing Radiation Policy • MP11 - Covid-19 Vaccine Handling and Management Policy • OP18 - Patients' Property Policy • OP92 – Clinical Coding Policy • OP106 - Safeguarding Children Supervision Policy • Ward Huddle - Standard Operating Procedure
11	**Other items discussed:** • There were none this month.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Patient Experience Bi-Monthly Update Report (October and November 2022)
Purpose of the Report:	To update on patient experience activity
Action required:	Approve
Assure	• Hospital visiting hub is operational and we continue to manage visiting in a controlled manner • Adherence to the PHSO principles on effective complaint handling
Advise	• 74 formal complaints were received into the trust. Overall response rate is 96% in November 2022. • PHSO – 2 cases closed. Outcomes partly upheld. Overall financial remedy of £600 assigned to RWT. • Review of the Trust Equality Objectives undertaken in readiness of the new EDS. • Launch of Volunteer Annual Review for 2022. • Results from the CQC National Maternity Survey 2022. Summary report attached and further reading available in reading room.
Alert	None
Author + Contact Details:	Director: Debra Hickman, Director of Nursing Alison Dowling – alison.dowling1@nhs.net
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led.**
Trust Strategic Objectives	1. To have an effective and well integrated health and care system that operates efficiently 2. Seek opportunities to develop our services through digital technology and innovation 3. Attract, retain and develop our staff, and improve employee engagement 4. Deliver a safe and high-quality service 5. Operationally manage the recovery from Coronavirus to achieve national standards 6. Maintain financial health – appropriate investment to patient services
Resource Implications:	None
Equality and Diversity Impact	None Identified
Publishing Requirements:	Can this document be published on the Trust's public page: Yes
Risks:	None
Risk register reference:	Not Applicable
Other formal bodies involved:	Senior Nurse and AHP Leaders Group
References	Not Applicable

Brief Report Details	
Executive Summary Title:	Patient Experience Bi-Monthly Update Report

This report outlines patient experience activity for October and November 2022 including:

- Complaint's data
- Family and Friends Test Results
- Volunteering update
- Visiting hub information
- Patient involvement update
- Equality, Diversity and Inclusion

Bi Monthly Update Report October and November 2022

1.0 Complaints (October and November 2022, September shown for comparisons purposes)

There was a total of 74 complaints received for this period compared to 96 for preceding two months.

Divisional comparison for complaints received is as follows:

	September	October	November
Division 1	22	19	17
Division 2	19	11	15
Division 3	11	6	6
Division 4	0	0	0
Estates and Facilities	0	0	0
Total	52	36	38

The top 3 themes for formal complaints received are shown in the table below:

	September	October	November
General care of patient	**18**	**15**	**15**
Wound/skin Management	2	2	0
Mobility	0	1	0
General lack of care	11	9	13
Co-ordination of care	1	1	1
General nursing care	1	2	0
Competence	1	0	0
Pain and discomfort assessment	1	0	0
Safe or conducive environment	1	0	1
Communication	**10**	**9**	**14**
Communication with patient	3	2	9
Communication with relatives	6	7	4
Communication between staff	1	0	1
Clinical Treatment	Did not feature in top 3 categories	**5**	**7**
Appropriateness of treatment		6	0
Choice of treatment		0	0
Complication of treatment		1	0
Patient Discharge	**3**	**7**	4
Lack of appropriate arrangements	2	3	3
Inappropriately discharged	1	4	1

For this reporting period, General Care of Patient is by far the category with the highest volume of complaints attributed to it (30 cases). Communication (23 cases) and Clinical Treatment (12) also feature in the top three. Whilst Clinical Treatment did not feature in the top three categories in September, it has however featured in the top three for both October and November.

Patient Discharge, whilst not featuring in the top three during November, it did feature highly in October and remains one of the top themes cumulatively over the financial year.

Over the course of the financial year, Attitude features in the top three however it should be noted that there has been a significant decline in complaints featuring attitude since September.

The following Directorates received the highest volume of complaints for October was Trauma and Orthopaedics (7) and Obstetrics and Gynaecology (4), and for November Obstetrics and Gynaecology (6) and General Surgery (4).

Upon a deep dive of those cases relating to sub-category General Lack of Care it is noted that ED (9 cases) is prominent for both months for cases aligned to this category followed by T & O (3 cases).

For T and O a thematic report has been done highlighting an ongoing trend for complaints relating to this category and this has been shared with senior management for improvements to be considered.

There will also be a thematic report written for ED written and shared with the respective senior managers and an action plan compiled.

Notable reductions have been experienced by Emergency Department where 6 complaints were received in total for October and November which represented a reduction of 64% when compared to 17 which were received for August and September in total.

Outcome of closed complaints:

	Sept	Oct	Nov
Not Upheld	25	29	31
Partially Upheld	12	17	18
Upheld	4	4	5
Total	41	50	54

The overall Trust response rate for cases closed in October and November is 96%. This compares with 97.5% in September 2022.

	Total of closed complaints	Within 30 working days or consent to breach was gained	Exceeding 30 working days without consent to breach	Performance against policy	Directorates where breach occurred
September	41	40	1	97.5%	Ophthalmology
October	50	48	2	96%	Div 1-Cardiology Div 3-Dermatology
November	54	52	2	96%	Div 2- ED Div 3- Primary Care

A review has recently been concluded for all complaints which have been paused pending a meeting or RCA investigation. The Patient Experience Team are working with the relative Directorates to ensure these complaints are closed in a timely manner.

Performance of complaint handling shows consistency for October and November. The Patient Experience team have reiterated to the relevant Directorates the correct process for gaining extensions which has been subject to change as part of the Complaints Management Policy OP08 review. A new process has also been introduced to tighten such breeches and it is hoped that this will show positive results.

PALS Concerns

The total number of PALS concerns which needed to be assessed and allocated to operational teams to respond totalled 64 in October and 34 in November. Top themes emerging relate to general care of patient and delay.

General care of patient does not highlight any specific trends other than perceived lack of care (possibly subjective) however those attributed to Delay are specifically relating to delay in receiving outpatient appointment and delay in receiving treatment.

The Patient Experience Team have adopted an early intervention approach to some of the concerns received. This has resulted in 41 cases during October and November achieving local resolution, negating the need for consideration of a PALS Concern or furthermore, escalation to a formal complaint. The theme of most of these cases relate to communication with relatives and patients, request for clinical information and appointments.

Parliamentary and Health Service Ombudsman (PHSO)

- There are 3 complaints currently being considered as a preliminary assessment prior to possible full investigation by PHSO; (Respiratory x2: Adult Community x1)
- There were no complaints accepted for formal investigation during October and November.
- There were two cases closed in November. One case was aligned to SALT/Therapy Services and the Local Authority. The outcome was that the complaint was partly upheld. Recommendations are a letter of apology, actions to address the identified failings in service provision, which were identified as failure of all parties in the EHC needs assessment and the LA's complaint handling. A financial remedy of £300 was assigned to RWT and £1100 to the Local Authority.
- Another case was aligned to Respiratory/Therapy Services and ED. The outcome was that the complaint was partly upheld. Recommendations are a letter of apology, action plan to address the identified failings in service provision, which were identified as failings in the provision of physiotherapy and communication about discharge. A financial remedy of £300 was assigned. This type of failing is not uncommon for formal complaints generally. Current capacity issues appear to have a direct contributory factor for discharges to be well planned and arrangements comprehensive.

2.0 Family and Friends Test (FFT)

The overall Trust wide response rate for October 2022 was 20% with 5160 (82%) recommending the Trust and 751 12% not recommending the Trust.

The overall Trust wide response rate for November 2022 is 18% with 4675 (82%) recommending the Trust and 730 13% not recommending the Trust.

The response rate and recommendation rate remain consistent with the previous months; however, the non-recommendation rates has seen a marginal increase of dissatisfaction.

Friends and Family Test 2021/22 & 2022/23	Inpatients and Day case (consolidated)			Outpatients			ED			Community		
	Sept	Oct	Nov	Sept	Oct	Nov	Sept	Oct	Nov	Sept	Oct	Nov
Recommendation Rate	92%	91%	91%	93%	93%	94%	71%	68%	68%	89%	92%	90%
Response Rate	28%	28%	26%	4%	5%	4%	18%	21%	18%	7%	6%	6%

Friends and Family Test	Antenatal			Birth			Postnatal Ward			Postnatal Community		
	Sept	Oct	Nov	Sept	Oct	Nov	Sept	Oct	Nov	Sept	Oct	Nov
Recommendation Rate	100%	82%	80%	97%	88%	92%	81%	81%	88%	89%	86%	86%

A working group is currently being established to specifically address all elements of patient feedback, in particular dissatisfaction and where areas of improvement can be identified. The patient experience team will also agree with senior managers of the area to pilot the mystery patient feedback tool to allow real time feedback to be fed back to managers for timely consideration and action.

The Trust has recently specifically recruited volunteers to help with providing information to patients whilst awaiting assessment and treatment within the ED department. It is early at this stage to determine whether this will have a positive impact but is being measured monthly.

The below table illustrates the percentage difference between the Trusts recommendation score for each touchpoint and the local STP and National results[1] for the month of November 2022 only.

	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
Trust overall	91%	94%	68%	90%	80%	92%	88%	86%
Compared to STP*	+2%	+1%	-1%	-1%	-4%	-2%	+13%	+8%
Compared to National*	-3%	+3%	-7%	-2%	-9%	-1%	-5%	-7%

Positive scores when comparing the Trust overall scores to those of the Black Country ICB are shown for inpatients, Outpatients, Postnatal Ward and Postnatal Community. With the Trust's scores being lower for ED, Community, Antenatal and Birth. The Trust scores for November indicate that scores are lower for all of the touchpoints against national measures with the exception of Outpatients which featured positively.

3.0 Volunteering

An annual review has been undertaken of volunteer services. A copy of the report is detailed at Appendix 1.

The Volunteer Service team recorded a video presentation for a live event called 'Give Back Get Ahead, with the Black Country Consortium. This was to offer an insight into NHS volunteer roles and how they might align in future for career pathways for young people.

The Trust Volunteer Handbook was launched and the first cohort of newly appointed volunteers were provided with this during induction.

[1] The Black Country and West Birmingham STP and National scores as at November 2022 data and taken from https://www.england.nhs.uk/publication/fft-test-data-august-2022/ on 16th January 2023.

Our first RWT volunteer successfully passed the Health Education England National Volunteer Certificate. He has been provided with a badge and certificate recognising his achievement of this national initiative.

Number of volunteer hours provided during this reporting period was 556 hours. (399 New Cross Hospital, 96 Community, 35 West Park, 11 Cannock Chase Hospital, 15 Other).

Locations Supported by Volunteers:

- **New Cross Hospital**
  - 131.75 hours – AMU
  - 95 hours – C18 Elderly care
  - 52.92 hours – C21 Stroke
  - 36 hours – Visiting Hub
- **West Park**
  - 24 hours - Outpatient Games and Activities
- **Cannock Chase Hospital**
  - 11 hours – Endoscopy
- **Community**
  - 96 hours Alfred Squire Vaccination Clinic

4.0 Visiting Hub

Up to and including October and November 2022, RWT has facilitated 76,289 bookings with a daily average of 250 bookings with 2 visitors allowed per booking. Most bookings continue to facilitate two visitors in line with national guidance. Appendix 2 shows the detail of the visiting bookings to date, including volume by ward and time slots.

The Trust have moved away from the direct collection of visitors passes and inpatient areas are provided with a list of visitor's bookings for that day. Visitors still use the telephony or online booking system to make their bookings.

The Trust will pilot during January, the introduction of a centralised visiting booking system for two of the emergency pathways (AMU and SEU).

5.0 Patient Involvement and Learning from complaints

- The need for the provision of training and staff updates for Ward C22 in relation to caring for someone living with Dystonia. This will be facilitated by the Renal Practice Educator Facilitator.
- Ward C22 to conduct detailed safety briefs every morning to instil a practice culture of cannula care and monitoring of other invasive devices to mitigate the associated risks.
- The need for a robust/agreed pathway for referral and treatment of (congenital talipes equinovarus) CTEV. Single pathway to be developed and agreed by T&O, Children's Services and Children's Physiotherapy & Occupational Therapy.
- To encourage relationship building with staff and families an information leaflet will be developed which will provide information on the role of the Community Children's Nurse team.
- The need to ensure that nutrition is included as a holistic approach to care and treatment. Initial admission contact between staff and families has been implemented on Ward C16 in order to ensure that dietary requirements are met for those patients who are unable to express their dietary restrictions and preferences.

6.0 Equality, Diversity and Inclusion

Work has continued around Accessible Information Standards working group, assessing Equality Assessments for Trust policies, and commencing work around a review of booked interpreting sessions within our Radiology department.

During the Trust Black History Month celebrations, our ED&I and Engagement Officer held an informative stand around Sickle Cell awareness with members of the Wolverhampton Sickle Cell and Thalassaemia support group. Work continues around our collaboration with this group and provision of a Sickle Cell working group within the Trust.

A training package was filmed and delivered to Nurse Education as part of the International Nurses acclimatisation agenda, around LGBTQ+ awareness.

A review of the Trust Equality Objectives was undertaken. Five new Equality Objectives were drafted in alignment with the updated NHS England Equality Delivery System. Preparations were also carried out for the roll out of the new EDS.

The six-monthly EDI report was submitted to the Quality, Safety Advisory Group to provide an update on progress on various equality workstreams

A working group has continued meeting around developing a joint guidance document for RWT and WHCT around legal requirements and best practice for working with Transgender staff and patients.

7.1 NHSE/I Funding – Aggression towards staff in ED training

Due to capacity issues and sickness within ED no further training took place in October and November. Further dates have been agreed with the final evaluation and report being concluded at the end of February.

Due to the positive feedback received to date ED have requested that a training video be produced as an ongoing resource.

8.0 Engagement

8.1 Co-Design Project

Following on from the year long project for patient involvement, The Trust are now working to implement Co-Design across other areas of the Trust using the toolkit designed as part of this project.

A manuscript titled ‘Co-Designing Health Care Solutions with Patient Representatives and Clinicians in a Large Acute Hospital Setting: Process and Engagement’ has been accepted for publication by the International Journal Of Nursing and Health Care Research.

8.2 Council of Members

The Trust Council of Members were consulted with around a potential for rebranding in the new year 2023, to be called ‘Patient Involvement Partners’. The members were happy to support the rebranding proposal and chose a new logo from designs presented. The rebranding and logo will be unveiled in 2023.

The members also supported a 15 steps assessment on renal wards. This will be extended to other wards as a rolling programme.

8.3 Observe and Act

Training was delivered to staff in Trauma and Orthopaedics and audits took place on wards A5 and A6 with positive results which were fed back to the Matron and teams. A summary report has been compiled and the relevant Matron and teams are reviewing and sharing the findings with their respective staff. Where improvement actions are identified, these will be implemented.

9.0 CQC National Surveys

National Maternity Survey 2022 – published by CQC January 2023.

Highlights

- The National Maternity Survey is required by the CQC for all NHS Trusts providing maternity services.
- All women receiving maternity services in February 2022 were selected for the survey.
- 378 women were included in the survey and 148 responded (39%).
- The average Mean Rating Score was 78.5%, higher than in 2021.
- The Trust scored in the top 20% of Trusts on 13 questions and in the bottom 20% of Trusts on 1 question out of a total of 59 questions.
- 7 questions showed at least 10% improvement on the 2021 score, and no questions got worse by 10% or more.

The one question where the Trust featured in the bottom 20% was:

Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you.

The survey is split into sections as follows:

1. The start of your care in your pregnancy
2. Antenatal check-ups
3. During your pregnancy
4. Your labour and birth
5. Staff caring for you
6. Care in hospital after the birth
7. Feeding your baby
8. Care at home after birth

Sections 1 and 4 scores were somewhat better or better than expected.

Where mothers' experience is best

- ✓ Mothers being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- ✓ Mothers being given enough information on induction before being induced.
- ✓ At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care.
- ✓ During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.
- ✓ Midwives providing mothers with relevant information, during their pregnancy, about feeding their baby.

Where mothers' experience could improve

- o Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- o Mothers being able to see or speak to a midwife as much as they wanted during their care after birth.
- o Mothers being able to get a member of staff to help when they needed it while in hospital after the birth.
- o Mothers feeling that midwives and other health professionals gave them active support and encouragement about feeding their baby.
- o During pregnancy, mothers receiving the help they needed when they contacted a midwifery team.

A summary of the survey results is shown at Appendix 3.

The results have been shared with senior leaders and operational teams and an action plan is being compiled to address where improvements can be made. Ongoing engagement is currently being undertaken with the support of a newly appointed chair of the Maternity Voice Partnership.

End of report

Appendices

Appendix 1 – Volunteer Annual Review 2022
Appendix 2 – Visiting Hub data x2
Appendix 3 – CQC National Maternity Survey 2022 headlines.

NHS
The Royal Wolverhampton
NHS Trust

Voluntary Services Annual Review 2022

The Royal Wolverhampton NHS Trust

Volunteer @RWT

Patient Experience

Safe & Effective | Kind & Caring | Exceeding Expectation

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Contents

Introduction

Royal Wolverhampton Voluntary Services, based within the Patient Experience Team, oversees recruitment, placements, and support to it's own volunteer workforce, and provides a centralised advice point to other organisations and services in the Trust who wish to recruit volunteers (further details on these groups can be found in section 9). This 2022 annual review provides a guide to highlights during 2022 (January – December) of all voluntary activity within the remit of the Patient Experience Team.

Legacy of the Covid-19 Pandemic and Clinical Volunteers

The commencement and duration of the Covid-19 pandemic, from early 2020, transformed NHS Voluntary Services. Nationally, we saw the large NHS Responders volunteer workforce form, which had a pivotal role is supporting communities with befriending, and companionship to people at a crucial time when socialising was not allowed, and support at large scale events such as vaccination centres and Covid testing sites.

Within Royal Wolverhampton NHS Trust, at the start of 2020, we realised that we needed urgent support in our clinical areas if possible, due to staff shortages and the changes we were quickly witnessing in our care systems. Unfortunately, the existing volunteer workforce in place at the time were unable to volunteer due to health concerns of the volunteers affected. Plus, many non-urgent volunteer services were suspended.

The clinical volunteer role was formed and a rapid recruitment process was underway. By May 2020 we had recruited an additional 120 Clinical Volunteers (CV's).

The role of the Clinical Volunteer was to undertake ward duties such as patient mealtime assistance, bed making, PPE stocks, face time calls with loved ones, errand running for staff, and tasks later developed into more therapeutic type activities with patients, such as simple companionship (essential in times of no patient visits allowed), and activities such as puzzles, games, exercise and gentle arts and crafts.

Individual risk assessments were carried out with the volunteers and they were not placed in areas at high risk of Covid-19 transmission, however in rehabilitation areas, some medical wards, and the Acute Stroke ward.

As opposed to what previously occurred with ward based volunteers, where a volunteer was always assigned to the same ward, the Trust developed a 'Shift booking system' in which a list is sent out to volunteers periodically to select the area in which they will go to volunteer – so that we can respond appropriately to urgent requests for volunteers where needed. Software was acquired to manage this process, and also offer the additional safeguard of tracking volunteer attendances and hours completed for each volunteer. Therefore we can provide better assurances around not only records of volunteer attendance, but also provide the right kind of voluntary support, in the right place, at the right time, to suit the needs of the Trust.

Since 2020, the success of the Clinical Volunteer programme has continued to grow and develop and is still delivered in 2022, with enhancements to the role including support at a Covid swab hub, extension of the Patient Activities programme, marshalling support in RWT Vaccination hubs, support on wards with answering calls from families during times of restricted visiting, and the Inpatient Visiting Hub during 2022.

Clinical Volunteers who have offered their support during 2022: (L-R) Isobelle, Gautam, Polly, Kuldip, Lucy and Debbie.

Funding

We are grateful to external funders without who's help we would have been unable to offer the full extent of the voluntary support we did during this period. These include NHSE/I Voluntary Partnerships, and the Pears Foundation, in partnership with Department for Digital, Culture, Media and Sport, and the National Lottery Community Fund.

Funding support was utilised in the following ways:

NHSE/I Voluntary Partnerships – Winter Volunteering Programme 2021

The Trust secured short term funding from NHSE/I Voluntary Partnerships in late 2021 to run volunteer programmes with three key objectives:

- Impact – reducing and relieving pressures on staff
- Improving patient / carer experience and patient wellbeing
- Provision of quality and meaningful opportunities for volunteers

Funding provided staff resource for additional Band 3 admin support from temporary staff bank, and also purchase of volunteer uniforms, stationary, publicity materials, and bespoke volunteer management software subscription.

We chose to focus on the following workstreams within this funded programme:

- Continuation of recruitment, training and support of Clinical Volunteers
- Piloting the use of volunteers in Emergency Department (Same Day Emergency Care)
- Volunteers supporting with initiatives around bringing together patients and their loved ones (Messages to Loved One Service, Facetime calls with loved ones, answering ward telephones to give family members updates in their loved ones, Inpatient Visiting Hub, and Patient Activities Programme to enhance wellbeing of inpatients during hospital stay).

Following success of the volunteer initiatives, volunteers have continued to support in these roles, (some services have wound down before the end of 2022) hours provided can be seen on page 5.

Pears Foundation, Department for Digital, Culture, Media and Sport, and National Lottery Community Fund Funding – #iwill Youth Volunteer Programme

Between 2021-2022, the Trust was fortunate to receive funding from The Pears Foundation, in partnership with Department for Digital, Culture, Media and Sport, and National Lottery Community Fund to deliver a 12-month programme for young volunteers.

Using feedback generated from young volunteers (age 16-21) themselves with a Co-design approach throughout, the programme was designed around enhanced support, training and supervision, with a focus on confidence building and career pathways. The programme aimed to engage with young people who may be further from educational or career opportunities for various reasons to offer this opportunity.

The funding was used for a full time Band 5 Volunteer Co-ordinator, celebration events, volunteer uniform, publicity materials including printing of the RWT Young Volunteers Reflective Log Book.

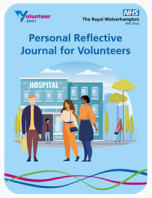
During the 12 months of the programme, 114 young people were provided with a supportive placement through the programme. (The target number in our proposal was 50). And engagement (virtual presentations and attendance at events), was carried out with a number of organisations including local schools, and colleges, The Way Wolverhampton, Wolverhampton City Council Looked After Children's Team and Youth Services, and Black Country Talent Match.

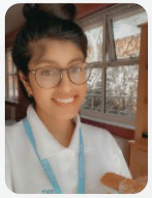
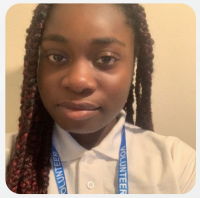
A Youth Volunteer Ambassador was appointed, who's role it was to represent RWT Volunteering internally and externally from the viewpoint of a Young person, and to help promote the programme and support other volunteers.

In addition a network of Peer Mentors was created – young volunteers who through the competencies and skills they developed, were able to mentor newly recruited volunteers to develop in the same way.

A Reflective Log Book was designed and printed – a tool for the young volunteer to record their whole volunteer journey from start to finish- reflecting on their changing ideas and perceptions and how their skills and confidence hopefully increase towards the end of their placement.

The Youth Volunteering Programme ended in April 2022, with the legacy that the Trust will continue to carry out the recommendations from the programme when working with young volunteers, including, regular reviews and reflective log book, recognising career progression as an important aspect of volunteering for young people, access to a network of peer mentors, and enhanced training, supervision, support and reward initiatives. We continue to work with the community partners formed during the programme to continue to recruit more young volunteers, including offering volunteer opportunities to sectors not previously reached.

Left to right: *Young Volunteers Ambassador Eve Adams, Personal Reflective Journal for Volunteers, bookmarks produced with young volunteers and patients, volunteer Dhavina with homemade truffles as part of patient activity, and Clinical Volunteer Adelina.*

Quotes from some of our young people engaged on the programme:

"The patients are very grateful, one told me; "The volunteers are great. We need more of them. They help us with the little things and free up the nurses to get on with other important tasks". I feel as though I make a difference!" – **Niraj**

"I initially started to volunteer as a way of gaining experience. Now, it is more than that to me. It is the sheer excitement of helping those who need help, being able to talk to patients and find out who they are aside from why they are in hospital. This is something I wasn't expecting to get out of volunteering but I genuinely look forward to each day I am volunteering" – **Adelina**

"I had originally applied for a degree in medicine and wanted to get some experience working within a healthcare setting to ensure it was the right decision for me. I have gained lots of new skills from volunteering across several different wards and getting opportunities to speak and work with many different people including doctors, nurses and physiotherapists really showed me the different avenues you can take into a career in healthcare. I thoroughly enjoyed talking to patients across different wards and helping improve their day just a bit even just with a cup of tea and some biscuits. I have really enjoyed volunteering at the trust and was welcomed by every ward I volunteered on which made the experience better" – **Isobelle**

"Volunteering has changed my whole career path and I am so grateful for being supported as much as I have. I feel a sense of belonging with the hospital and it has played a vital role in shaping my future" – **Lewis**

"Volunteering has helped with me getting paid employment with the Trust as it allowed for me to gain experience which then helped with my CV" – **Mohammed**

Projects and Workstreams

During 2022, a number of different projects and workstreams have been covered by Clinical Volunteers support. These include:

Covid Swab Hub

Volunteers supported the Covid Swab Hub at New Cross Hospital acting as a 'runner' for staff to take urgent items between the hub and the Pathology labs. 100 number of volunteer hours was provided to the hub between January 2022- July 2022

Virtual Covid ward

Volunteers supported the Virtual Covid ward based at the Science Park in admin roles. 149 number of volunteer hours was provided to the service between January 2022-August 2022

Vaccination Hubs (New Cross Hospital, Alfred Squire Medical Practice, Penn Manor Medical Practice)

Clinical volunteers have supported the RWT staff vaccination hub, and also community hubs in our Primary Care network GP practices. 114 number of volunteer hours was provided to the hub between January 2022-September 2002.

General ward support

Clinical Volunteer support has continued on our inpatient wards. 2612 number of volunteer hours was provided to the wards between January 2022-December 2022

Patient Activity Programme

As previously discussed, the patient activity programme has continued during 2022. 336 number of volunteer hours was provided to rehabilitation wards at West Park Hospital and Cannock Chase Hospital between January 2022-December 2022.

In September 2022 additional funding has been provided by the Trust Charity for activity resources for elderly care wards C18 and C19.

Inpatient Visiting Hub

The inpatient visiting hub was set up in March 2022 to facilitate restricted bookings for carers to visit their loved ones. The hub in the Heart and Lung Centre, is staffed 7 days per week. Volunteer support this facility as an extra pair of hands to relieve the pressure of paid staff, and also a meet and greet guide to the service. 557 number of volunteer hours was provided to the hub between March 2022-December 2022.

Same Day Emergency Care

We have piloted a volunteer support role within the waiting area of SDEC to relive pressure on staff and provide regular updates and reassurance to waiting patients. 184 number of volunteer hours was provided to the hub between January 2022-December 2022.

Endoscopy Waiting Room

This role was established in August 2022 upon request from a Senior Sister. Volunteers relieve pressure on staff by providing regular updates and reassurance to waiting patients and where permitted, refreshments. 83 number of volunteer hours was provided to the service between August 2022-December 2022.

Volunteers and Career Progression

As highlighted earlier in this review, volunteer feedback indicates that support with educational and career progression is important, especially with the younger cohorts, but also in some degree, to all volunteers of working age. Volunteers tell us that not only does volunteering make them feel good about themselves by supporting the Trust and their community, it provides them with the following benefits:

- Insights into what it's really like working in the NHS and exposure to the variety of job roles
- Enhancement of skills including communication, interpersonal skills with patients and staff, confidence, and creativity and opportunity to bring along their ideas
- Experience, essential for careers in the NHS, but also job applications within other sectors, and University and college applications
- Access to inhouse training, and out software to record their hours and gain recognition awards and certificates
- Opportunity to increase their social networks and make new friends

We have been able to support several volunteers with gaining the next step in their career progression in the following ways:

- In 2022, 3 volunteers joined the Temporary Staffing Bank as Health Care Assistants
- In 2022, 3 volunteers joined the Temporary Staffing Bank as admin support
- 3 volunteers gained acceptance for medical degrees at University
- 2 volunteers gained paid work elsewhere
- 3 volunteers gained substantive paid positions within the Trust

National Case Studies

We were able to celebrate the success with our volunteers gaining employment nationally through case studies shared through the NHSE/I network.

During Careers Week in March 2022, within the 'We Are The NHS' campaign, championing roles across Healthcare Support Workers, Nurses and AHPs, one of our young volunteers Deborah, was selected as she had gained a post on the Trust temporary staffing bank as a HCA from gaining the skills she acquired as a volunteer. Deborah spoke to communications staff from NHSE/I about her story, and her personal motivation for joining the NHS. Deborah has since commenced a medical degree at University. Deborah's story was shared during National Careers Week by NHS England.

NHS Cadets

In 2020, the Trust signed an agreement with NHS England and St Johns Ambulance that we would host NHS Cadets volunteers from the Foundation Programme (14-16 years), and Advanced Programme (16-18 years). The NHS Cadets programme is a training programme for young people offering skills training and information on various careers within the NHS, with the opportunity for volunteer placements for cadets on the Advanced programmes. 2021 was our first cohort of cadets and following the end of the training in summer 2022- 7 Advanced cadets were interested in extending their programme to volunteering placements. The 2nd NHS cadets Cohort has now started in the Autumn of 2022 with further volunteers being placed with us in 2023.

Deborah, who gained a position as a Bank HCA using the skills she acquired as a Clinical Volunteer. Her story was featured nationally as part of NHS Careers Week.

Reward, recognition, and Thanks

Volunteer services offers opportunities for volunteers to be rewarded for their hours completed which can be generated via the Better Impact software- Bronze, Silver and Gold awards are issued at specific points and the volunteers may collect certificates. In 2022 we also introduced 'Volunteer of the month' which is a recognition scheme aimed at highlighting volunteers who have gone above and beyond for that particular month. The volunteers receive a printed certificate which we feature with a photo of them having received it, on social media.

During Volunteers Week 2022 the theme was 'A Time to Say Thanks'. We wrote to all volunteers to thank them for their time and enclose a signed thank you card from Chief Executive and Chairman of the Trust, and also a hot drinks voucher. We featured several volunteer case studies over Trust social media during the week, culminating in a live 'Instagram takeover' of Niraj, a young volunteer on shift at C21, our acute stroke ward. 7 posts were uploaded as part of Niraj's shift, which between them gathered an impressive 448 likes and 14 comments!

Pictures from Niraj's 'Instagram takeover' shift on our Acute Stroke ward, featured as part of Volunteers Week 2022

Engagement

During 2022, engagement with our community has continued, we have proudly delivered presentations to or attended events about our volunteering service, at the following:

- Helpforce – Connecting to Communities- Insight into engaging with volunteers age 16+- March 2022
- Wolverhampton 'Wolves at Work' Youth Summit at the Way Youth Zone, March 2022
- RWT Trust wide Recruitment event – July 2022
- 'Give Back, Get Ahead' – Black Country Consortium, as part of Careers Week
- National Care Leavers Event – Wolverhampton City Council
- Wolverhampton City College – attended Freshers Week events and Employers Breakfast Meeting
- South Staffordshire College – Freshers Week events
- Cannock Chase High School – presentations to 6th Form students

Statistics

- 107 volunteers joined in 2022 from 3 cohorts
- Total number of active volunteers at end of 2022 – 248
- 100 left due to various reasons including change of circumstance and professional development
- Latest recruitment in September had 155 expressions of interest of which 118 applications were made in which 103 were successful past interview stage
- 4051 volunteer hours given in 2022, covering New Cross, West park, Cannock Chase and the community
- New requests for Volunteer Support: 12 areas, including:
  - ED
  - Alfred Squire Vaccination
  - B4
  - A5/6
  - Respiratory centre
  - HR and Survey Packs
  - C26/C41
  - Cardiac Rehab
  - Fairoak at CC Hospital
  - Beynon Centre
  - C12 Discharge Lounge
  - Staff Wellbeing Hub

Other Voluntary Services

Other Voluntary services in RWT not contained within this report have continued to flourish in 2022, including Therapy Services activity groups at West Park Hospital, and Breastfeeding peer supporters.

Designed & Produced by the Department of Clinical Illustration,
New Cross Hospital, Wolverhampton, WV10 0QP Tel: 01902 695377.

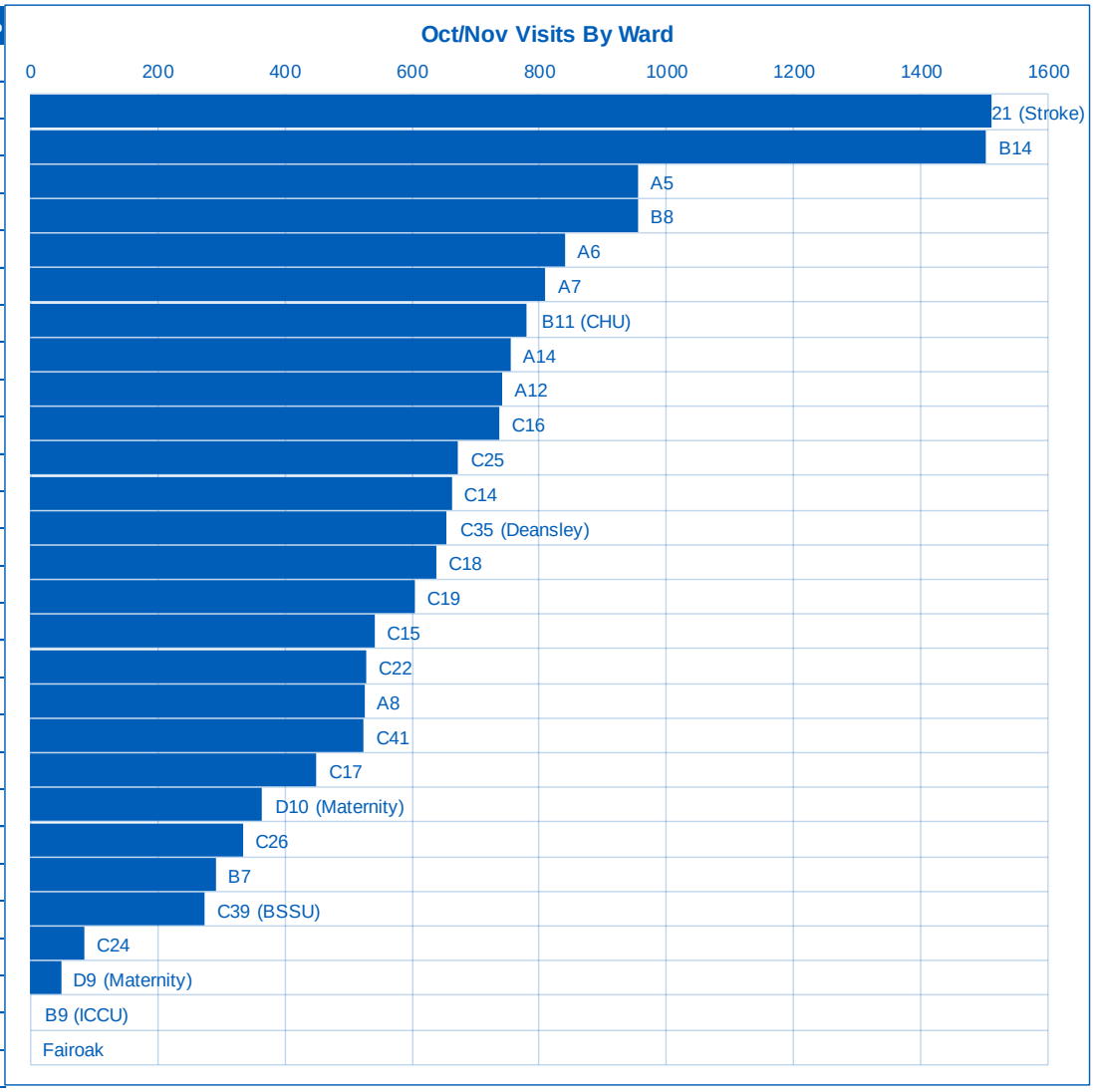
MI_11124814_29.12.22_V_1

Bookings	Oct/Nov
Number of Bookings	16801

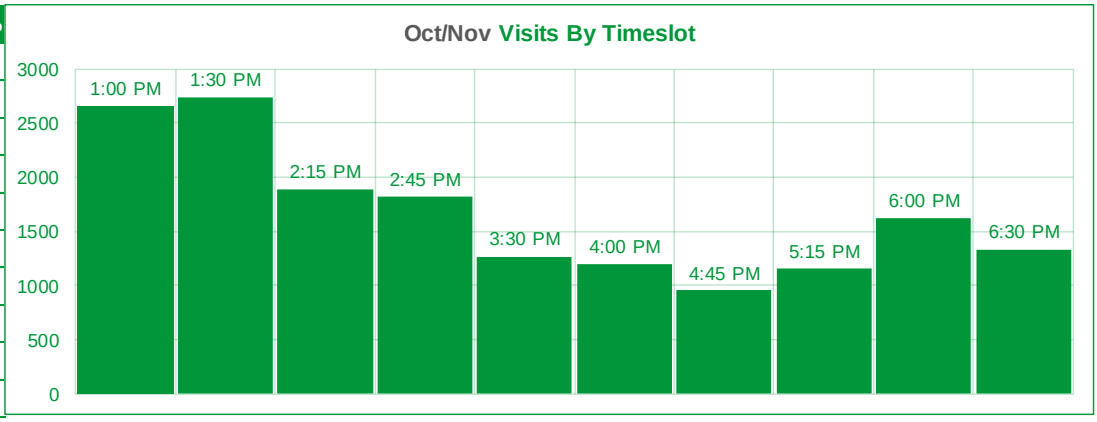
Visiting Dashboard
Oct/Nov: 01/10/2022 - 30/11/2022

The Royal Wolverhampton NHS Trust

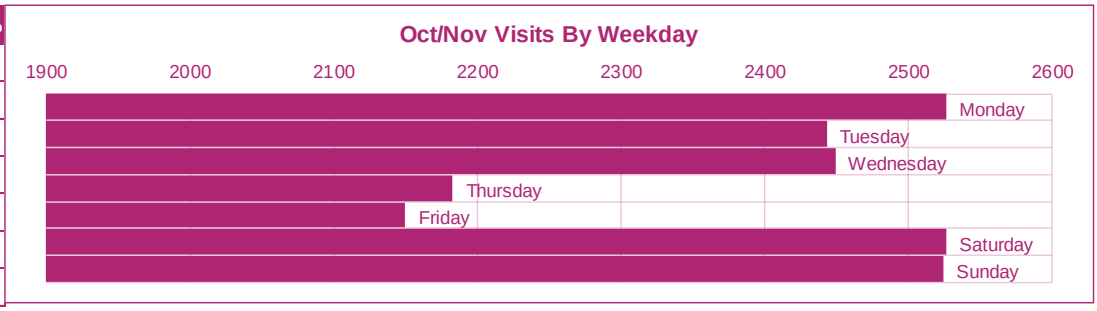
Visits by Ward	Oct/Nov	Oct/Nov %
C21 (Stroke)	1510	9%
B14	1503	9%
A5	955	6%
B8	955	6%
A6	840	5%
A7	810	5%
B11 (CHU)	781	5%
A14	755	4%
A12	742	4%
C16	737	4%
C25	673	4%
C14	662	4%
C35 (Deansley)	654	4%
C18	638	4%
C19	604	4%
C15	541	3%
C22	528	3%
A8	525	3%
C41	524	3%
C17	450	3%
D10 (Maternity)	364	2%
C26	334	2%
B7	291	2%
C39 (BSSU)	273	2%
C24	85	1%
D9 (Maternity)	48	0%
B9 (ICCU)	0	0%
Fairoak	0	0%



Timeslot	Oct/Nov	Oct/Nov %
1:00 PM	2653	16%
1:30 PM	2737	16%
2:15 PM	1892	11%
2:45 PM	1821	11%
3:30 PM	1270	8%
4:00 PM	1198	7%
4:45 PM	954	6%
5:15 PM	1156	7%
6:00 PM	1620	10%
6:30 PM	1335	8%



Weekday	Oct/Nov	Oct/Nov %
Monday	2526	15%
Tuesday	2443	15%
Wednesday	2449	15%
Thursday	2183	13%
Friday	2150	13%
Saturday	2526	15%
Sunday	2524	15%



Safe & Effective | Kind & Caring | Exceeding Expectation

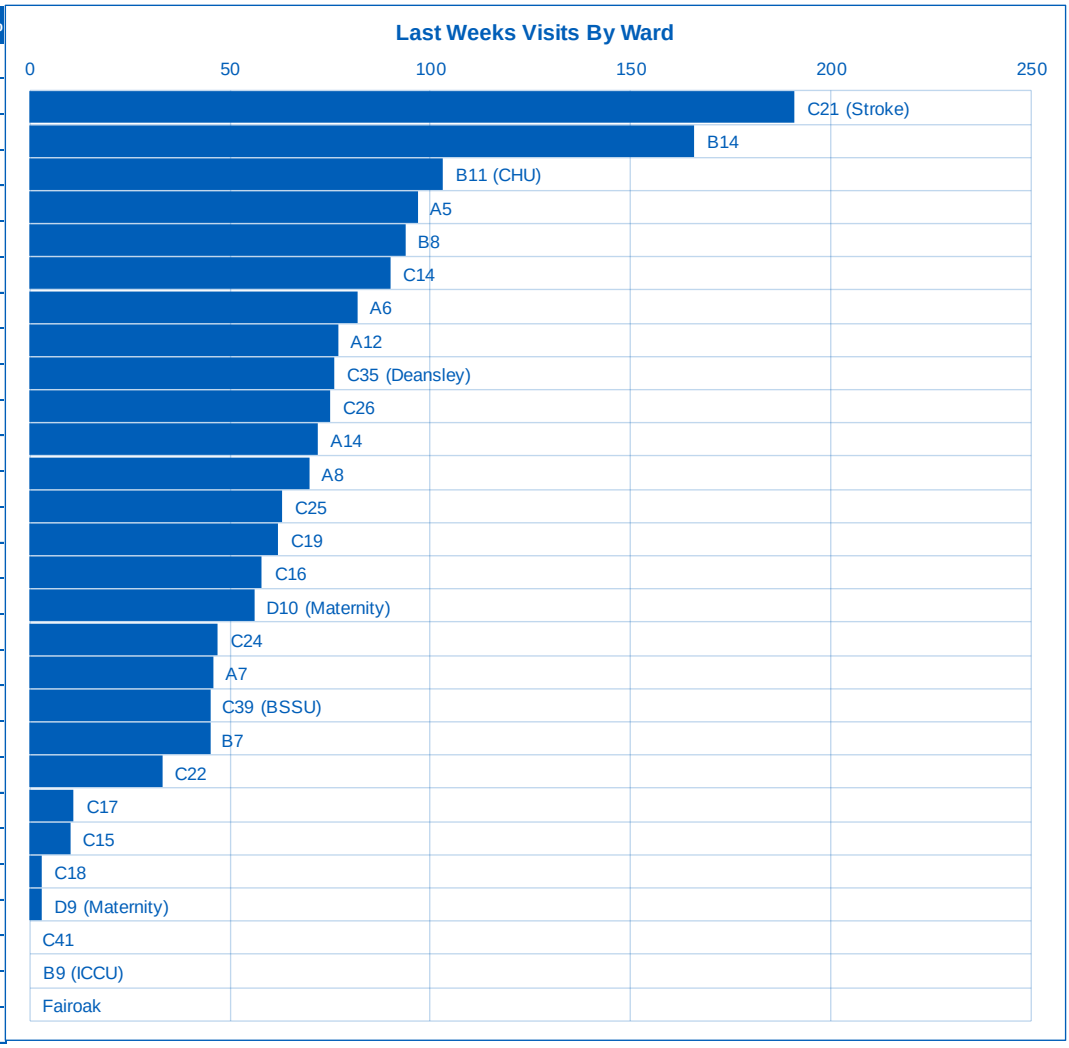
Bookings	TOT	LW
Number of Bookings	76289	1679
Average Daily Bookings	254	240
Daily Capacity Fulfilled		34%

Key	
TOT	Total
LW	Last Week

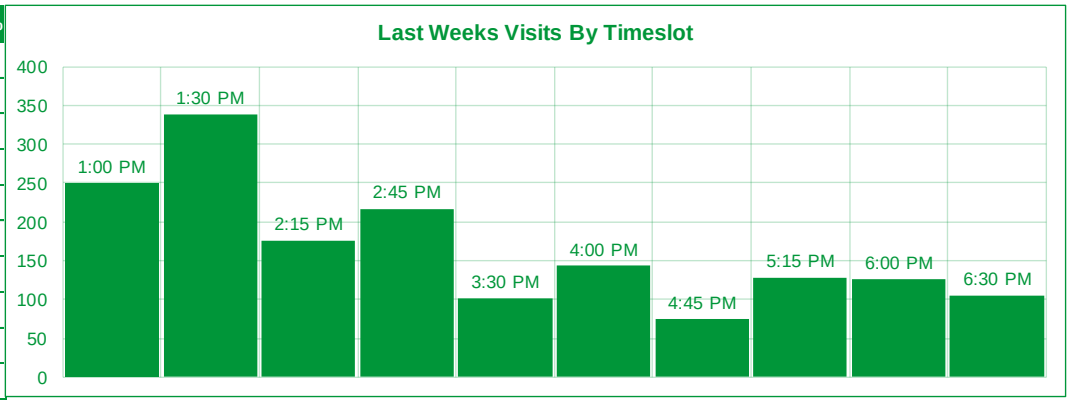
Visiting Dashboard
TOT: 16/03/20222 - 08/01/2023
LW: 02/01/2023 - 08/01/2023

NHS
The Royal Wolverhampton NHS Trust

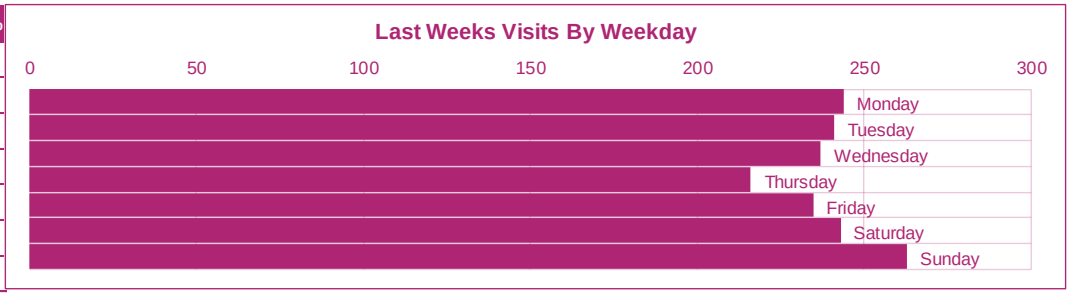
Visits by Ward	TOT	TOT %	LW	LW %
C21 (Stroke)	7499	10%	191	11%
B14	6737	9%	166	10%
B11 (CHU)	3745	5%	103	6%
A5	4098	5%	97	6%
B8	4282	6%	94	6%
C14	2332	3%	90	5%
A6	3667	5%	82	5%
A12	3090	4%	77	5%
C35 (Deansley)	3199	4%	76	5%
C26	2032	3%	75	4%
A14	3124	4%	72	4%
A8	2053	3%	70	4%
C25	2392	3%	63	4%
C19	2759	4%	62	4%
C16	3025	4%	58	3%
D10 (Maternity)	1463	2%	56	3%
C24	2498	3%	47	3%
A7	2760	4%	46	3%
C39 (BSSU)	1627	2%	45	3%
B7	1420	2%	45	3%
C22	2575	3%	33	2%
C17	1838	2%	11	1%
C15	2737	4%	10	1%
C18	2974	4%	3	0%
D9 (Maternity)	138	0%	3	0%
C41	2081	3%	0	0%
B9 (ICCU)	11	0%	0	0%
Fairoak	40	0%	0	0%



Timeslot	TOT	TOT %	LW	LW %
1:00 PM	10387	14%	249	15%
1:30 PM	12955	17%	338	20%
2:15 PM	7675	10%	176	10%
2:45 PM	8679	11%	217	13%
3:30 PM	5933	8%	101	6%
4:00 PM	6275	8%	143	9%
4:45 PM	4411	6%	75	4%
5:15 PM	5366	7%	128	8%
6:00 PM	7118	9%	126	8%
6:30 PM	6252	8%	105	6%



Weekday	TOT	TOT %	LW	LW %
Monday	10695	14%	244	15%
Tuesday	10639	14%	241	14%
Wednesday	10907	14%	237	14%
Thursday	10885	14%	216	13%
Friday	10728	14%	235	14%
Saturday	11205	15%	243	14%
Sunday	11230	15%	263	16%



2022 Maternity Survey: Early release of CQC benchmark results for The Royal Wolverhampton NHS Trust

This report provides benchmark results for The Royal Wolverhampton NHS Trust, in advance of publication of the 2022 maternity survey. It contains the scoring and 'banding' (how your trust performed compared to other trusts across England), but does not include the lowest & highest scores for England. These results can only be shared at official publication of the survey results.

By sharing results now, you will be able to see how your trust performed on individual questions in advance of the publication.

If you require any assistance, have any queries, or would like to provide feedback on the format of this report, please contact the CQC Surveys Team at: patient.survey@cqc.org.uk.

2022 Maternity Survey

The 2022 maternity survey involved 121 NHS trusts in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women aged 16 years or over who had a live birth between 1st and 28th February 2022 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2022. Almost 21,000 responses were received, an adjusted response rate of 47%[1].

The maternity survey first ran in 2007 with other surveys being carried out in 2010, 2013, 2015, 2017, 2018, 2019 and 2021. The questionnaire underwent a major redevelopment ahead of the 2013 survey so results for 2022 are **only comparable** with 2013, 2015, 2017, 2018, 2019 and 2021.

CQC will use the results from the survey to build an understanding of the risk and quality of services and those who organise care across an area. Where survey findings provide evidence of a change to the level of risk or quality in a service, provider or system, CQC will use the results alongside other sources of people's experience data to inform targeted assessment activities

[1]The 'adjusted' response rate is reported. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

Antenatal and postnatal care

Some respondents may have experienced antenatal and postnatal care in different trusts. This may be for many reasons such as having to travel for more specialist care or due to variation in service provision across the country.

Trusts were therefore asked to carry out an 'attribution exercise' to identify individuals in their sample that were likely to have received their antenatal and postnatal care from the trust. This was done using either electronic records or residential postcode information.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust. Trusts that did not provide attribution data do not receive results on the antenatal and postnatal sections of the survey.

Data is provided voluntarily, and not all trusts provided this data. The antenatal and postnatal care questions are therefore benchmarked against those other trusts that also provided this information.

Making fair comparisons between trusts

People's characteristics, such as age and number of previous births can influence their experience of care and the way they report it. For example, older people tend to report more positive experiences than younger people. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of people.

To account for this, we 'standardise' respondent data to ensure that a trust does not appear better or worse than another due to its respondent profile. For maternity surveys, we standardise by age and parity (whether or not a mother has given birth previously).

Scoring

For each question in the survey that can be scored, individual responses are converted into scores on a scale of 0 to 10. For each question, a score of 10 is assigned to the most positive response and a score of 0 to the least positive. The higher the score, the better the trust's results.

It is not appropriate to score all questions because some of them do not assess a trust's performance.

Interpreting your data

The better and worse categories, displayed in the column with the header '2022 Band' in the tables below, are based on an analysis technique called the 'expected range'. It determines the range within which your trust's score could fall without differing significantly from the average score of all trusts taking part in the survey. If the trust's performance is outside of this range, its performance is significantly above or below what would be expected. If it is within this range, we say that its performance is 'about the same'.

Where a trust's survey results have been identified as better or worse than the majority of trusts, it is very unlikely that these results have occurred by chance. If your trust's results are 'about the same', this column will be empty.

If fewer than 30 respondents have answered a question, a score will not be displayed for this question. This is because the uncertainty around the result is too great.

Trend data

Scores from the previous survey are displayed where available. In the column with the header 'Change from 2021' arrows indicate whether the score for the 2022 survey has increased significantly (up arrow), decreased significantly (down arrow) or has not significantly changed from 2021 (no arrow). A statistically significant difference means that the change in the result is unlikely to be due to chance.

Significance is tested using a two-sample t-test. Please note that historical comparisons are not provided for section scores as the questions contained in each section can change.

Where a result for 2021 is not shown, this is because the question was either new in 2022, or the question wording and/or response options have been changed. Comparisons are also not shown if a trust has merged with another trust(s) since the 2021 survey, or if a trust committed a sampling error in 2021.

Further information

The full national results will be available on the CQC website later this year, together with the technical document which outlines the survey methodology and the scoring applied to each question: www.cqc.org.uk/maternitysurvey

Results for The Royal Wolverhampton NHS Trust: Executive Summary

Respondents and response rate

- 148 The Royal Wolverhampton NHS Trust patients responded to the survey
- The response rate for The Royal Wolverhampton NHS Trust was 39.36%

Banding

Better

Your trust's results were much better than most trusts for **1** questions.

Your trust's results were better than most trusts for **2** questions.

Your trust's results were somewhat better than most trusts for **1** questions.

Worse

Your trust's results were much worse than most trusts for **0** questions.

Your trust's results were worse than most trusts for **0** questions.

Your trust's results were somewhat worse than most trusts for **0** questions.

Same

Your trust's results were about the same as other trusts for **47** questions.

Tables of Results

Table 1: The start of your care in pregnancy

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
B3. Were you offered a choice about where to have your baby?	106	3.7		2.6	↑
B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	116	7.6	Somewhat better	6.1	↑
B5. At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	121	7.0	Better	5.3	↑

Table 2: Antenatal check-ups

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
B8. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	118	7.2		6.1	↑
B9. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	121	9.1		8.1	↑
B10. During your antenatal check-ups, did your midwives listen to you?	120	8.9		8.6	
B11. During your antenatal check-ups, did your midwives ask you about your mental health?	121	8.8		8.6	

Table 3: During your pregnancy

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
B12. Were you given enough support for your mental health during your pregnancy?	66	8.8		8.7	
B13. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	105	8.0		8.1	
B14. Thinking about your antenatal care, were you spoken to in a way you could understand?	119	9.5		9.1	
B15. Thinking about your antenatal care, were you involved in decisions about your care?	118	8.8		8.4	
B16. During your pregnancy did midwives provide relevant information about feeding your baby?	119	7.6		7.1	
B17. Did you have confidence and trust in the staff caring for you during your antenatal care?	120	8.5			
B18. Thinking about your antenatal care, were you treated with respect and dignity?	119	9.4			

Table 4: Your labour and birth

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
C4. Were you given enough information on induction before you were induced?	44	8.5	Much better	7.0	↑
C5. And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	40	7.9	Better		
C6. Were you involved in the decision to be induced?	43	8.7		8.4	
C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	98	8.5		7.8	
C12. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	136	9.1		8.0	↑

Table 5: Staff caring for you

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
C14. Did the staff treating and examining you introduce themselves?	142	9.0		8.8	
C16. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	143	7.5		7.8	
C17. If you raised a concern during labour and birth, did you feel that it was taken seriously?	91	8.0		7.4	
C18. During labour and birth, were you able to get a member of staff to help you when you needed it?	136	9.0		8.5	
C19. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	141	9.3		9.2	
C20. Thinking about your care during labour and birth, were you involved in decisions about your care?	138	8.6		8.7	
C21. Thinking about your care during labour and birth, were you treated with respect and dignity?	142	9.1		8.7	
C22. Did you have confidence and trust in the staff caring for you during your labour and birth?	143	8.9		8.7	
C23. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	126	7.0		6.5	

Table 5: Staff caring for you *(continued)*

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
C24. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	126	7.9			

Table 6: Care in hospital after birth

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
D2. On the day you left hospital, was your discharge delayed for any reason?	142	6.3		6.6	
D4. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	130	7.0		7.3	
D5. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	142	7.6		7.4	
D6. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	141	8.3		8.4	
D7. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	125	2.9		2.8	
D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	140	8.9		8.9	

Table 7: Feeding your baby

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
E2. Were your decisions about how you wanted to feed your baby respected by midwives?	119	8.8		8.6	
E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	110	7.4		7.4	

Table 8: Care at home after the birth

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
F1. Thinking about your postnatal care, were you involved in decisions about your care?	115	8.5			
F2. If you contacted a midwifery or health visiting team, were you given the help you needed?	105	8.2		8.6	
F5. Would you have liked to have seen or spoken to a midwife…	118	5.7		5.3	
F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?	105	7.6		7.1	
F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	117	8.8		8.3	
F8. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	109	8.6		7.9	
F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	116	8.5		8.3	
F11. Did a midwife or health visitor ask you about your mental health?	117	9.6		9.4	

Table 8: Care at home after the birth *(continued)*

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
F12. Were you given information about any changes you might experience to your mental health after having your baby?	115	7.2		7.2	
F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	107	8.6		8.2	
F14. Were you given information about your own physical recovery after the birth?	116	7.4		6.9	
F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	102	7.2		6.7	
F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	44	6.4		5.6	
F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	105	8.3		7.6	

Table 9: Section Scores

Section	2022 Score	Band
1. The start of your care in your pregnancy	6.1	Somewhat better
2. Antenatal check-ups	8.5	
3. During your pregnancy	8.7	
4. Your labour and birth	8.6	Better
5. Staff caring for you	8.4	
6. Care in hospital after the birth	6.8	
7. Feeding your baby	8.1	
8. Care at home after birth	7.9	

Table 10: Demographic information

Characteristic	Percent
Total respondents	148
Response rate	39.4
Parity	
Primiparous	41.3
Multiparous	58.7
Age	
16-18	0.0
19-24	7.0
25-29	21.7
30-34	38.5
35+	32.9
Ethnicity	
White	67.1
Multiple ethnic groups	3.5
Asian or Asian British	20.3
Black or Black British	7.0
Arab or other ethnic group	1.4
Not known	0.7

Table 11: Demographic information

Characteristic	Percent
Religion	
No religion	40.6
Buddhist	0.0
Christian	37.1
Hindu	2.8
Jewish	0.0
Muslim	5.6
Sikh	10.5
Other religion	2.1
Prefer not to say	1.4
Sexuality	
Heterosexual/straight	91.5
Gay/lesbian	0.0
Bisexual	4.2
Other	0.0
Prefer not to say	4.2
Gender	
Gender same as sex at birth	99.3
Gender not the same as sex at birth	0.0
Prefer not to say gender	0.7

patient PERSPECTIVE

Rigorous survey methods, reliable results.

PATIENT EXPERIENCE SURVEY HEADLINE REPORT

The Royal Wolverhampton NHS Trust

National Maternity Survey 2022

Sample: Women who received maternity services in February 2022

Note: to access full reporting go to www.patientperspective.co.uk

EXECUTIVE SUMMARY

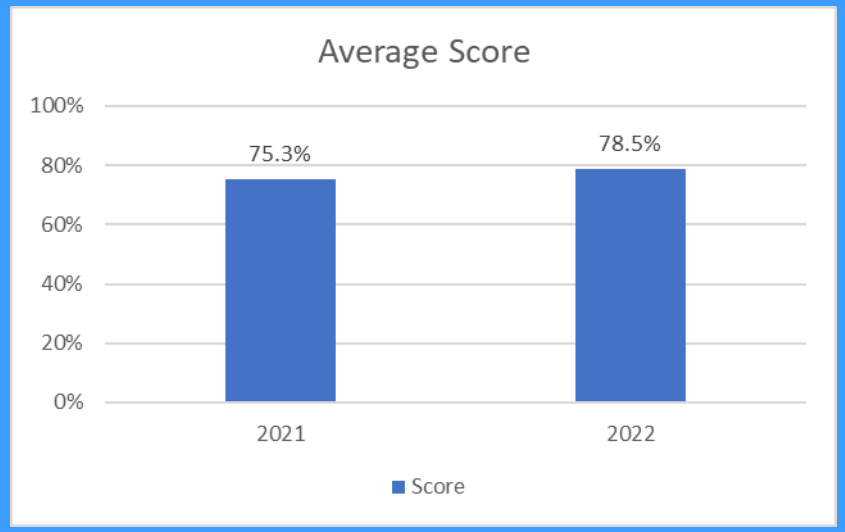
This report summarises the headline findings of the **2022 National Maternity Survey**.

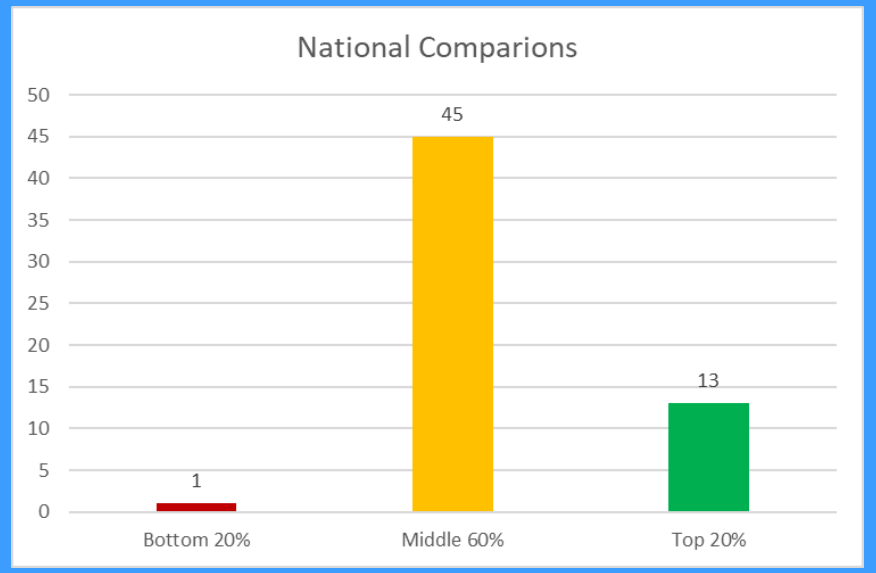
- The National Maternity Survey is required by the CQC for all NHS Trusts providing maternity services.
- All women receiving maternity services in February 2022 were selected for the survey.
- 378 women were included in the survey and 148 responded **(39%)**. The Patient Perspective average response rate for all 31 Trusts it surveyed was 48%.
- The average Mean Rating Score was **78.5%,** higher than in 2021.
- You scored in the **top 20% of Trusts** on **13** questions and in the **bottom 20% of Trusts** on **1** question out of a total of 59 questions.
- **7** questions showed **at least 10% improvement** on the 2021 score, and **no questions** got **worse by 10%** or more.

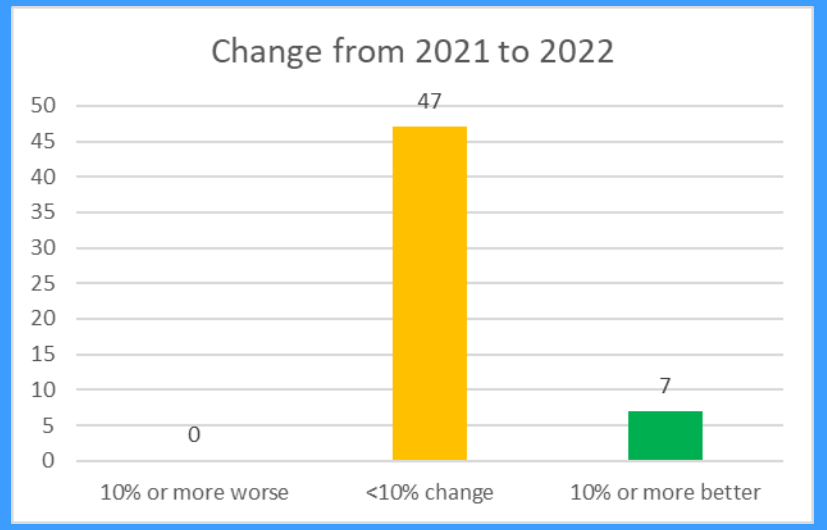
Full results including tables, free text comments, trends and benchmarks can be found at www.patientperspective.co.uk

patient PERSPECTIVE

RESULTS DASHBOARD
NATIONAL MATERNITY SURVEY 2022







24 January, 2023

patient PERSPECTIVE

Questions and scores #1

The Royal Wolverhampton NHS Trust					
Question	Question Text	2021 Score	2022 Score	Change since 2021	National Comparisons
Antenatal Care					
B3_1	Were you offered a choice about where to have your baby: Yes – a choice of hospitals	56%	68%	10% or more better	Top 20%
B3_2	Were you offered a choice about where to have your baby: Yes - at home	6%	22%	10% or more better	Middle 60%
B3_4	Were you offered a choice about where to have your baby: No – I was not offered any choices	78%	88%	10% or more better	Middle 60%
B4	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	59%	72%	10% or more better	Top 20%
B5	At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	52%	67%	10% or more better	Top 20%
B8	During your antenatal check-ups, did the midwives appear to be aware of your medical history?	61%	69%	<10% change	Middle 60%
B9	During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	82%	89%	<10% change	Top 20%
B10	During your antenatal check-ups, did your midwives listen to you?	87%	87%	<10% change	Middle 60%
B11	During your antenatal check-ups, did your midwife ask you about your mental health?	84%	85%	<10% change	Middle 60%
B12	Were you given enough support for your mental health during your pregnancy?	85%	89%	<10% change	Middle 60%
B13	During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	82%	79%	<10% change	Middle 60%
B14	Thinking about your antenatal care, were you spoken to in a way you could understand?	91%	95%	<10% change	Top 20%
B15	Thinking about your antenatal care, were you involved enough in decisions about your care?	84%	88%	<10% change	Middle 60%
B16	During your pregnancy did midwives provide relevant information about feeding your baby?	70%	73%	<10% change	Middle 60%
B17	Did you have confidence and trust in the staff caring for you during your antenatal care?	n/a	83%	n/a	Middle 60%
B18	Thinking about your antenatal care, were you treated with respect and dignity?	n/a	92%	n/a	Middle 60%

patient PERSPECTIVE

Questions and scores #2

Question	Question Text	2021 Score	2022 Score	Change since	National
Your labour and the birth of your baby					
C4	Were you given enough information on induction before you were induced?	71%	85%	10% or more better	Top 20%
C5	And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	n/a	81%	n/a	Top 20%
C6	Were you involved in the decision to be induced?	82%	89%	<10% change	Top 20%
C7	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	78%	82%	<10% change	Middle 60%
C12	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	80%	90%	10% or more better	Middle 60%
C14	Did the staff treating and examining you introduce themselves?	88%	90%	<10% change	Middle 60%
C16_1	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during early labour	91%	86%	<10% change	Middle 60%
C16_2	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the later stages of labour	90%	89%	<10% change	Bottom 20%
C16_3	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the birth	98%	99%	<10% change	Middle 60%
C16_4	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, shortly after the birth	93%	91%	<10% change	Middle 60%
C16_5	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: No, not at all	75%	75%	<10% change	Middle 60%
C17	If you raised a concern during labour and birth, did you feel that it was taken seriously?	76%	80%	<10% change	Middle 60%
C18	During labour and birth, were you able to get a member of staff to help you when you needed it?	85%	89%	<10% change	Middle 60%
C19	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	92%	93%	<10% change	Middle 60%
C20	Thinking about your care during labour and birth, were you involved in decisions about your care?	87%	87%	<10% change	Middle 60%
C21	Thinking about your care during labour and birth, were you treated with respect and dignity?	86%	90%	<10% change	Middle 60%
C22	Did you have confidence and trust in the staff caring for you during your labour and birth?	86%	89%	<10% change	Middle 60%
C23	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	67%	69%	<10% change	Top 20%
C24	During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	n/a	78%	n/a	Middle 60%

patient PERSPECTIVE

Questions and scores #3

Question	Question Text	2021 Score	2022 Score	Change since 2021	National Comparisons
Postnatal care					
D2	On the day you left hospital, was your discharge delayed for any reason?	67%	61%	<10% change	Middle 60%
D4	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	73%	70%	<10% change	Middle 60%
D5	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	75%	77%	<10% change	Middle 60%
D6	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	84%	83%	<10% change	Middle 60%
D7_1	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: Yes	23%	26%	<10% change	Middle 60%
D7_2	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as they were restricted to visiting hours	44%	39%	<10% change	Middle 60%
D7_3	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as there was no accommodation for them in the hospital	95%	90%	<10% change	Top 20%
D8	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	88%	89%	<10% change	Middle 60%
Feeding your baby					
E2	Were your decisions about how you wanted to feed your baby respected by midwives?	87%	88%	<10% change	Middle 60%
E3	Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	73%	74%	<10% change	Middle 60%
Care after birth					
F1	Thinking about your postnatal care, were you involved in decisions about your care?	n/a	83%	n/a	Top 20%
F2	If you contacted a midwifery or health visiting team were you given the help you needed?	84%	81%	<10% change	Middle 60%
F5	Would you have liked to have seen a midwife...	51%	56%	<10% change	Middle 60%
F6	Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?	69%	71%	<10% change	Middle 60%
F7	Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	83%	87%	<10% change	Middle 60%
F8	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	81%	84%	<10% change	Middle 60%
F9	Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	82%	84%	<10% change	Middle 60%
F11	Did a midwife or health visitor ask you about your mental health?	93%	97%	<10% change	Middle 60%
F12	Were you given information about any changes you might experience to your mental health after having your baby?	70%	72%	<10% change	Middle 60%
F13	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	80%	83%	<10% change	Middle 60%
F14	Were you given enough information about your own physical recovery after the birth?	66%	73%	<10% change	Top 20%
F15	In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	64%	71%	<10% change	Middle 60%
F16	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	60%	59%	<10% change	Middle 60%
F17	In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	74%	81%	<10% change	Top 20%

patient PERSPECTIVE

POINTS TO DISCUSS

Points to discuss:

- ❑ What is your overall impression of these results?
- ❑ What are you most pleased about in these results?
- ❑ What are you most unhappy about in these results?
- ❑ What works? What have you learned from your successes in other areas that you can use to help you make improvements to women's experiences of maternity care?
- ❑ What hasn't worked so far? What have you learned from what hasn't worked that you can either avoid doing in future or can do differently next time?
- ❑ What do you see as the priority areas for improving women's experiences of maternity services?

Factors to consider when setting priorities for improvement:

- ❑ **Organisational Fit** – how do these results triangulate with other performance data and existing organisational priorities and service improvement initiatives?
- ❑ **Commissioning requirements** – what external priorities have been set?
- ❑ **National comparisons** – in which areas are you scoring lower than other organisations and National averages
- ❑ **Internal benchmarks** – how do services/departments/wards/teams/parts of the pathway compare?
- ❑ **Actionable topics** – is this an area you can actually do something about? Are there any quick wins that will help get the patient experience improvement programme started?

NEXT STEPS AND ACTIONS

- ❑ **Detailed review of the results**
- ❑ **Dissemination of results** – consider with which stakeholder groups (internal and external), in which level of detail and in what format to share the results widely
- ❑ **Identify your priority areas for improvement** – ensuring these are linked with current priorities and are fully integrated into existing service improvement initiatives will mean they are more likely to be acted upon
- ❑ **Involve staff and service users** in deciding upon the actions to take to make the improvements real and lasting
- ❑ **Set up a process for ongoing monitoring** of the actions and improvements and regular communication about progress to stakeholders

- ❑ **Consider whether any further detailed analysis or support would be helpful** in supporting your quality improvement initiatives and whether there is anything else we can help you with. Our enhanced services include:
  - ❑ Detailed thematic analysis of written comments from women to improve the depth of reporting about experiences of care
  - ❑ Training for staff (including train the trainer programmes) in the interpretation of survey results and how to get the most from your survey programme will build capacity for improvement
  - ❑ Dedicated service improvement workshops and events built around your patient experience survey results

To discuss how we can help you further please contact our Senior Project Manager, Chris Henderson:

chris.henderson@patientperspective.org

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Learning from Deaths
Executive Summary:	Mortality Data – SHMI and Crude Mortality The paper presents the Trust's mortality data as at November 2022 and the work being undertaken to scrutinise and continually improve. The SHMI value published for the period August 2021 to July 2022 is 0.9491. The Trust is now ranked 31st out of 121 Trusts across the country and remains within the expected range. The crude mortality rate for the last three months has been as follows: • September 2022 – 1.67% • October 2022 – 1.78% • November 2022 – 1.69% Medical Examiner Service The percentage of deaths reviewed by the Medical Examiner (ME) over the last three months is as follows: • September 2022 – 92% • October 2022 – 93% • November – 98% The roll-out of the current Medical Examiner Service out into the community is progressing on target and will be statatory from April 2023. RWT now have **37** GP practices/Hospice referring into the RWT Medical Examiner service and initial meetings are continuing with wider PCNs to expand the rollout further. There are a remaining **12** GP practices to come on board from the Wolverhampton/South Staffs area and it is planned for all to come on board in January/February 2023. The Medical Examiner Service has reviewed the following number of community deaths from September to November 2022: • 63 cases of which 84% discussions with bereaved families/carers took place • 62 cases of which 92% of discussions with bereaved families/carers took place • 87 cases of which 91% discussions with bereaved families/carers took place. Mortality Reviews As at 10th January 2023, outstanding SJRs for in hospital deaths is as follows: • 67 SJR1s outstanding of which 19 are outstanding with a date of death more than 8 weeks ago • 5 SJR2s outstanding of which 2 are outstanding with a date of death more than 8 weeks ago. The Mortality Review SJR process has now been rolled out into RWT PCN practices. The outcome of the reviews is to be presented to the Mortality Review Group in February 2023 and will be reported to TMC in the next report. As at 10th January 2023, outstanding SJRs for RWT PCN is as follows:

	• 8 SJR1s outstanding of which 6 are outstanding with a date of death more than 8 weeks ago.
Action Requested:	Receive and note
For the attention of the Board	To note the SHMI of 0.9491, this remains within the expected range for the past year.
Assure	The Board has previously been reassured through data analysis that the previously increased SHMI is not an indicator of avoidable mortality or quality of care. However, work continues to review and, where possible, enhance quality of care provision across admission pathways with elevated SMR's. Work also continues to address coding & data capture with respect to accuracy and completeness prior to submission of data.
Advise	The SHMI is within the expected range. The SMR is studied as part of a suite of indicators used to look at quality of care, experience and service provision as part of the Learning from Deaths Programme.
Alert	RWT Diagnostic Groups with higher than expected SHMI (August 2021 to July 2022) have been listed below with details of actions being taken to investigate these further: 1. Chronic renal failure – A case note review has been undertaken and a presentation has been presented to the Clinical Pathway meeting in September 2022, an update has been provided within Section 3 of the report. An action identified is that the renal team need to proactively undertake death validation since majority of cases were coded incorrectly. 2. Pneumonia – Presented at the Clinical Pathway meeting in January and June 2022 with a further presentation in February 2023 to provide an update on the workstreams currently being worked on and progress made to date on changes implemented. Further detail to be provided in the next report following the presentation to the Clinical Pathway meeting. 3. Epilepsy; convulsions – A case note review has been undertaken and the outcome of this is due to be presented to the Clinical Pathway Meeting in January 2023. 4. Acute Cerebrovascular Disease – A case note review has been completed and presented to the Clinical Pathway meeting in June 2022 and assurance has been provided on the quality of care given from case note reviews. A further report was provided to Trust Board in October 2022 providing assurance against the metrics, the current challenges faced and an action plan. Further presentation to the Clinical Pathway Meeting in March 2023.
Author + Contact Details:	Karenjit Sahota - Head of Chief Medical Officer Portfolios Email: Karenjit.Sahota@nhs.net on behalf of Dr Jonathan Odum Chief Medical Officer and Dr Ananth Viswanath Deputy Chief Medical Officer
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 6. Be in the top 25% of all key performance indicators
Resource Implications:	Revenue: Capital: Workforce: Funding Source: N/A

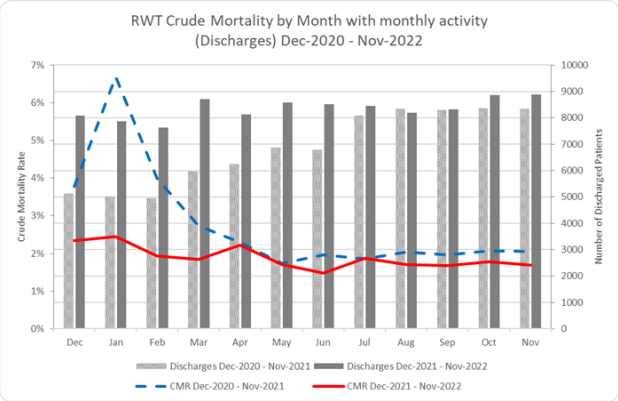
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, 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	N/A
Risks: BAF/ TRR	BAF SR 12
Public or Private:	Public
Other formal bodies involved:	Mortality Review Group/Compliance Oversight Group/Quality Standards Improvement Group/Quality Governance Assurance Committee/Trust Management Committee
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

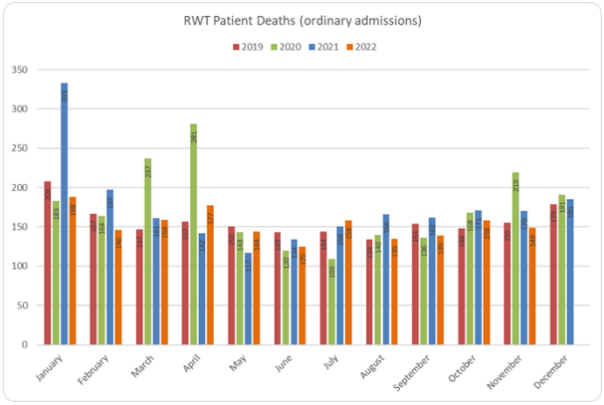
The Royal Wolverhampton NHS Trust

Learning from Deaths Update of monthly activity for November 2022

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

1.1 Crude mortality



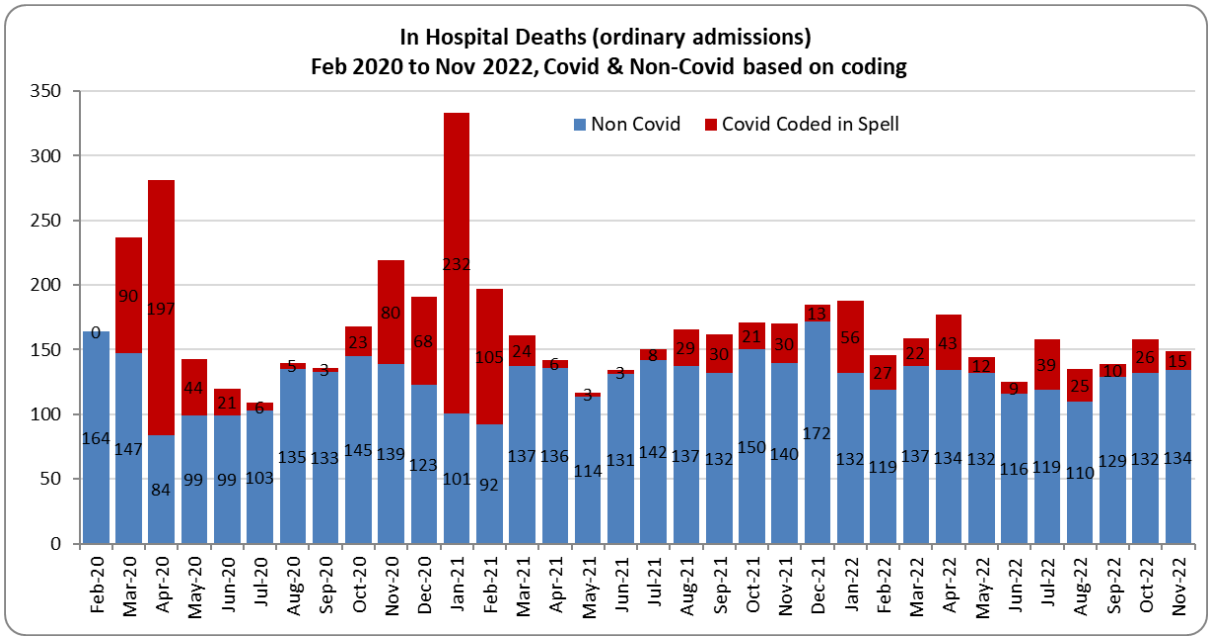


The crude mortality rate for the last three months has been as follows:

- September 2022 – 1.67%
- October 2022 – 1.78%
- November 2022 – 1.69%

The number of deaths for the same period has been as follows:

- September 2022 – 139 deaths of which 10 of these deaths were Covid related based on parts 1 or 2 of the death certificate
- October 2022 – 158 deaths of which 26 of these deaths were Covid related based on parts 1 or 2 of the death certificate
- November 2022 – 149 deaths of which 15 of these deaths were Covid related based on parts 1 or 2 of the death certificate



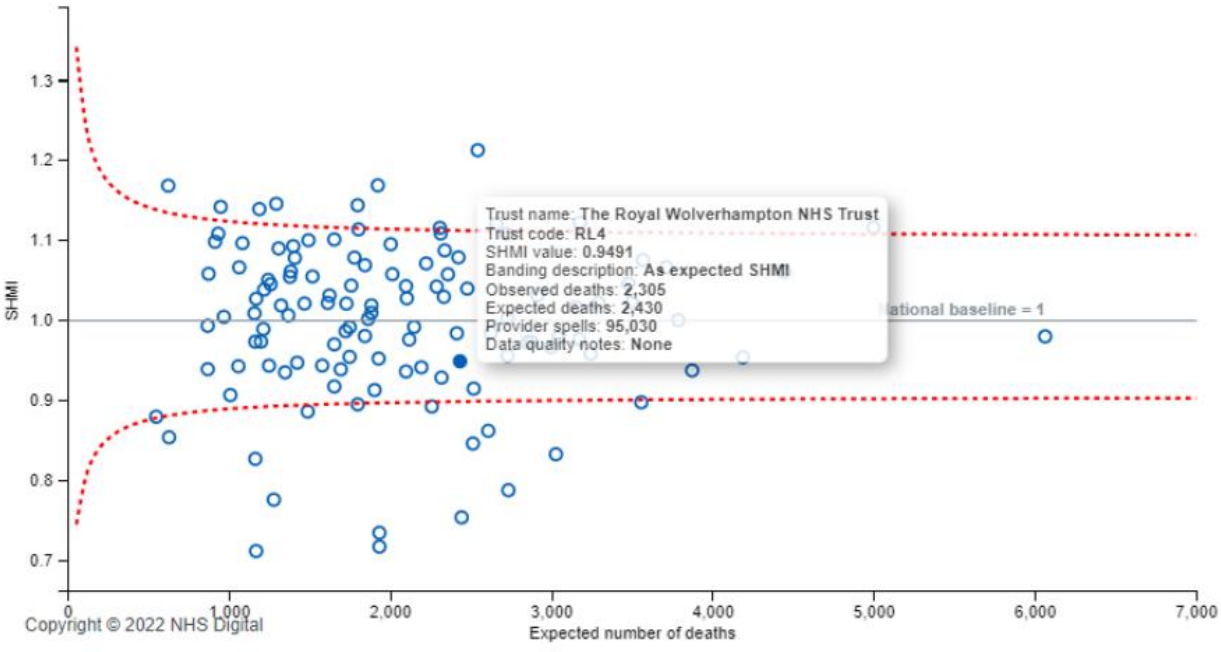
If any of the episodes within a provider spell have a COVID-19 diagnosis code, then the spell is excluded from the SHMI. Additionally, if COVID-19 is recorded anywhere on the death certificate, then the death and the spell it is linked to are excluded from the SHMI.

The following table shows in-hospital deaths and crude mortality for October 2022 by SHMI diagnosis group (SHMI episode). The group 'Allergic reactions, aftercare & screening, R codes' is the diagnosis group Covid sits within.

Primary SHMI Diagnosis Group of Hospital Admission (SHMI episode)	Number of In Hospital Deaths	Number of Discharges	Crude Mortality	Alerting Group in most recent SHMI (July'21 to June'22)	Alerting Group in most recent HSMR
Pneumonia (excluding TB/STD)	24	135	15.1%		
Congestive heart failure; nonhypertensive	13	66	16.5%		
Acute cerebrovascular disease	11	76	12.6%		
Acute myocardial infarction	11	129	7.9%		
Septicaemia (except in labour), Shock	11	78	12.4%		
Allergic reactions, aftercare & screening, R codes	7	164	4.1%		
Acute and unspecified renal failure	5	32	13.5%		
Cancer of bronchus; lung	5	21	19.2%		
Other gastrointestinal disorders	4	93	4.1%		
Respiratory failure; insufficiency; arrest (adult)	3	10	23.1%		
Skin disorders	3	62	4.6%		
Gastrointestinal hemorrhage	3	68	4.2%		
Intestinal infection	3	59	4.8%		
Aspiration pneumonitis; food/vomitus	3	16	15.79%		
Others (38 Groups, 2 or less per group)	**52**	**2283**	**2.2%**		
ALL	**158**	**8708**	**1.78%**		

1.2 SHMI (Inpatient deaths plus 30 days post discharge)

The SHMI value published for the period August 2021 – July 2022 is 0.9491. The Trust is now ranked 31st out of 121 Trusts (with 1st being the lowest) across the country and remains within the expected range.



1.3 RWT SHMI trend

Time period	SHMI Value *	SHMI Crude Mortality %
Apr-21 to Mar-22	0.973	2.61
May-21 to Apr-22	0.964	2.53
June-21 to May-22	0.969	2.52
Jul-21 to Jun-22	0.964	2.48
Aug-21 to Jul-22	0.949	2.43

*NHS Digital December 2022

1.4 SHMI in comparison with neighbouring Trusts

Trust	August 2021 to July 2022
The Royal Wolverhampton NHS Trust	0.949
The Dudley Group NHS Foundation Trust	1.144
Walsall Healthcare NHS Trust	1.062
Shrewsbury And Telford Hospital NHS Trust	1.030
University Hospitals Of North Midlands NHS Trust	1.023
Sandwell And West Birmingham Hospitals NHS Trust	1.032

1.5 RWT Diagnostic Groups with higher than expected SHMI*

In the table below, those in red are outliers; those in amber are not outliers but lie just below.

Diagnostic Group (CCS)	SHMI	Expected number of deaths	SHMI 95% CI Lower	Number of patients discharged who died in hospital or within 30 days	Number of mortalities occurring in the hospital	Number of total discharges	Percentage of mortalities occurring in hospital
158 - Chronic renal failure	308.32	4	164	13	6	99	46%
122 - Pneumonia	131.22	263	117.7	345	271	1476	79%
83 - Epilepsy; convulsions	196.2	9	114.2	17	12	519	71%
109 - Acute cerebrovascular disease	126.16	162	109.4	204	163	1020	80%
59 - Deficiency and other anemia	140.28	19	92.4	27	12	727	44%
135 - Intestinal infection	152.88	12	92	19	12	934	63%
107 - Cardiac arrest and ventricular fibrillation	142.35	17	91.2	24	23	36	96%
2 - Septicemia (except in labor)	103.36	212	90.1	219	182	979	83%

*August 2021 to July 2022, Source - HED Summary Hospital-level Mortality Indicator, NHS Digital based SHMI, diagnostic groups with <5 expected deaths are excluded

For the alerting diagnosis groups the following actions are being taken:

- Chronic renal failure – A case note review has been undertaken and a presentation has been presented to the Clinical Pathway meeting in September 2022. Further update has been provided within Section 3: Clinical Pathway meeting.
- Pneumonia – Presented at the Clinical Pathway meeting in January and June 2022 with a further presentation in February 2023 to provide an update on the workstreams currently being worked on and progress made to date on changes implemented. Further detail to be provided in the next report following the presentation to the Clinical Pathway meeting.
- Epilepsy; convulsions – A case note review has been undertaken and the outcome of this is due to be presented to the Clinical Pathway Meeting in January 2023.
- Acute Cerebrovascular Disease – A case note review has been completed and presented to the Clinical Pathway meeting in June 2022 and assurance has been provided on the quality of care given from case note reviews. A further report was provided to Trust Board in October

2022 providing assurance against the metrics, the current challenges faced and an action plan. Further presentation to the Clinical Pathway Meeting in March 2023.

- Deficiency and other anaemia – A coding and clinical case note review is being undertaken for this diagnostic group by the Mortality Lead and Coding Team.
- Intestinal Infection – An internal audit is currently being undertaken to review the coding. Following the review of the coding, follow up actions will be determined on next steps.
- Cardiac arrest and ventricular fibrillation – A coding review is to be undertaken.
- Acute Myocardial Infarction – A coding review has been completed and this diagnosis group were due to present at the Clinical Pathway Meeting in November 2022, however, due to sickness this has been postponed and now are due to present in January 2023.
- Septicaemia - the data is currently being analysed by the Information Team and the Sepsis Lead; this diagnosis group is due to present the findings to the Clinical Pathway Meeting in February 2023.

NHS Digital and HED data is reviewed monthly to identify any alerting or near to alerting diagnosis groups.

2. Directorate Learning / Feedback

The January 2023 Mortality Review Group meeting was stood down due to operational pressures. At the Mortality Review Group meetings in October, November, and December 2022 the following Directorate Learning and Feedback has been presented:

Renal

Renal presented two cases to MRG in October 2022. An SJR identified overall poor care as earlier palliative care should have been provided as well as anticipatory medication, poor communication and the respect form was incomplete. The case was discussed at the department mortality meeting and feedback was given to all staff of the importance of completing all aspects of the respect form. The directorate felt the poor care rating was harsh since the patients symptoms were reviewed regularly during daily ward rounds and the patient had no specific symptoms and the patient was stable. Anticipatory medicine was not required until when the decision was made that this patient is at end of life. Further palliative input was not sought earlier since the patient was felt to be at baseline and had no symptoms to address. Even though the pushback from the directorate regarding the care rating was fair it was raised by the chair that the level of care can only be determined based on the notes and therefore the rating remained, and the learning was taken back to the Directorate.

The second case presented was in relation to a death which had an overall poor care rating and had been referred to the coroner. The coroner feedback outlines the death was due to a complication arising from a necessary medical procedure. The directorate have reviewed the case and agree the death was tragic, however, all protocols were followed with treatment being prompt and appropriate at every stage of management and the patient had consented to the procedure. The learning taken away from this case was to consider whether medical management of hyperkalemia (including using the potassium lowering medications) to avoid doing a difficult line out of hours would be an option in some cases and to ensure the person being asked to do the procedure is fully competent and signed off or ask if ITU doctors can help with dialysis lines out of hours. In this case the person who did the line was signed off for temporary lines and had support from an ITU registrar, however, further discussions are ongoing within the directorate.

Diabetic Medicine

The Diabetes team presented one case to MRG in November 2022. The case presented had been rated as adequate in all individual phases of case, however, overall had a poor care rating due to

concerns raised by the nutrition team. The review of the case identified learning since there were issues with documentation and management of PIC lines and output charts were not correct. Further feedback to the directorate has been given in relation to discussions and involvement of the nutrition team and gastro team. It was agreed this case should be discussed at the next Mortality Reviewers meeting for further discussion and possible recalibration.

Older Adults Medicine

Three cases were presented at the December 2022 MRG in relation to Older Adults Medicine. In the first case, the SJR raised concerns regarding the lack of observations between 12pm to 5:30pm, delays in arranging the group and save and issues around resuscitation. The case identified learning including an unexpected laboratory result which should have prompted an urgent re-assessment of the patient including observations and NEWS2 calculation and the availability and consideration of blood products at Cannock are to be communicated to the team. Following discussions of the case it was agreed that an incident should be raised as there were omissions in care which led to a degree of harm.

The SJR in the second case found there were lots of aspects of good care, but the fracture was missed which delayed the Trauma and Orthopaedics review. The case was discussed at the directorates mortality and morbidity meeting. The case identified learning was to reiterate to junior colleagues the importance of reviewing the joints above and below the reported areas of injury. Further in patients with cognitive decline, whether its dementia or learning disabilities it was agreed there is benefits to screening more fully. The learning from the case is to be shared with the T&O team.

The SJR review in the third case related to ED and ongoing care, particularly around a missed fracture and the delay in placing the patient on the metastatic spinal cord compression pathway. The case was discussed at the directorates mortality and morbidity meeting. This is a historic case and the directorate now routinely use gold standard framework and prompts to help with decision making. Further learning taken away from this case is having a support process for new or returning consultants. The learning in this case will be shared with the Oncology team.

3. Clinical Pathway Meeting

There have been two Clinical Pathway Meetings held during the reporting period focusing on Chronic Kidney Disease (CKD) and Heart Failure.

3.1 Chronic Kidney Disease (CKD)

The Clinical Pathway Meeting on 22nd September 2022 focussed on CKD. Dr Manivarma Kamalnathan presented the following update:

- The current level of the SHMI for the period March 2021 to February 2022 shows ICD Diagnosis Code 156 (Nephritis, Nephrosis and Renal Sclerosis and 158 (Chronic Renal Failure). The expected number of deaths was 7 and the observed deaths were 16 with a total number of discharges of 304. The SHMI was 210.12.
- A case note review was undertaken looking at whether the primary diagnosis was accurate or if there were problems with the care provision and alternative options for caring the patient in the community avoiding hospital admission.
- The 16 deaths included 8 deaths in hospital and 8 in the community. It was established the primary diagnosis was recorded incorrectly in majority of these cases. There were no problems with the care provision and all patients had respect forms. It was established that two patients that had passed away in hospital had advanced CKD 5 and could have been managed in the community.

CKD Action Plan

1. Head of Clinical Coding to send monthly data so that the Renal team can proactively undertake death validation
2. Information Team to undertake an analysis to review the trend of CKD admissions for 156 and 158 diagnosis groups over the last three years so the trend for complex infections or whether the patients have CKD can be reviewed.
3. It was agreed the CKD team would present a further update to the Clinical Pathway meeting in relation to the palliation side of the process.

3.2 Heart Failure

The Clinical Pathway Meeting on 24th November 2022 focussed on Heart Failure and a summary has been provided below:

- The crude mortality for heart failure is seeing a downward trend and has reduced from 14% to 13%. It is still above the National Heart Failure audit of 9% although the data is not strictly comparable.
- The SHMI is 108.42 for the period July 2021 to June 2022 and is no longer alerting.
- The National Heart Failure audit is showing improvements from 2017 to 2021. The team are capturing patients with heart failure assuming they are the right patients and adding to the register. 55% of patients are seeing a Consultant Cardiologist which is higher than the national average of 47% and 81% of patients are having input from a specialist from the heart failure team including nurses versus a national requirement of 83%.
- The Heart Failure team have seen improvements in medication from pre-pandemic figures to now. Partly this is due to good care and have the time to review patients co-morbidities. The improvements made in medication is improving quality of care in patients which is correlating with the reduction in the SHMI.
- The Heart Failure team presented a number of challenges at the previous Clinical Pathway meeting update in relation to ECHO, Nursing Service, Death Validation and In-Reach. The update on each of these areas is as follows:
    - ECHO - Cardiac investigations has many vacancies and sickness which is a challenge for the team. A “Quick Look” Trial was undertaken, however, it did not demonstrate the benefits expected. Heart Failure team are continuing to triage all IP referrals so that patients are prioritised according to clinical urgency. Recruitment remains a challenge, however, consideration is being given to apprentice echocardiographers outside national programme.
    - Nursing Service – Additional nurse allocated to in-reach and a new experienced nurse has been appointed. Gap analysis undertaken as long waits for nurse led clinics.
    - Death validation – case note reviews of patients coded as died with Heart Failure undertaken to review accuracy
    - In-Reach – increased nurse and senior doctor input and additional consultant recruited now.
- Overall, the data and performance has improved despite the challenges.

Heart Failure Action Plan

1. Heart Failure business case for 7-day service

3.3 Same Day Emergency Care Activity (SDEC)

An internal analysis was undertaken to estimate the impact to the SHMI if SDEC activity was removed. Following the analysis, it was established as a worst case scenario the effect of excluding SDEC would be an increase in SHMI from 0.964 to 1.101 when analysing July 2021 to June 2022 SHMI data. However, this modelling is only for RWT therefore this gives a worst-case scenario as it assumes other Trusts data will not change. Although this is slightly higher than the current SHMI it is likely the Trust will remain in the expected range banding. Further it was estimated that 12 diagnostic groups may have a higher than expected SHMI, however, all the groups are either current or have recently been outliers therefore they are being actively monitored as part of the mortality/learning from deaths process.

4. Medical Examiner Service

In Hospital Deaths

The percentage of deaths reviewed by the Medical Examiner (ME) over the last three months is as follows:

- September 2022 – 92%
- October 2022 – 93%
- November – 98%

The percentage of cases that had an ME assessment which included discussions with bereaved families/carers in consistently reaching over 95%.

Community Deaths

The roll-out of the current Medical Examiner Service out into the community is progressing on target and will be statatory from April 2023. RWT now have 37 GP practices/Hospice referring into the RWT Medical Examiner service and initial meetings are continuing with wider PCNs to expand the rollout further. There are a remaining 12 GP practices to come on board from the Wolverhampton/South Staffs area and it is planned for all to come on board in January/February 2023.

Detail regarding the number of community deaths reviewed by the RWT ME Service and contacts with bereaved over the last three months has been provided below:

	September 2022	**October 2022**	**November 2022**
Community Deaths - ME Scrutiny undertaken	**63**	**62**	**87**
% of community deaths scrutinised by an ME that have had a discussion with bereaved families/carers	**84%**	**92%**	**91%**

Other Medical Examiner Updates

The Trust is waiting on updates from the Regional team regarding the requirment for the ME assessments to be completed on a national digital system. Once the Trust has had sight of this, we will develop processes how this system will work complimentary and in parallel to the internal Learning from Deaths IT Platform.

The Trust has been informed by the National Medical Examiner bulletin that there is an intention to to remove the requirement to complete form Cremation 4 (part 2) when the statutory medical examiner scheme is in place in all settings. RWT have had no further correspondence regarding this or estimated timelines. The National Medical Examiner office will provide updates to the funeral sector as the implementation of the statutory medical examiner scheme progresses and they move to remove form Cremation 4 in legislation.

5. Mortality Reviews - Structured Judgement Reviews (SJRs)

As at 10th January 2023, outstanding SJRS for in hospital deaths is as follows:

- 67 SJR1s outstanding of which 19 are outstanding with a date of death more than 8 weeks ago
- 5 SJR2s outstanding of which 2 are outstanding with a date of death more than 8 weeks ago.

The Mortality Review SJR process has now been rolled out into RWT PCN practices. The Trust has begun using a selection criterion in the same way for in-hospital deaths (as per Learning from Death Policy OP87) for Mortality Reviews. This selection criteria began in April 2022 however, due to the Mortality Reviewer having access issues to EMIS to undertake the review it has been delayed. All issues have now been resolved and 25 reviews have been undertaken. The outcome of the reviews is to be presented to MRG in February 2023 and an update will be presented in the next report.

As at 10th January 2023, outstanding RWT PCN SJRs is as follows:

- 8 SJR1s outstanding of which 6 are outstanding with a date of death more than 8 weeks ago.

6. Learning from Deaths (LfD) IT Platform

The Learning from Deaths IT Platform was rolled out successfully on 1st December 2020. Phase 1 of minor changes requested have been released into the 'live' LfD system in July 2022. Phase 2 of the changes which will incorporate the out of hospital deaths within the system and this work is due to commence in January 2023.

The Royal Wolverhampton NHS Trust

Trust Board

Meeting Date:	7th February 2023
Title:	Quality Improvement (QI) update Q3
Purpose of the Report:	The report provides an update on the activities of the Quality Improvement team over the last quarter.
Action required:	Receive for assurance
Assure	• Over 120 staff have received QSIR training during 2022 with extremely positive post evaluation feedback – see pg 5. • The QI action plan has been signed off by the Improvement, Innovation and Research Group (reporting into the Joint Committee Steering Group) • Division 1 leadership team and directorate triumvirates are the first to undertake a bespoke one-day Fundamentals in QI (20-01-23). This will be offered to all Divisions during the coming year and is part of the QI action plan. • Capacity has been identified to train 300 staff during 2023 • The work on introduction of the liver bundle in the Emergency department has built on the success of the project in AMU and is delivering sustained improvements in outcomes. The work has recently been published in The British Journal of Nursing.
Advise	• There were 2 appointments to the clinical lead posts in the last quarter with Dr Richard Morse supporting Division 1 and Dr Raj Pitchika supporting division 3. • A joint celebration and awards event (with the QI team from WHT) is planned for July 2023 whereby staff will submit QI work (poster format) and selected projects will be presented on the day. • Learning from a number of projects continues to emphasise the importance of triumvirate sponsorship to ensure multidisciplinary engagement.
Alert	• The pressures on emergency care have continued to build through the last quarter in common with most other organisations around the country. This has stalled formal QI work with the Emergency Services teams and other Directorates across the Trust with several meetings stood down to release staff to deal with the operational pressures.
Clinical implications and view	N/A
Patient, carer, public impact and views	N/A
Author + Contact Details:	Dr Lee Dowson – Associate Medical Director for Quality Improvement Tel 01902 695243 Email leedowson@nhs.net
CQC Domains	1. To have an effective and well-integrated health and care system that operates efficiently 2. Seek opportunities to develop our services through digital technology and innovation 3. Attract, retain, and develop our staff, and improve employee engagement 4. Deliver a safe and high-quality service 5. Operationally manage the recovery from Coronavirus to achieve national standards 6. Maintain financial health – appropriate investment to patient services

Trust Strategic objectives 	**Care – Excel in the delivery of care**	☒
	Colleagues – support our colleagues	☒
	Collaboration – effective collaboration	☒
	Communities – improve the health of our communities	☐
Resource Implications:	None	
Report Data Caveats	None	
Equality and Diversity Impact	None	
Risks:	None to note.	
Risk register reference:	N/A	
Other formal bodies involved:	None	
References	None	

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Quality Improvement Update

Quality Improvement Team

Kate Salmon - Deputy Chief Strategy Officer - Improvement & Collaboration

Dr Lee Dowson - Associate Medical Director for Quality Improvement

January 2023

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Contents

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Executive Summary

Assure:

- 44 members of staff have completed QSIR Practitioner and 83 completed QSIR Virtual in 2022 (Pg 4) with excellent feedback allowing ongoing improvement of the courses.
- A community of practice is being developed to support staff undertaking QI work post training with initial meetings held in Wolverhampton and Walsall to co-create it. (Page 6 and 7)
- A bespoke QSIR fundamentals training day has been organised for the division 1 directorate triumvirates on 20/1/23 sponsored by the divisional team.
- Capacity has been identified to train 300 staff in 2023
- Work to reduce length of stay at Cannock including cryotherapy and enhanced recovery is delivering statistically significant flow and patient benefits Pg 9
- The work on introduction of the liver bundle in the Emergency department has built on the success of the project in AMU and is delivering sustained improvements in outcomes. The work has recently been published in The British Journal of Nursing. (Pg. 13)
- The QI action plan has been signed off by the Improvement, Innovation and Research Group (reporting into the Joint Committee Steering Group)

Advise :

- There were 2 appointments to the clinical lead posts in the last quarter with Dr Richard Morse supporting Division 1 and Dr Raj Pitchika supporting division 3.
- A celebration event is planned for July 2023 whereby staff will submit QI work and selected projects will be presented.
- The Medical Directorate continues to engage with the Right Patient, Right Place programme but there are limited examples of changes being tested and only modest gains in the flow metrics at this stage.
- Learning from a number of projects continues to emphasise the importance of triumvirate sponsorship to ensure multidisciplinary engagement.

Alert:

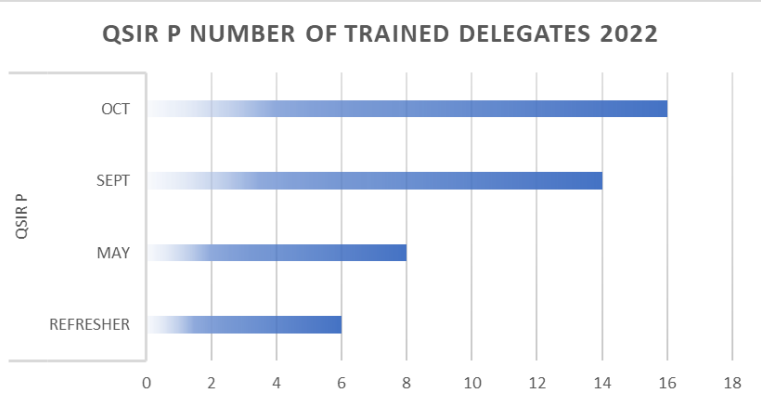
- The pressures on emergency care have continued to build through the last quarter in common with most other organisations around the country. This has stalled formal QI work with the Emergency Services teams and other Directorates across the Trust with a number of meetings stood down to release staff to deal with the operational pressures.

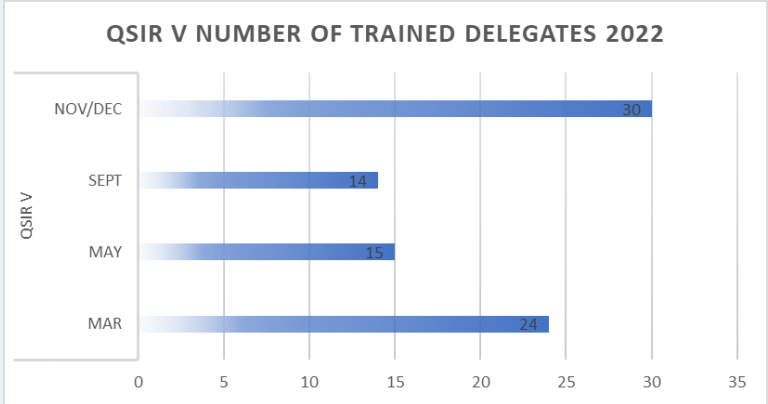
Quality Improvement Team

The Royal Wolverhampton NHS Trust

Capacity & Capability

- 2022 has seen the relaunch of face to face training with the 5 day QSIR Practitioner and the online QSIR virtual course being completed by 127 colleagues. (*NB – below indicates the beginning of each cohort and numbers, face to face training has continued throughout November and December).
- We have two new members of the team, a Project Manager (B6) and Project Officer (B5) who will provide additional 'hands-on' support to Directorates in the implementation of their QI projects.
- The team are aiming to deliver QSIR training to 300 colleagues during 2023 through additional QSIRP cohorts, an additional one day fundamentals course and a bespoke QI training programme for colleagues working within Estates & Facilities.





Quality Improvement Team

The Royal Wolverhampton NHS Trust

Capacity & Capability

The team have been delighted with the QSIR P post course evaluations which provides valuable feedback that has been incorporated into future training plans; it is also encouraging that participants have used their new found skills with their teams e.g. a QSIR Practitioner has used the tools to facilitate a Process Mapping session at an Audiology Away Day.

A very valuable day Lots of learning but made real with live examples. Great sessions, great delivery – will definitely recommend to colleagues

The Course has been FANTASTIC. The facilitators have applied the knowledge to practice and have allowed discussion that has helped my learning

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Capacity & Capability

Developing a Quality Improvement Community of Practice

The team have been consulting with colleagues who have completed the 5-day QSIR Practitioner Course on the benefits of establishing a Community of Practice for Quality Improvement.

The following benefits have been identified:

- Shared learning and knowledge – avoiding solving the same problems that others have solved before
- Create a shared purpose, sense of belonging and community spirit
- Tap into and harness tacit knowledge
- Keep people engaged with QSIR and the QI team
- Capturing and understanding impact – cultivating the changes that are taking place across the organisation and developing QI capability at all levels
- Devolving ownership of QI to individuals and teams, therefore contributing to the spread and sustainability of QI

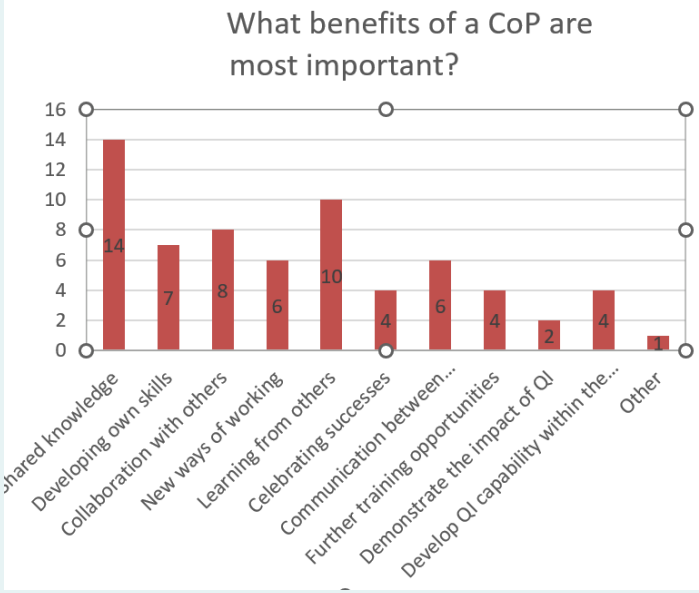
Quality Improvement Team

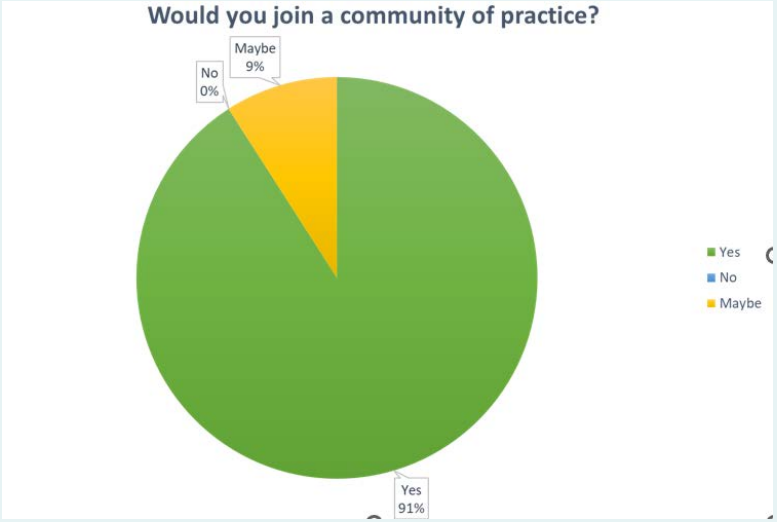
The Royal Wolverhampton NHS Trust

Capacity & Capability

Developing a Quality Improvement Community of Practice

In Quarter 4 we will be developing and testing an online platform for the community to access and share knowledge, as well as planning to deliver a launch event for the community.





Quality Improvement Team

The Royal Wolverhampton NHS Trust

Team Events & Away Days

Team Away Day	Themes	Outcomes
Capacity Services Away Day 13th 14th October 2022	• Process • Workforce • Communication / Branding	• Three clear workstreams identified with clear clinical operational leadership • Monitoring of progress established at directorate level
Women's and Neonatal Leadership Away Day (recommended following a Deloitte review into culture and ways of working)	• SWOT analysis of the current service • Developing a strategy for the service • Defining aims and objectives of the service	• A draft strategy has been produced. There will be a consultation process for staff and patients to contribute to/comment on the strategy; key to this is strengthening relationships and MDT working.
Division 1 Management team and Directorate Triumvirate's bespoke QSIR Fundamentals Training 20th January 2023	• One day course providing an introduction to quality improvement methodology and tools which can be implemented in their local area to drive improvements.	• Develop QI knowledge & skills • Application of QI methodology, tools and techniques • Sharing own experiences of leading improvements and learning from others • Increase QI capacity and capability and to encourage others to undertake further QSIR training within the Division.

Quality Improvement Team

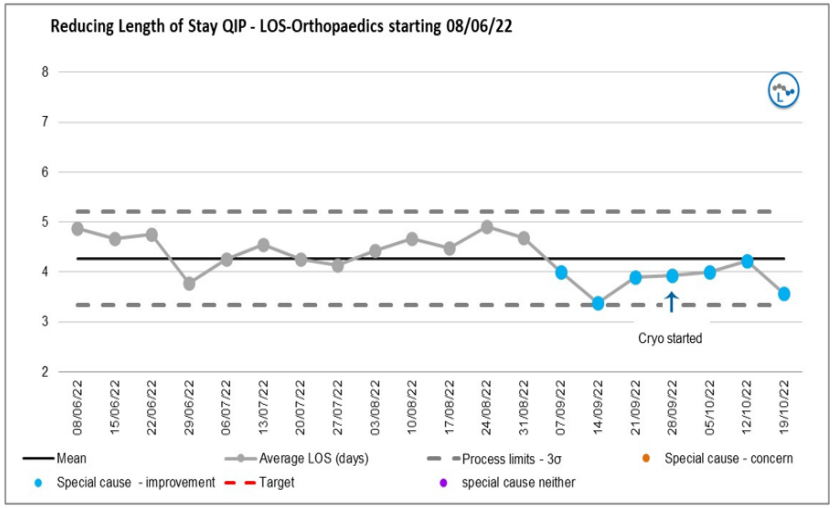
The Royal Wolverhampton NHS Trust

Theme 2 – Patient Flow

Division 1 Flow Workstreams

Reducing Length of Stay for Primary Hip and Knee replacements at Cannock Chase Hospital through the use of cryotherapy

The project is testing the use of cryotherapy in 200 consecutive primary knee replacements with the aim of reducing length of stay and improving post operative pain management. The initial data from the week commencing 28/9/22 – 19/10/22 shows the length of stay has reduced from an average of 4.1 days to 3.9 days. The data is also showing a reduced need for post operative pain management e.g. the average use of codeine (60mg dose) has reduced from 14.1 to 6.5 doses. An enhanced recovery programme also started just prior to this PDSA; the team are working to confirm which change had the most significant impact on LOS.



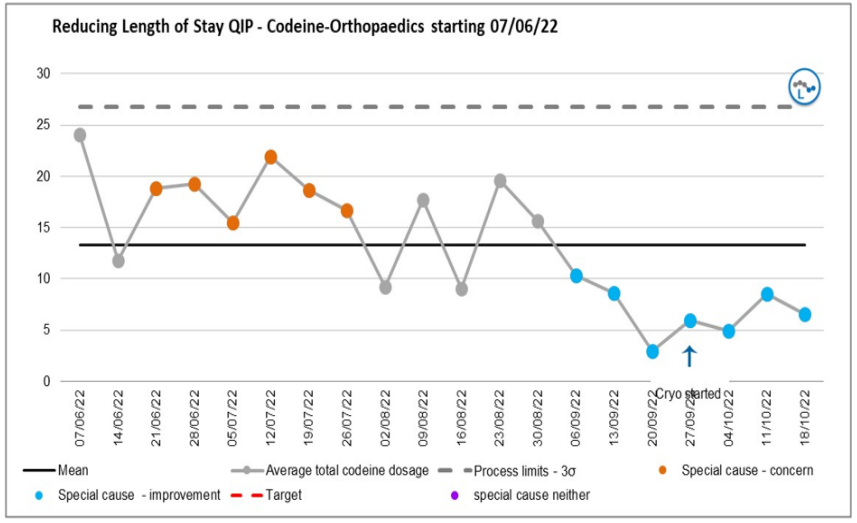


Fig 1 SPC Chart – reducing length of stay for primary knee arthroplasty

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Theme 2 – Patient Flow

Division 2 Flow Workstreams with operational team engagement are below - Focus continues to be on projects that expedite earlier in the day discharges and reducing length of stay;	
Right Patient – Right Place	The Right Patient Right Place programme continues with wide representation from directorates across the Division to support the programme. The QI team are supporting directorates with huddle observations and constructive feedback to identify and support teams with opportunities to expedite earlier in the day discharges. As previously reported, outcomes from this programme will take more of a longer term to realise.
Huddle Tool	Huddle constraint refinements are active and are being utilised by the patient flow team. Huddle reasons are shared across the operational leads in the organisation on a weekly basis and reported to the Non-Elective Flow Improvement Group (NEFIG) on a monthly basis for review and discussion. The QI Team are supporting the Paediatric directorate with the launch of the huddle tool expected in January 2023. The team will support the introduction of the tool in huddles and how the team can improve their data depth and quality by utilising the tool as part of their unit huddles going forward.
Ambulance Receiving Centre (ARC – formerly Ambulance Offload Project)	The QI Team and Division 2 Service Improvement Partner continue to support this project where required.
Criteria-Led Discharge Trial	Criteria Led Handover was implemented on 14 Nov 22 and expanded to out of hours on 2 Dec. Metrics show a clear reduction in time between bed assigned and bed occupied. Feedback received is that staff are pleased with the new process. There is a small working group with nursing representation from each area to review all nursing documentation with a view to streamline and reduce duplication.

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Theme 2 – Patient Flow

Division 2 Flow Workstreams with operational team engagement are below - Focus continues to be on projects that expedite earlier in the day discharges and reducing length of stay;

Older Adult Medicine -Huddle Support - Fairoak

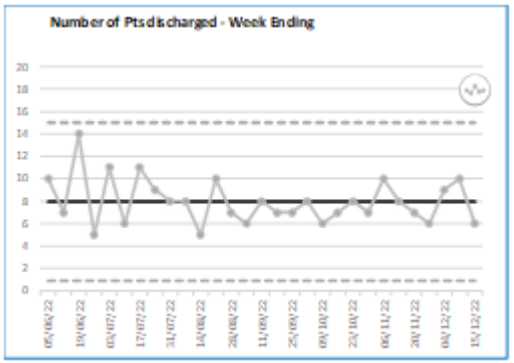
During July 2022 the senior nursing team on the Fairoak Ward encouraged external observations and a review of practice at huddles to try to improve both patient flow and staff experience. Huddle observations took place in July 2022.

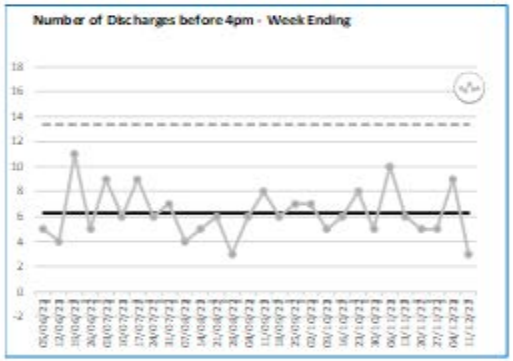
Plan - The team on Fairoak reviewed current practices and identified interventions which could positively impact the time that the team use to huddle. Changes introduced led to greater consistency of action focused huddles, and overall, the team felt changes during the project had a positive impact on patient flow, as well as on efficient ward team working.

Do - The team discussed the observation feedback and saw room for improvement. During the period of August – October 2022 the team introduced a number of changes;

1. Review of Huddle Board format to make it more action focused - record tasks, owner and when to be completed.
2. Introduction of early-afternoon post-huddle action progress check.
3. Consultant presence on the ward to support complex MDT patients.

Study –





Act – Whilst data does not suggest a statistically significant change at present, the team continue to review progress and develop their aim, with a focus to reduce the number of late arrivals (post 6pm) to the Fairoak Ward. Data will be reviewed with the team on a quarterly basis to understand changes in performance.

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Theme 2 – Patient Flow

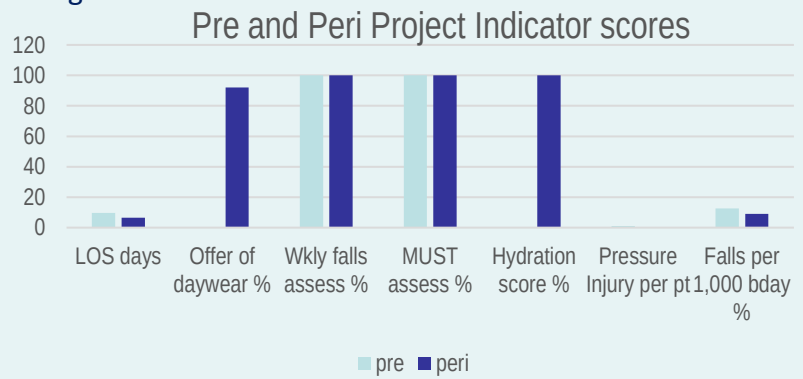
Division 3

End patient Deconditioning (#End PJ Paralysis)

Project Aim:
Reduce the number of patients remaining in bed (where applicable) by 10% on C19 by end February 2023
Increase the number of patients wearing daywear (where applicable) by 10% on C19 by end February 2023.

Successes and Lessons Learned :

- Successes (Key indicators displayed as bar chart attached)
- Data shows more patients were sitting out during project on ward C19
- Length of Stay was at 9.7 days prior to project, this reduced to 6.4 days on ward C19 during project
- Suitable footwear was assessed and used pre and peri project
- Offering patients daywear 0 % baseline 92% peri project
- Falls assessment remained 100% pre and peri project
- Weekly falls assessments remained at the 100% baseline during project
- MUST assessment remained at 100% pre and peri project
- Patient access to fluids 66% baseline increased to 100% peri project
- Hydration scores? % pre project increased to 100% peri project
- Pressure injury pre project x1 incident reduced to 0 incident peri project
- Falls per 1,000 bed days 12.5% pre project reduced to 9% peri project
- Improvement in Multi-disciplinary team working



Quality Improvement Team

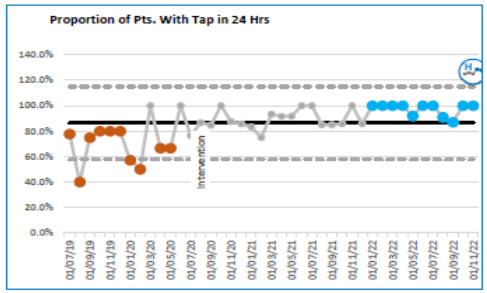
The Royal Wolverhampton NHS Trust

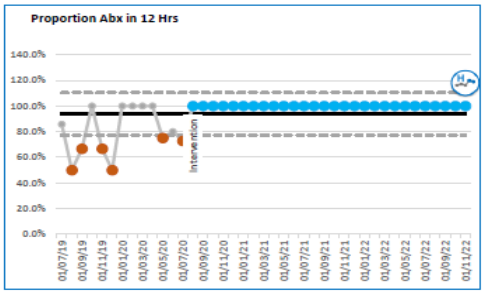
Theme 3 – Patient Safety

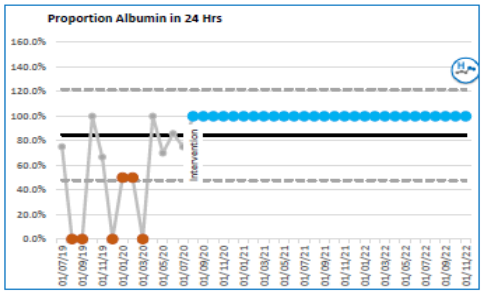
Learning from accurate data from mortality, benchmarking and governance systems, and aiming to reduce unwanted variability the team continue to support staff to deliver a safer service. Projects falling within this work stream include:

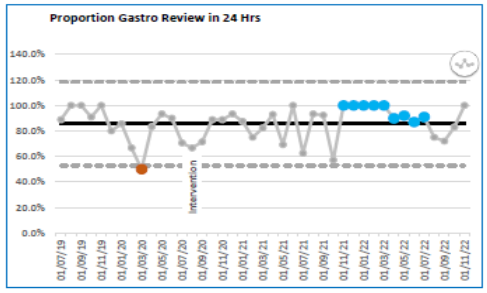
Decompensated Liver Bundle in ED

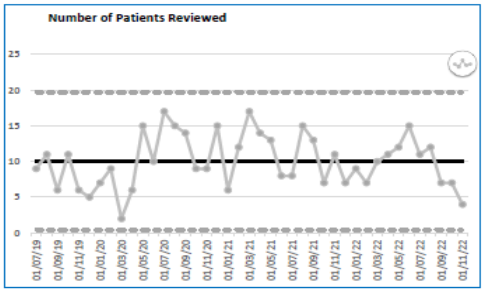
The introduction of the Decompensated Liver Bundle within the Emergency Department took place in December 2021 as an extension of the work that the team had undertaken to introduce the bundle for patients in AMU. Initial data (December 2021 – May 2022) suggested an improvement in the percentage of patients receiving Decompensated Liver interventions whilst in the Emergency Department. The chart below demonstrates the overall increased use of the cirrhosis bundle across the Emergency Portals and the performance against associated targets.

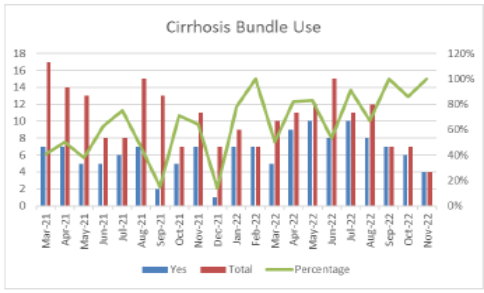












The team continue to meet to discuss data capture and review performance, and to maintain education packages to support training and awareness for ED staff on the bundle.

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Theme 3 – Patient Safety

Division 1 QI overview of Patient Safety Projects	
Planned Obstetric Surgery Improvement Project	. QI Project Brief has been signed off. Dr Nina Johns will be leading the project, which aims to reduce over running of Obstetric operating lists by 50% by December 2023. There are two interventions that will be tested: Introduction of a complexity scoring system for planned obstetric surgery Implementation of an electronic planned obstetric surgery booking system
Improving Phlebotomy Pathway in Ante Natal Clinics	A process mapping session will be organised, following a blood sampling error RCA and several unreported near misses. The process will help understand the current state and identify areas for improvement (session was due to take place on 25/10/22 but was cancelled due to CQC visit).

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Areas of Focus January – March 2023

The team are currently supporting projects / work programmes across the organisation however key areas of focus over the next 3 months include:

Capability & Capacity	• Finalise planning of bespoke Estates and Facilities QI programme • Collaborative working with QI colleagues in Walsall to finalise plans for a QI awards and celebration event to be held in July 2023
Division 1	• Reducing Length of stay for primary hip and knee replacements - In Quarter 4 the QI team will be facilitating a cause-and-effect workshop with key stakeholders to create a driver diagram for reducing length of stay and to develop a portfolio of Quality Improvement projects to reduce length of stay for primary hip and knee replacements
Division 2 – Patient Flow	• Supporting ED programmes of work. • Provide input into Right Patient Right Place initiatives with a focus on Earlier in the Day Discharges. • Undertake Huddle Observations with feedback and support across Division 2. • Continue to support workstreams from the Stroke Away Days supporting operational teams with ongoing actions.

Areas of Focus January – March 2023

January – March 2023 Cont….	
Division 3	• Deep dive into the Acute paediatric service with triangulation of data to identify opportunities for improved efficiencies particularly focussing on productivity gains, an action plan will be developed as a result of this work • Commencing Paediatric Huddle tool implementation A21 • Completion of QIP support for Rheumatology medical staff project • Paediatric outpatient DNA and caseload risk stratification work to commence February • Podiatry and Orthotics DNA and devices projects working groups to commence February (data collection completed) • Paediatric surgical information leaflet project completed awaiting Governance sign off to move to next stage • Nutrition and Dietetics Wellbeing project support provided with bespoke QSIR training and project formatting undertaken, data collection commenced on all sites

Trust Board Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee:	Quality Governance Assurance Committee
Date(s) of Committee Meetings since last Board meeting:	Meetings since last Board meeting: 25th January 2023
Chair of Committee:	Louise Toner
Date of Report:	27th January 2023

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	**Matters of concerns, gaps in assurance or key risks to escalate to the Board** **Cancer Improvement Plan** Cancer metrics remain challenging with improvements in 2 week waits but less so for 28 and 62 week waits. However, it is an improving picture in all breast waiting times. Histopathology turnaround times continue to contribute to the overall delays in the improvement plans particularly for patients waiting for 28 and 62 weeks. Discussions are ongoing to try and improve this situation through prioritizing requests. MRI and CT metrics are improving but ultrasonography remains a challenge given the ongoing workforce shortages in the group. Mutual aid continues in the areas where this is possible, however, despite seeking national aid for patients with a Renal Tumour this is not available due the shortage of expertise in the area. Services are experiencing increased referrals, especially during periods of advertising associated with regarding a particular tumour site A lead cancer nurse is now in post and a medical lead will follow. **Ambulance waits and ED Breaches** These remain a concern across the NHS and has been particularly challenging over the festive period because of strike action by Paramedics and an increase in patients with Flu and other respiratory conditions. However, the additional ARC facility that is now fully operational is providing additional spaces for ambulance “drop offs” has proved to be successful. The “Push Model” continues to be used to improve patient flow through the system. Further, expansion of community services and the virtual ward is helping, to an extent, with these services continuing to expand facilitating where possible admission avoidance.

Staffing levels

Staffing level concerns continue to be identified across all of the divisions; however, more staff are in the pipeline which will improve the situation. Ongoing challenges with overseas recruitment in terms of visa's etc., are being managed as much as they can be given that most of the issues are not within the Trust's gift to resolve.

Sickness rates, maternity leave and retention rates are contributing to the overall situation in ensuring there is sufficient staff available to provide safe care. However, there has been some improvement in these metrics

Medicines Management

AS per previous reporting there are challenges remaining however, these are being addressed through the Medicines Management Group with work ongoing across RWT and WHT to improve storage and policy compliance. Further, a QI project is in operation.

ADVISE **Area's that continue to be reported on and/or where some assurance has been noted/further assurance sought**	The numbers of medically fit for discharge patients – now termed Criteria to Reside patients continues to add pressure to ambulance waits and ED breaches. However, a huge amount of activity has taken place with ward staff in respect of patient discharges and use of the Discharge Lounge. This together with some Winter Plan related funding to facilitating packages of care in place to facilitate discharge. Discussions are ongoing regarding supporting care homes with accessing staffing through the RWT Bank staff, however, the challenges re the terms and conditions and funding of services continues. Sepsis compliance for ED and inpatients is showing continued improvements as are the Stroke related metrics. Despite significant amounts of time and input through a range of staff and activities, including through the Friday "Back to the Floor" initiative, observations on time are not meeting the set targets. However, the changed methodology is sound and a much better indicator than that previously used. More targeted work is continuing with those areas failing to meet the target. There has been a slight increase in the number of falls occurring within however, within set tolerance levels. Smoking rates at the time of delivery have risen and it is hoped access to additional funding will assist in improving this metric, however, this will take time to improve and is a public health initiative to reduce smoking but across all groups . Induction of labour rates have increased, and this is now a QI project. Birth rate numbers are increasing, and this is subject to ongoing review. The report on the recent CQC visit to the maternity services has now been published with actions ongoing to meet the requirements set out in the report and in particular changes have been made to the triage service and discussions are taking place to review triage across RWT and WHT to further improve the service. From an infection control perspective, the increased incidence in CDiff continues, a picture that is apparent across the country. A range of actions to manage the situation and reduce the incidence are in place. A review by a Regional IPC Lead is planned to take place in the very near future to provide external view on anything else that could be undertaken. Further the IPCT are actively involved with ward and departmental staff to provide advice and guidance to assist in reducing the upward trajectory of CDiff cases. QSAG Report The paper provided a Trust overview with reports on the highlights from each division. A range of discussions took place regarding each of the divisions together with consideration of the: 104-day Harm Review – 52 patients affected: however, no physical or psychological harm was identified. It was noted that now the lead cancer nurse is in post the 104-day process will be reviewed.

	It was reported that there has been an increase in Serious Untoward Incident actions being completed. Further it was noted that Audit compliance was low in some areas. However. It was explained that this is not unusual at this time of the year, and it was anticipated this will show improvement as the year progresses. Discussion took place around the CQC self-assessment report Other issues identified are discussed where appropriate in other parts of this report. .

ASSURE Positive assurances & highlights of note for the Board	The Trust CNST submission was received that identified compliance in all areas. The submission had been reviewed by the LMNS who supported this; however, it was agreed before final submission to the CEO for "sign off" That the Director of Nursing would review the submission to further confirm compliance. Stroke metrics are showing continued improvement Comprehensive QI report, with a number of reviews in place that are showing improvements. 1 to 1 in care in Labour has been maintained despite ongoing staffing challenges
Recommendation(s) to the Board	There were none

Changes to BAF Risk(s) & TRR Risk(s) agreed	There were 4 new risks this month and 2 risks have been removed from the Trust Risk Register: **4 New Risks** 5482 – Emergency CT Brain scanning in ED 5610 – Increase in Haemodialysis numbers 5671 – POCT manufacturer contracts due to expire 5961 – Shortage of ICCU Consultants **2 Risks removed** 5681 – Radiography Workforce Levels at Critical Level 4472 – Delays in timely assessment and treatment in ED **8 Red Risks** 5849 – Reduced scan capacity in Fetal Medicine Department 5802 – Div 2MFFD patient numbers 5246 – Lack of Consultant cover within Cancer Services 5610 – Increase in Haemodialysis numbers 4900 – Histology cases breaching turnaround time targets 4596 – QS 104 – Gallstone Disease 5388 – Mental Capacity Assessment **Risk Changes** 1984 – Backlog of Ophthalmology Review patients – moved to amber from Red 5849 – Reduced Scan Capacity in Fetal Medicine Departed – moved from Amber to Red **Awaiting Removal from Register** 5536 – Provision of Mental Health Beds Changes in the risk register were discussed to clarify how and why some of the decisions were made and if a risk was increased had there been any related harm that led to the escalation. For example – Reduced scan capacity in fetal medicine where members were advised what had been put in place to mitigate the risk – additional externally sourced sonographers to provide assurance to members. In respect of the Board Assurance Framework, the new, still, draft template for reporting was again used and members advised that moving forward risks will be visible in real term following the implementation of Datix QI – anticipated to be in December 2023 at RWT and April 2023 at WHT. This would enable any issues to be discussed and reviewed in real time. Detail information was provided on the new framework and each of the 3 confirmed risks and the new risk that is still in draft format, of which 2 are red risks:

	SR 15 – Finance related - has been reviewed SR 16 – Performance Related – is being reviewed SR 17 – Equality related – has been reviewed SR 18 – Cyber Security Related - is currently being populated .

ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, changes to Work Plan)**	All of the reports that were for noting/information/assurance were discussed. No further actions were identified.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	Cancer Improvement Plan Trust Risk Register and Heat Maps Board Assurance Framework Integrated Quality and Performance Report Quality and Safety Advisory Group Report CQC Compliance Internal Self-Assessment Report External Reviews Registry Update Report Health and Safety Update Report Quality Improvement – update Report Mortality Quality Improvements – Learning from deaths WARD to Board – CNST approval for CEO “sign off” Draft QGAC Terms of Reference

ACTIVITY SUMMARY Major agenda items discussed including those Approved	A range of discussions took place as identified in the sections above.
Matters presented for information or noting	Health and Safety Report CQC Compliance Internal Self-Assessment Report Quality Improvement Q3 update External Reviews Registry Update report
Self-evaluation/ Terms of Reference/ Future Work Plan	The Terms of Reference were discussed, and a few amendments made including to further review membership to include members who attend regularly in the own right but who may also deputise for more senior colleagues. A plea was made to ensure the authors of papers identify in full an acronym with the abbreviation in brackets to be used thereafter. Members felt that working these out was quite a challenge in some instances they were not able to locate the definition using search engines. A similar request was made to ensure nothing is embedded into papers as these cannot be opened so members are unable to access. The same applies to excel spreadsheets with multiple tabs as the tabs are not accessible. Members acknowledged all of the hard work of staff especially during the festive period and colleagues were asked to convey the committee's thanks for this.
Items for Reference Pack	

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Chief Nursing Officer and Director of Nursing Report
Purpose of the Report:	Regular report to advise members on updates from the Group Chief Nurse and Trust Director of Nursing for assurance.
Action required:	**Receive for assurance**
Assure	• There were no Trust-attributable Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia in November and December 2022. • The Trust continues to plan and execute monthly recruitment events with a dedicated recruitment event held in November 2022 at Cannock Chase Hospital (CCH) and the next event at New Cross Hospital on Saturday 21st January 2023, for all specialities.
Advise	• The Trust is unable to present Nursing and Midwifery workforce data this month due to national issues with the ESR Business Intellingence administration system affecting the ability to access reporting functionality. • Care Hours Per Patient Day (CHPPD) has increased in November to 7.6 and again in December to 7.7. • 133.9 WTE Registered Nurses and Midwives are in the recruitment pipeline with 43.5 WTE having start dates. • 56.41 WTE Unregistered staff are in the recruitment pipeline with 25.92 WTE having start dates. • An emergency cross-divisional daily staffing meeting was in place throughout December 2022 to ensure appropriate deployment of staff and to maintain safe staffing levels. • The Nursing Workforce Team have co-ordinated a variety of Nursing and Midwifery Workforce Retention. Please see Appendix 1 for more information. • In response to Winter pressures, and in agreement with the Heads of Nursing, it has been agreed to pause the self-assessment quality audits until the 31st January 2023, for Division 1 and 2. We will continue with the peer assessment audits, including the leadership audit, to ensure we maintain oversight of quality and safety. • Observations on time performance remains challenging. November 2022 saw a small increase in compliance to 74.7% from October when it was 71.9%. However, in December 2022 it decreased again to 71.8%. There is ongoing communication and focus to improve completion of patient observations on time and staff report awareness of this being one of the priority areas for improvement. The Deteriorating Patient Group maintains the overall oversight of performance, learning and triangulation. • There were 9 Covid-19 outbreaks in November 2022 and 3 in December 2022 • There were 3 Device related hospital acquired Bacteraemia

	(DRHABs) in November 2022 which is under the trajectory and 6 in December 2022 which were over trajectory. Our monthly target is four.
Alert	• There were 3 *Clostridioides difficile (c diff)* infections reported in November 2022 and 8 in December 2022 against a monthly target of 5. The overall position remains above the external trajectory. The Trust continues to progress its improvement actions via the newly formed C diff Task and Finish Group. • The Deep Clean programme is currently on hold as no decant facility is available however routine cleaning of isolation rooms is being achieved. • There were 50 pressure ulcers (PUs) reported on Datix in December 2022 in comparison to 29 in November 2022. The rise in PUs was noted across both, the inpatient and community, settings. • The Safeguarding Adults Team continue to experience some staffing challenges, and this will remain the case until February 2023. Mitigations have been put in place to minimise any potential risks.
Clinical implications and view	Quality Safety Assurance Group Policy Group Workforce Group Matrons, Senior Nurses, Midwifes and Health Visitors Group Subject-specialist groups.
Author + Contact Details:	Director: Debra Hickman, Director of Nursing Catherine Wilson – Deputy Director of Nursing Email – C.wilson12@nhs.net Martina Morris – Deputy Director of Nursing (interim) Email – m.morris16@nhs.net
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective**: care, treatment and support to achieve 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 is 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.
Trust Strategic Objectives	1. To have an effective and well-integrated health and care system that operates efficiently 2. Seek opportunities to develop our services through digital technology and innovation 3. Attract, retain and develop our staff, and improve employee engagement 4. Deliver a safe and high-quality service 5. Operationally manage the recovery from Coronavirus to achieve national standards 6. Maintain financial health – appropriate investment to patient

	services.
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.
Equality and Diversity Impact	No negative impact.

Public or Private	Public
Risks:	Corporate Risk Register: Mental Capacity, Deprivation of Liberty Safeguards (DoLs) Assessments
Risk register reference:	Risk reference: 5338
Other formal bodies involved:	As above
References	A variety of references apply to the topics outlined in this report.

Brief/Executive Report Details	
Brief/Executive Summary Title:	Chief Nursing Officer and Director of Nursing Report
Item/paragraph 1.0	Key points from the report include: • In December 2022, there were 30 formal complaints received. This represents a 19% decrease on the previous month. However, it is noted that when compared to the same reporting period in 2021, there were 42 formal complaints received, this volume represents a comparable decrease of 28%. Notable reductions for this month have been experienced by General Surgery, Head and Neck and Primary Care, with increased volumes in ED and Adult Community Services. The decline in volume which has been experienced is not uncharacteristic for this time of the year. • In terms of Friends and Family Test performance, the overall Trust wide response rate for December 2022 was 16% with 3666 (77%) recommending the Trust and 792 (17%) not recommending the Trust. The response rate had seen a 2% decrease when compared with the previous month; the recommendation rate had seen a decline in score from 82% in November to 77% in December 2022. The largest contributory factor was from within our inpatient areas where a 3% reduction in recommend was experienced. All 3 divisions experienced a reduction, more notably within Division 1 and this will be monitored for individual areas to highlight and act upon any reoccurring reductions in the recommend score responses. Our Emergency department and our Outpatients departments remained consistent. There have been declines in response rates for all of the main touch points reported nationally, there has however been positive improvements in recommendation rates for day case and birth. • The aim of the Back to the Floor concept is to improve patient experience through strengthened, visible, senior clinical Nurse, Midwife and Allied Health Professional (AHP) leadership. As a team, we are dedicating one day per week to spending a day in a clinical area. Since the introduction of 'Back to the Floor' initiative on 4th November 2022, a variety of clinical areas have been visited and an initial thematic report based on formal feedback received provides a summary of themes. Please see separate report as Appendix 3. • Patient observations on time compliance remains challenging. November 2022 saw a small increase in compliance to 74.7% from October when it was 71.9%. However, in December 2022 it decreased again to 71.8%. There is ongoing communication and focus to improve completion of patient observations on time and staff report awareness of this being one of the priority areas for improvement. The Quality team have met the Ward Managers to discuss the importance of clear communication at handover and transfer events about observations which are due and ensuring sufficient working equipment is available. The Practice Education facilitators have also been asked to prioritise this key workstream and the associated Shared Decision-Making Council for observations is now underway. There have been no patient harm incidents reported in relation to late observations as monitored via the Deteriorating Patient Group. • There were 50 pressure ulcers (PUs) reported on Datix in December 2022 in comparison to 29 in November. The rise in PUs was noted across both, the inpatient and community, settings. Upon analysis, the themes emerging from reported community pressure ulcers has been related to the frailty of end-of-life patients and also factors relating to staff sickness and level of staff experience. In the acute setting analysis of the themes suggest the high acuity of increasingly complex patients with a diagnosis of Influenza and/or Covid-19 and the long waits for ambulances, pre-admission, and a long stay within our Emergency department has impacted on our patients tissue viability. Quality improvement plans are in place to ensure learning from the incidents. As part of our rapid

improvement process, we have identified gaps in knowledge and this is to be addressed with face-to-face education sessions to develop and strengthen staff knowledge, supported by practice education facilitators. This will also include the use and effect of profiling beds. We continue to support a mattress replenishment scheme to ensure effective pressure relief from mattresses.

- In terms of falls, the Trust continues to achieve well within The Royal College of Physicians average performance benchmark of 6.63 falls per 1000 occupied bed days with November 2022 data at 3.01 (96 falls) and December 2022 data at 3.65 (121 falls). We continue to undertake weekly fall review meetings where lessons learnt are identified and shared learning is promoted. A joint Falls Prevention Steering Group is planned for 25th of January 2023 to oversee falls prevention and reduction work.
- A clinical accreditation scheme implementation proposal has been developed and is being socialised with various Nursing and Midwifery forums across RWT and WHT, with the plan of launching it in April 2023. The accreditation programmes facilitate the development of a set of standards against which to measure quality of excellence in nursing and midwifery care and this is central to demonstrating improvement.
- Ongoing improvement activities remain in place with regards to Methicillin-resistant Staphylococcus Aureus (MRSA) acquisition, Methicillin-sensitive Staphylococcus Aureus (MSSA) bacteraemias and Device Related Hospital Acquired Bacteraemias (DRHABs). An invited C-Difficile focussed review by the Assistant Director of Infection Prevention and Control – NHS England, Midlands is being organised.
- The Safeguarding service has experienced significant staff shortages throughout December and into January 2023, which has led to prioritisation of 'On Call' and support within the Emergency Department. Projects, including the Mental Capacity Assessment (MCA) Service Improvement Project, are currently on hold and it is anticipated it will recommence by February 2023 when staffing improves. Compliance with the completion of Deprivation of Liberty Safeguards (DoLS) referrals remains good, with 34 applications completed in December 2022.There were 40 in November 2022, which was an improvement since 29 in October 2022.
- During December 2022 and into January 2023, we experienced extreme pressures due to increased flow at emergency portals, staff sickness and being responsive to support the Ambulance Service Industrial action therefore we instigated the Emergency cross-divisional daily staffing meeting to ensure appropriate deployment of staff and maintain safe staffing levels. We also utilised support from non-clinically facing corporate Nursing teams to support staffing numbers across the Emergency Portals and Medical Wards.
- The overall combined Care Hours Per Patient Day (CHPPD) has increased in November 2022 to 7.6 and increased again in December 2022 month to 7.7.A robust plan remains in place to continually monitor individual areas and ensure areas with lower CHPDD receive newly recruited staff members. This is also incorporated into the monthly challenge, confirm and support meetings for areas. The Model hospital dashboard reports 8.0 CHPPD to be the national median which was last reported in August 2022.
- Currently there are 133.9 WTE Registered Nurses and Midwives in the recruitment pipeline with 43.5WTE having start dates. Monthly recruitment events continue with a dedicated recruitment event held in November at Cannock Chase Hospital and the next event at New Cross Hospital on Saturday 21st January 2023, for all specialities. Although focus continues on Domestic recruitment and growing retention initiatives the Clinical Fellowship model still remains the main pipeline for recruitment requiring significant support for these newly appointed groups of staff.

	• The Unregistered recruitment pipeline is currently at 56.41 WTE with 25.92 WTE having start dates.

Reference Pack – Report Details Chief Nursing Officer and Director of Nursing Report 7/02/2023

NURSING QUALITY DATA

- The Nursing Quality Dashboard (Appendix 1) provides an 'at a glance' view of ward/department/service performance with regards to structure, process and outcomes and it is provided for information. However, please note that this is not available for this report due to reasons out of the Trust's control. Please see page 15 of this report for more details.
- 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.

Key points from the November and December 2022 Trust level nursing quality metrics- aligned with the Clinical System Framework 	**Action/Mitigation**
Please note unfortunately, due to reasons outside of the Trust's control, we are unable to present Nursing and Midwifery registered workforce data this month due to national issues with the ESR Business Intellingence administration affecting the ability to run reports. This is also why there is limited graphical data contained within the report this month. However, please note that the registered Nursing and Midwifery staff vacancies have been on a downward trajectory each month since July- November, last reported at 5.5% vacancies.	Currently, there are 133.9 WTE Registered Nurses and Midwives in the recruitment pipeline with 43.5 WTE having start dates. From an International recruitment perspective, in December 2022, we had 8 Clinical Fellows arrive with a further 39 in January 2023. The Trust continues to plan and execute monthly recruitment events with a dedicated recruitment event held in November 2022 at Cannock Chase Hospital (CCH) and the next event for New Cross Hospital on Saturday 21st January 2023, for all specialities. Although focus continues on Domestic recruitment and growing retention initiatives the Clinical Fellowship model still remains the main pipeline for recruitment requiring significant support for these newly appointed groups of staff. The Nursing Workforce Team have co-ordinated a variety of Nursing and Midwifery Workforce Retention activities. Please see Appendix 1 for more information.
Please note unfortunately, due to reasons outside of the Trust's control, we are unable to present Nursing and Midwifery unregistered workforce data this month due to national issues with the ESR Business Intellingence administration affecting the ability to run reports. This is also why there is limited graphical data contained within the report this month. However, please note that the unregistered Nursing and Midwifery staff vacancies have been on a downward trajectory each month since July-November, last reported at 1% vacancies.	Active recruitment continues for unregistered nursing and midwifery staff, including The Princes Trust initiative, inclusive of a monthly rolling advert for the temporary staffing (Bank) to support the ward/departments. Currently there are 56.41 WTE in the unregistered staff local pipeline with 25.92 WTE having start dates.

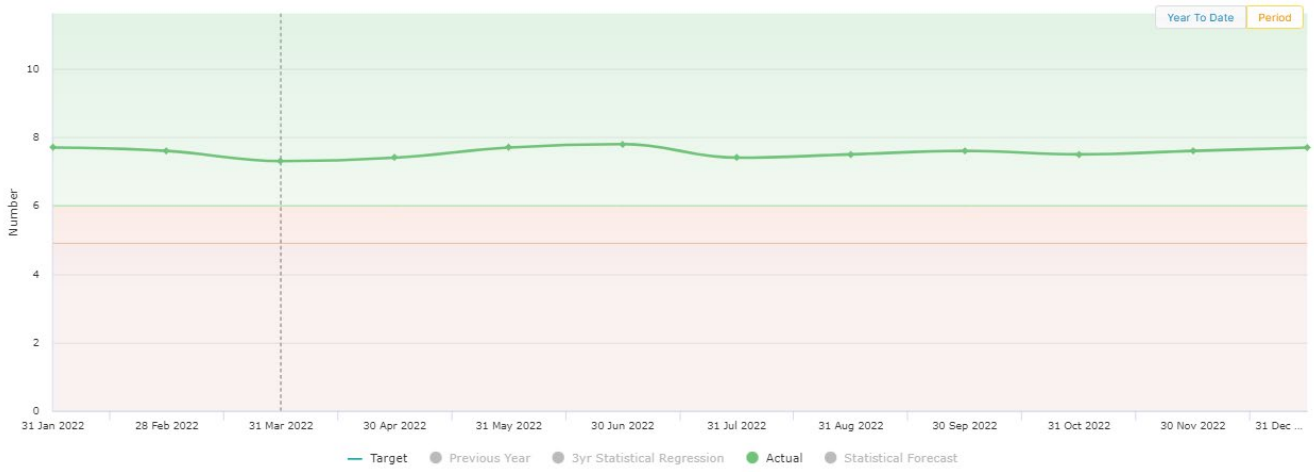
Care Hours Per Patient Day (CHPPD) has increased in November at 7.6 and increased again in December month to 7.7.	Effective recruitment and supportive rostering confirm and challenge meetings are underway to ensure best rostering practice to ensure safe staffing and an increased CHPPD. The Model hospital dashboard reports 8.0 CHPPD to be the national median which was last reported at August 2022. A robust plan remains in place to continually monitor individual areas and ensure areas with lower CHPPD receive recruited staff members. Additional training and daily challenge are in place to ensure accurate data in captured and entered by the ward areas. During December 2022 and into January 2023, we experienced extreme pressures due to increased flow at emergency portals coupled with ongoing capacity challenges, staff sickness and being responsive to support the Ambulance Service Industrial actions therefore we instigated the Emergency cross-divisional daily staffing meeting to ensure appropriate deployment of staff and maintain safe staffing levels. We also utilised support from non-clinically facing corporate Nursing teams to support staffing numbers across the Emergency Portals and Medical wards. On occasion it is necessary for staff to move from one clinical area to another to ensure safe staffing in our clinical areas and maintain patient safety. To support the requests for movement of staff we have developed a 'Helping Hands' Charter outlining expectations and behaviours of those making the request, the staff member being moved and the receiving clinical area. This has been presented at Senior Nurse meetings and will be launched in January 2023 and displayed in all clinical areas. Please see Appendix 2 for more details.
Unfortunately, due to the ongoing National ESR issues, we are unable to provide the overall sickness data report.	Operational experience suggests an increase in sickness across all Divisions in November and December 2022, aligned with a surge in Winter viruses and Covid-19. Where there is unplanned sickness, the Safe Care application is utilised to ensure safest staffing is maintained across all areas and this is reviewed daily as a minimum. Long term sickness is being managed in line with sickness and absence policy.
Mandatory Training levels have remained static across the last 12 months. In November it was 92.9% and in December 2022 it was 90.8 %.	Monitoring of mandatory training levels continues, and completion of training are encouraged.

Executive Level Nursing Quality Dashboard

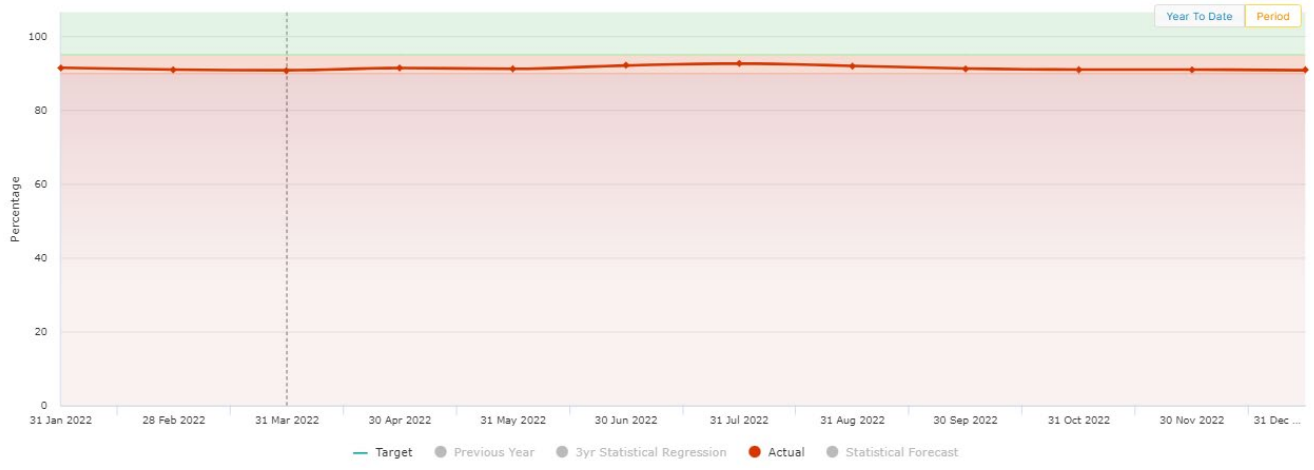
The Trust and Division lines contains all totals across the areas (this may also be outpatient areas) whereas the breakdown under each division show the totals for each of the individual areas.

Patient Voice Elements updated 18/05/2022. Other Datix Elements update as of - 12/05/2022

Category	Measure Name
Structure	CHPPD (Care Hours Per Patient Day)



Category	Measure Name
Structure	Mandatory Training % - trend from last month



Exception Report

- Following the successful band 7 quality away day and management day, this is now being rolled out further to all band 6 nurses and any remaining Ward Managers in March and April 2023. An e-handbook for Ward Managers is in development to reflect the content of the two away days.

- The Trust has an ambitious target to ensure that all eligible registered Nurses and Midwives become Supervisors and Assessors to support the increase in student capacity. The Trust compliance is on an upward trajectory and is currently at 74% as at December 2022. An online education package is currently in development by the digital learning team.

- We have mapped our organisations against the new National Gold Standard Framework for Preceptorship and have a couple of points to address. To achieve this, we would need to ensure an Executive Sponsor is in place and our Preceptors are offered at least 8 hours education each year and this would be a positive change in practice if endorsed. We will then be fully compliant at which point we could apply for the accreditation Interim Quality Mark Scheme (IQMS).

https://www.england.nhs.uk/long-read/national-preceptorship-framework-for-nursing/

QUALITY AND SAFETY EXCEPTION REPORTS

Patient Experience

Complaints
In December 2022, there were 30 formal complaints received. This represents a 19% decrease on the previous month. However, it is noted that when compared to the same reporting period in 2021, there were 42 formal complaints received, this volume represents a comparable decrease of 28%. Notable reductions for this month have been experienced by General Surgery, Head and Neck and Primary Care, with increased volumes in ED and Adult Community Services. The decline in volume which has been experienced is not uncharacteristic for this time of the year.

33 ongoing complaints were closed of which 22 were closed within 30 working days. 10 took longer than 30 days but gained consent to breach due to necessity for longer timescales to provide comprehensive responses. In terms of outcomes, from the 33 complaints closed for December 2022 cases (or 67%) were not upheld. 1 case (or 3%) was fully upheld in this reporting period. This was in relation to a staff members professionalism and work is in progress to improve the individuals practice.

The overall Trust complaints response rate was 97% which is a positive 1% increase on the previous month's performance. The Patient Experience team have been working with the operational teams to work to bring outstanding complaints to a closure. This is reflected in a reduction of the need for extensions to complaint response timescales.

Particular themes for cases closed relate to general care of patient, clinical treatment and communication.

Friends and Family Test
In terms of Friends and Family Test performance, the overall Trust wide response rate for December 2022 was 16% with 3666 (77%) recommending the Trust and 792 (17%) not recommending the Trust.

The response rate had seen a 2% decrease when compared with the previous month; the recommendation rate had seen a decline in score from 82% in November to 77% in December 2022. The largest contributory factor was from within our inpatient areas where a 3% reduction in recommend was experienced. All 3 divisions experienced a reduction, more notably within Division 1 and this will be monitored for individual areas to highlight and act upon any reoccurring reductions in the recommend score responses. This reduction in performance will be a key agenda item at the next Patient Experience Group with senior managers and key actions agreed to analyse and reverse this trend. The Emergency department and our Outpatients departments remained consistent. There have been declines in response rates for all the main touch points reported nationally, there has however been positive improvements in recommendation rates for day case and birth.

Nursing and Midwifery Quality

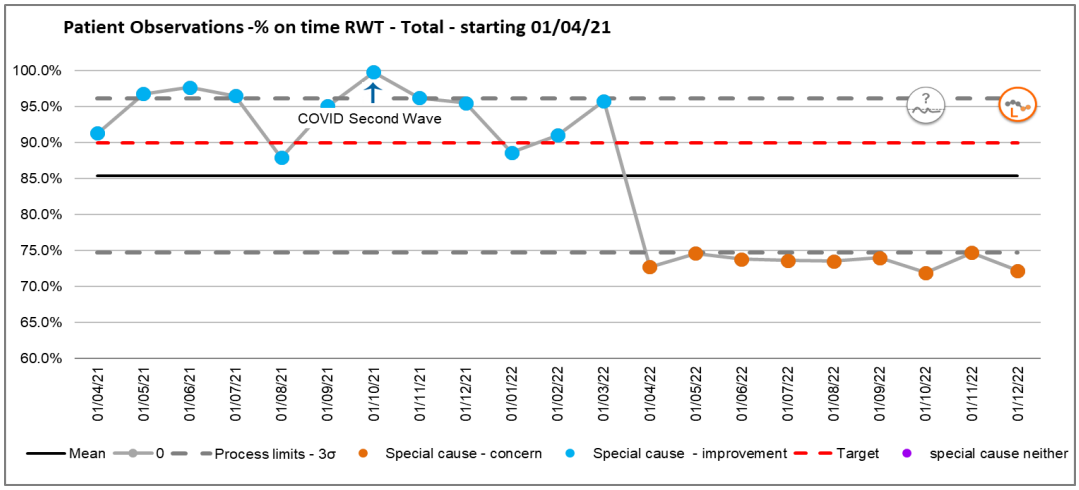
The aim of the Back to the Floor concept is to improve patient experience through strengthened, visible, senior clinical Nurse, Midwife and Allied Health Professional (AHP) leadership. As a team, we are dedicating one day per week to spending a day in a clinical area. Since the introduction of 'Back to the Floor' initiative on 4th November 2023, a variety of clinical areas have been visited and an initial thematic report based on formal feedback received provides a summary of themes. Please see separate report as Appendix 3.

During December 2022, there was an upgrade to Vitals Clinical and Careflow connect, which overall was deployed successfully. However, there were some challenges with information being captured in the Vitals Clinical system within the immediate upgrade period, which was subsequently resolved. The data pertaining to December has been cleansed within the system to ensure accuracy of reporting.

Patient observations on time compliance remains challenging. November 2022 saw a small increase in compliance to 74.7% from October when it was 71.9%. However, in December 2022 it decreased again to 71.8%. There is ongoing communication and focus to improve completion of patient observations on time and staff report awareness of this being one of the priority areas for improvement. The Quality team have met the Ward Managers to discuss the importance of clear communication at handover and transfer events about observations which are due and ensuring sufficient working equipment is available. The Practice Education facilitators have also been asked to prioritise this key workstream and the associated Shared Decision-Making Council for observations is now underway. There have been no patient harm incidents reported in relation to late observations as monitored via the Deteriorating Patient Group.

The graph below provides data over time for patient observation completed on time.

Chart 1: Patient Observations % on time 01/04/21-31/12/22



There were 50 pressure ulcers (PUs) reported on Datix in December 2022 in comparison to 29 in November. The rise in PUs was noted across both, the inpatient and community, settings. Upon analysis, the themes emerging from reported community pressure ulcers has been related to the frailty of end-of-life patients and factors related to staff sickness and level of staff experience. In the acute setting analysis of the themes suggest the high acuity of increasingly complex patients with a diagnosis of Influenza and/or Covid-19 and the long waits for ambulances, pre-admission, and a long stay within our Emergency department has impacted on our patients tissue viability. Quality improvement plans are in place to ensure learning from the incidents. As part of our rapid improvement process, we have identified gaps in knowledge and this is to be addressed with face-to-face education sessions to develop and strengthen staff knowledge, supported by practice education facilitators. This will also include the use and effect of profiling beds. We continue to support a mattress replenishment scheme to ensure effective pressure relief from mattresses.

During December 2022, 46 incidents of Moisture Associated Skin Damage (MASD) incidents were reported, representing a slight increase from 40 MASD incidents reported in November 2022. There is a plan to pilot a Moisture Associated Skin Damage Assessment in January 2023. A wound prevention and healing ambition document has been developed and will form the basis for an overarching improvement plan.

The graphs below provide pressure ulcer and MASD data – including numbers and rates.

Chart 2: Pressure Ulcers Total Hospital and Community Reported 01/04/21- 31/12/22

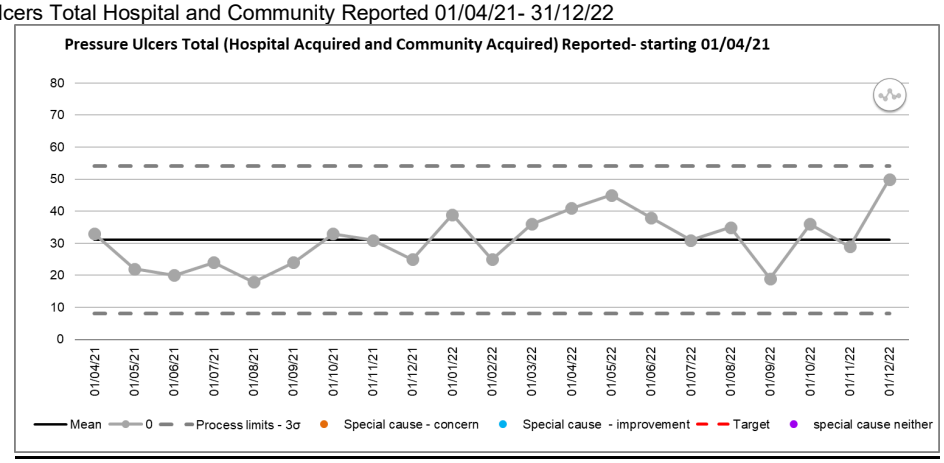


Chart 3: Pressure Ulcers Hospital Reported 01/04/21- 31/12/22

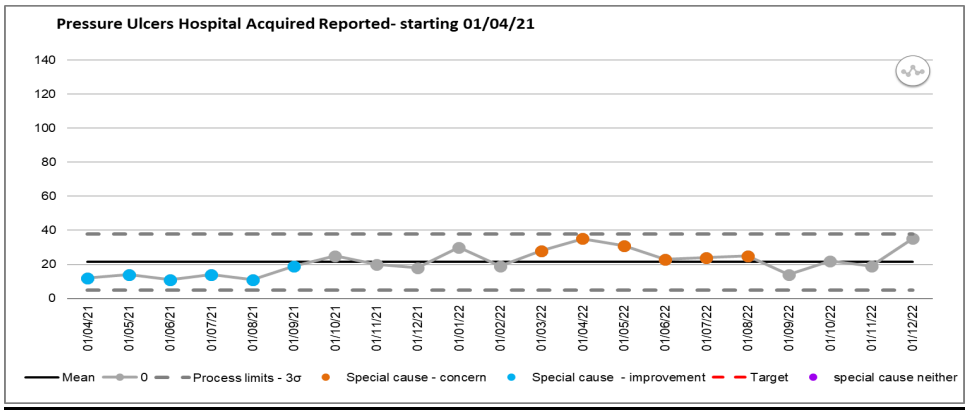


Chart 4: Pressure Ulcers – Community Reported 01/04/21- 31/12/22

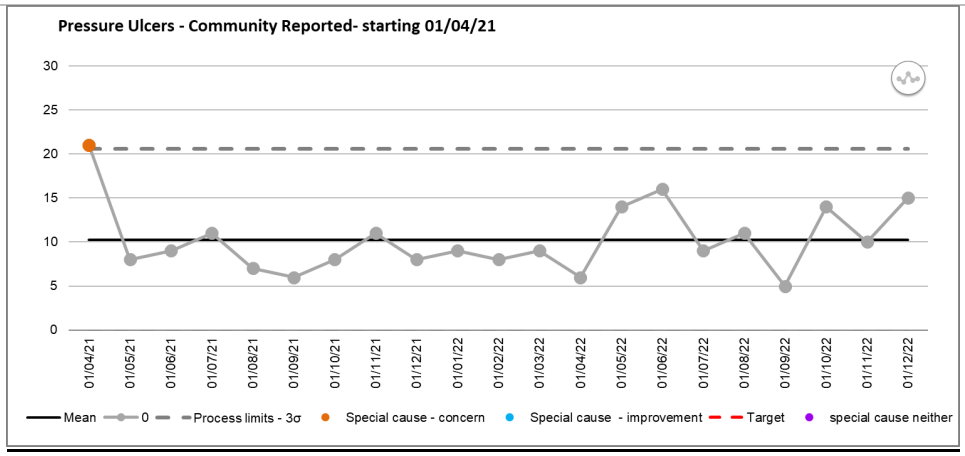


Chart 5: Pressure Ulcers - Hospital Inpatient Rate Per 1000 Occupied Bed Days 01/04/21- 31/12/22

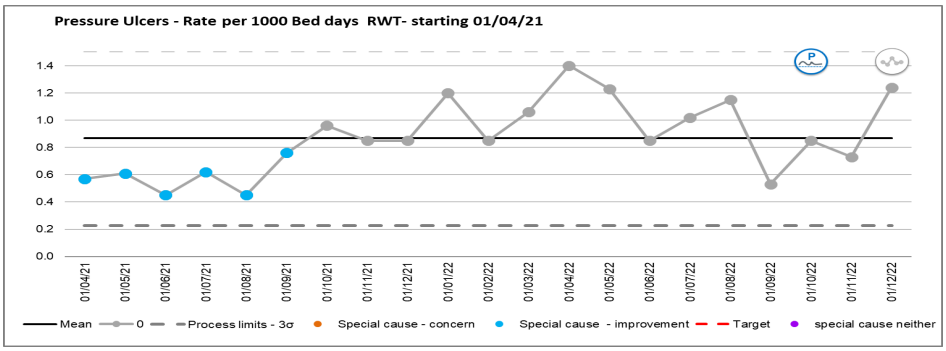


Chart 6: Pressure Ulcers – Community Rate per 10,000 Per Patient Population 01/04/21- 31/12/22

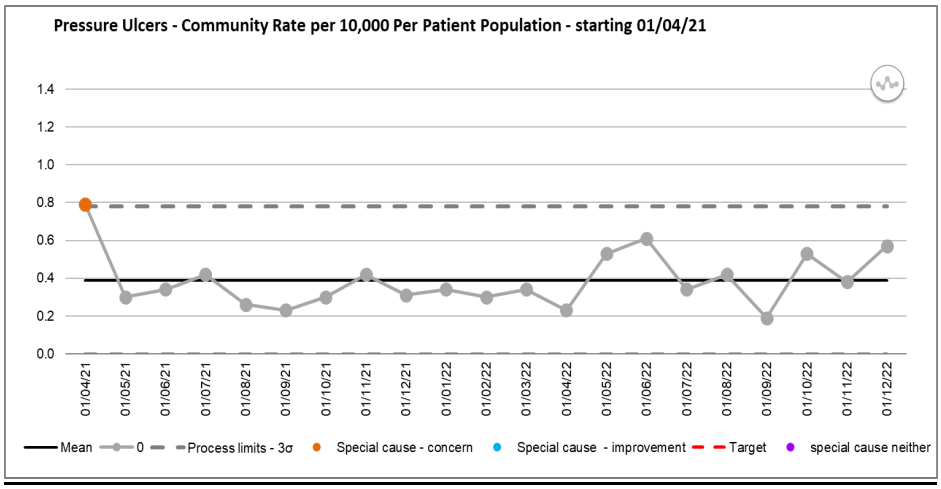
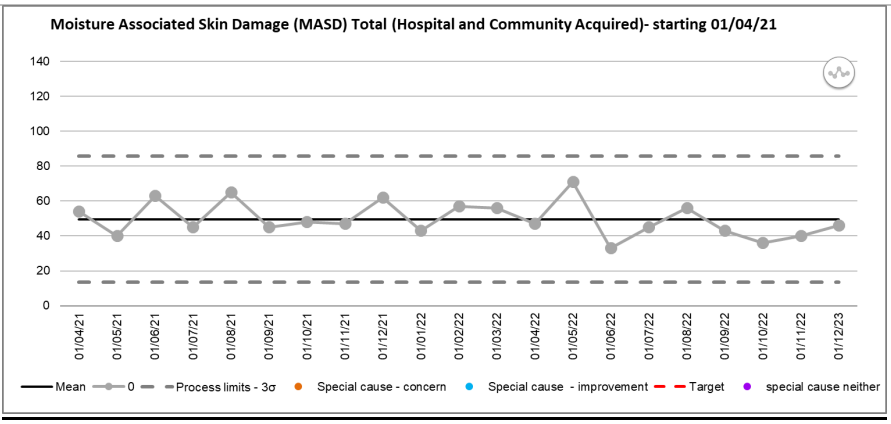


Chart 7: Moisture Associated Skin Damage (MASD) Total (Inpatient and Community) Reported RWT 01/04/22 – 31/12/22



In terms of falls, the Trust continues to achieve well within The Royal College of Physicians average performance benchmark of 6.63 falls per 1000 occupied bed days with November 2022 data at 3.01 (96 falls) and December 2022 data at 3.65 (121 falls). We continue to undertake weekly fall review meetings where lessons learnt are identified and shared learning is promoted.

A joint Falls Prevention Steering Group is planned for 25th of January 2023 to oversee falls prevention and reduction work across both, The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). In addition, there are plans to review the bed rails policy and ensure it is aligned across both organisations.

The graph below provides data over time for falls.

Chart 1: Falls – Total Hospital Inpatient and Outpatient Reported 01/04/21- 31/12/22

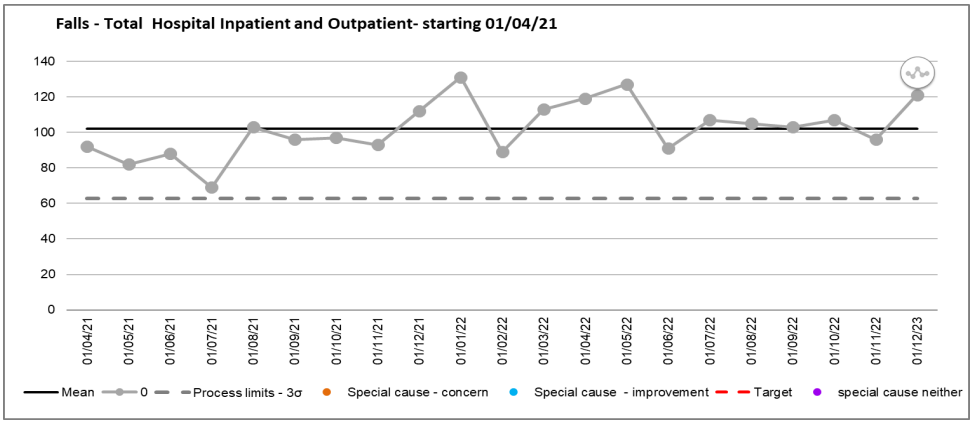
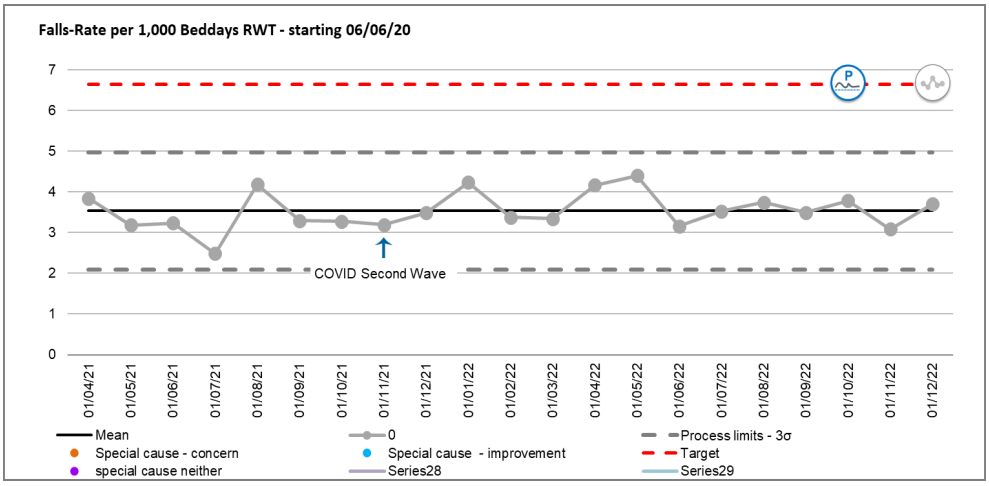


Chart 2: Falls Rate Per 1000 Bed Days Hospital Inpatients 01/04/21- 31/12/22



The number of medication errors reported decreased in November 2022 to 34, from 60 reported in October. December saw a small increase to 38 medication errors. The medicines management storage action plan and medicines management risk are currently being reviewed and the Ward leaders, Matrons and Heads of Nursing and Midwifery have been reminded of the importance of monitoring medicines management practices and safety compliance within their areas.

A review of all nursing quality audit questions has been completed for both Trusts with an options appraisal offered in relation to methodology, audit questions and sample size to facilitate benchmarking. Trend reports remain unavailable to share due to outstanding updates in My Assurance. A Standard Operating Procedure (SOP) for Opening and Closing Wards and the Supportive Meal Times policy have been reviewed and put forward for approval. In response to Winter pressures, and in agreement with the Heads of Nursing, it has been agreed to pause the self-assessment audits until the 31st January 2023, for Division 1 and 2 which will release time for ward managers to focus on the pressing priorities within their clinical areas. We will continue with the peer assessment audits, including the leadership audit, to ensure we maintain oversight of quality and safety.

Shared Decision-Making councils continue to be developed to explore quality improvement opportunities through shared learning in the delivery of high-quality care. There are now six shared decision-making councils with the second meeting for Medication Safety and Documentation/Digitalisation planned in January 2023. Other existing councils include Falls, Observations and new councils planned include Community Audit documentation and Nutrition and Hydration. This model will extend to work streams within quality such as Ward Accreditation planned for January 2023.

A clinical accreditation scheme implementation proposal has been developed and is being socialised with various Nursing and Midwifery forums across RWT and WHT, with the plan of launching it in April 2023. The accreditation programmes facilitate the development of a set of standards against which to measure quality of excellence in nursing and midwifery care and this is central to demonstrating improvement. Accreditation brings together key measures of Nursing, Midwifery and clinical excellence in care into one overarching framework to enable a comprehensive assessment and evaluation of the quality of excellence in care at ward, unit or team level. When used effectively, it can drive continuous improvement in patient outcomes, and increase patient satisfaction and staff experience at a ward and unit level. With a clear direction and a structured approach, it creates the collective sense of purpose necessary to help communication, encourage ownership and achieve a robust programme to measure and influence excellence in care delivery (NHS England 2019). A detailed implementation plan has been developed and the concept will be piloted during February – March 2023.

Maternity

Please see the separate report being presented to the Trust Management Committee (TMC) in January 2023 and subsequently to Trust Board in February 2023.

Adult and Children Safeguarding

Compliance with the completion of Deprivation of Liberty Safeguards (DoLS) referrals remains good, with 34 applications completed in December 2022.There were 40 in November 2022, which was an improvement since 29 in October 2022. Two DoLS authorisations have been granted in the last six weeks, which demonstrates a positive improvement in comparison to previous years data (an average of one granted per year 2021-2022).

An improvement has been noted in the compliance rate for Initial Health Assessments for Children and Young People in Care, which now stands at 67%, in comparison to 50% in the previous two months. Guidance has been received from NHSE in relation to finances for out of area health assessments. A better understanding needs to be sought, to confirm that appropriate funding for this service is being received.

The Safeguarding service has experienced significant staff shortages throughout December and into January 2023, which has led to prioritisation of 'On Call' and support within the Emergency Department. Projects, including the Mental Capacity Assessment (MCA) Service Improvement Project, are currently on hold and it is anticipated it will recommence by February 2023 when staffing improves.

The Clinical System Framework

The current Clinical System Framework reached its final milestone in December 2022. A more detailed report will be produced during January 2023, to provide the final overview of achievements. Engagement has been undertaken to shape the new framework. The draft framework is undergoing some final rounds of engagement and will now be available during March 2023, with the approved version launched in Spring 2023, which will be shared with Trust Board members. Going forward, this will be renamed the Quality Framework (QF).

Infection Prevention and Control (IPC)

Infection Prevention and Control – November 2022 Outbreak update

Dates	Area affected	Organism	No of patients affected	No of HCAIs	Findings/Actions
2nd Nov 2022	C14 (C26)	COVID-19 Outbreak	3	3	Trust Action Plan
11th Nov	CHU	COVID-19 Outbreak	3	3	Trust Action Plan
11th Nov	Deans	COVID-19 Outbreak	2	2	Trust Action Plan
13th Nov	C16	COVID-19 Outbreak	5	5	Trust Action Plan
15th Nov	C25	COVID-19 Outbreak	9	7	Trust Action Plan
23rd Nov	WP2	COVID-19 Outbreak	4	4	Trust Action Plan
28th Nov	C39	COVID-19 Outbreak	7	7	Trust Action Plan
30th Nov	A7	COVID-19 Outbreak	3	1	Trust Action Plan
30th Nov	A8	COVID-19 Outbreak	3	3	Trust Action Plan

Total of COVID outbreaks = 9
35 HCAIs linked to outbreaks in November
4 HCAIs linked to outbreaks in October
7 - not linked to an outbreaks
Total patients identified with HCAIs = 46

November surveillance

Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia = 0

Methicillin-sensitive Staphylococcus Aureus (MSSA) bacteraemia = 2
21/16 cases year to date
Internal annual trajectory 24

MRSA Acquisition = 1
30/16 cases year to date
Internal annual trajectory 24

Actions
MRSA Pathway in place to support staff in decolonisation treatment and screening
Inpatients screened every 30 days

Advise - Side rooms are in demand for other alert organisms so a risk assessment of the patient must take place and the patient isolated according to the Isolation matrix in IP Policy 10
MRSA Screening compliance for November will be available on InPhase.

***Clostridioides difficile* = 3**
39/38 cases year to date
External annual trajectory 58

Actions
Task and finish group meet monthly
C-difficile action plan updated
Environmental audits completed monthly
Weekly ward rounds with Microbiologist
Weekly antimicrobial ward rounds with Microbiologist and Antimicrobial Pharmacist
Involved in collaborative work with NHS England (NHSE)
Targeted education completed on B14 and West Park Hospital

Advise
Deep clean programme recommenced 1st December
An NHSE IPC Visit is scheduled for 30th January 2023 – This has a multidisciplinary approach.

Alert
Weekly decontamination of side rooms with C difficile patients are not achieved due to capacity pressures.

Gram Negative bacteraemia
***E coli* = 9**
63/69 cases year to date
External annual trajectory 103
***Klebsiella* = 2**
22/23 cases year to date
External annual trajectory 35
***Pseudomonas aeruginosa* = 4**
12/10 cases year to date
External annual trajectory 18

Actions
Involved in Gram Negative collaborative work with NHSE
Catheter Working Group to review use of catheters and scoping definition for Catheter associated urinary tract infection (CAUTI)
Scoping definition for Hospital acquired and Ventilator associated pneumonia (HAP) (VAP)

Device related Hospital Acquired Bacteraemia (DRHABs) = 3
38/32 cases year to date
Internal annual trajectory 48

Advise – 2 line and 1 cannula related

Actions
Dedicated Intravenous Resource team

All DRHABs are reviewed at IP scrutiny

COVID
As of 12th December, there are 32 cases in the Trust.
RWT continue to be in capacity extremis so Day 7 LFTs are completed and if negative can be deescalated
Contact patients are not cohorted

Combined Risk assessment for RWT and Walsall Healthcare NHS Trust has been updated to reflect the changes in guidance

Influenza
86 positive flu cases identified with 62 requiring admission
Increasing numbers in December – 123 cases in the first 11 days

Advice – Cohort bays for positives and contacts are also cohorted together

Norovirus
No cases in November

Respiratory Syncytial Virus (RSV)
137 positive cases identified, predominantly paediatrics and most discharged home.

Infection Prevention and Control –December 2022 Outbreak update

Dates	Area affected	Organism	No of patients affected	No of HCAIs	Findings/Actions
4th Dec	ICCU	CPE	2	2	Incident Action Plan
9th Dec	C21	C. diff SI	2	2	Incident Action Plan
13th Dec	WPH1	COVID-19 Outbreak	7	7	Trust Action Plan
16th Dec	C25	Influenza A PII	2	2	Incident Action Plan
20th Dec	C21	COVID-19 Outbreak	8	7	Trust Action Plan
29th Dec	A5	COVID-19 Outbreak	8	7	Trust Action Plan

Total of COVID outbreaks = 3
19 HCAIs linked to outbreaks in December
24 HCAIs linked to outbreaks in November

11 not linked to an outbreaks
Total patients identified with HCAIs = 54

ICB local outbreak procedure has been agreed, RWT are now following this reporting process

All the incidents and outbreaks have been reviewed at Grand Outbreak meetings which take place weekly on Tuesdays and Thursdays.

Occupational Health are maintaining a database of all COVID Positive staff for December, the COVID reporting phone line has now closed.

December surveillance

MRSA bacteraemia = 0

MSSA bacteraemia = 4
25/18 cases year to date
Internal annual trajectory 24

MRSA Acquisition = 3
33/18 cases year to date
Internal annual trajectory 24

Actions
MRSA screening and decolonisation targeted education planned

Advise – Infection Prevention team are supporting wards and the capacity team to prioritise side room requirements according to the Isolation matrix in IP Policy 10
MRSA Emergency Screening compliance for December will be available on InPhase

***Clostridioides difficile* = 8**
47/43 cases year to date
External annual trajectory 58

Actions
Task and finish group meet monthly
C-difficile action plan updated
Environmental audits completed monthly
Weekly ward rounds with Microbiologist
Weekly antimicrobial ward rounds with Microbiologist and Antimicrobial Pharmacist
Involved in collaborative work with NHSE
Targeted education continues across the Trust

Advise
Deep clean programme has ceased
NHSE Visit on 30th January – multidisciplinary approach

Alert
Weekly decontamination of side rooms with C-difficile patients are not achieved due to capacity pressures.

Gram Negative bacteraemia
***E coli* = 12**
75/75 cases year to date
External annual trajectory 103
***Klebsiella* = 3**
25/26 cases year to date
External annual trajectory 35
***Pseudomonas aeruginosa* = 1**
13/12 cases year to date
External annual trajectory 18

Actions
Involved in Gram Negative collaborative work with NHSE, currently all meetings cancelled due to pressures regionally
Catheter Working Group to review use of catheters and scoping definition for Catheter associated urinary tract infection (CAUTI)

Device related Hospital Acquired Bacteraemia (DRHABs) = 6
44/36 cases year to date
Internal annual trajectory 48

Advise – 4 line and 2 urinary catheter related

Actions
Dedicated Intravenous Resource team
All DRHABs are reviewed at IP scrutiny meeting

COVID
As of 11th January, there are 56 cases in the Trust.

Influenza
As of 11th January, there are 20 cases in the Trust

Advise – positive patients cohorted, contacts identified and cohorted

NHSEi have produced the Midlands IPC Management of Influenza cases which RWT and WHT have incorporated into the Risk Assessment for Management of Respiratory Viruses.

Respiratory Syncytial Virus (RSV)
93 positive cases were identified in December, predominantly paediatrics and most discharged home

Norovirus
There were no cases in December

Group A Streptococcus (GAS)

1 case in Paediatrics in first week of December linked to infected chickenpox

Please also refer to the wider IPC report being presented at Trust Management Committee in January 2023 and onto Trust board in February 2023.

Research and Innovation

There is nothing new to report this month for Research and Innovation.

Executive Level Nursing Quality Dashboard

The Trust and Division lines contains **all totals** across the areas (this may also be outpatient areas) whereas the breakdown under each division show the totals for each of the individual areas.

Please note unfortunately, due to reasons outside of the Trust's control, we are unable to present an Exective Level Nursing Quality Dashbard this month due to national issues with the ESR Business Intellingence administration affecting the ability to access the reporting functionality. This is also why there is limited graphical data contained within the report this month.

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Walsall Healthcare NHS Trust

Nursing & Midwifery Retention Activity Summary

Catherine Wilson -Deputy Director of Nursing, January 2023

Introduction

Given the National shortage of Nurses and Midwives Retention has never been more important to sustain safe staffing. The Trusts have many positive broad approaches to retention, such as the Trusts well-being offer and development opportunities and this paper attempts to centralise the information about specific Nursing and Midwifery Retention activities.

Internal Transfer Scheme

In August 2022 we seconded a Chief Nurse Fellow to streamline, relaunch and promote use of the Internal transfer scheme. This scheme creates opportunities to move to another area more swiftly than via traditional recruitment processes and also promotes internal development rather than losing staff to an external organisation. This has been completed at Royal Wolverhampton Trust (RWT) and work is now underway at Walsall HealthCare Trust. Utilisation is in its infancy, and so far at RWT we have had 12 successful internal transfer placements since November 2022. We know from the success of other organisations, Sherwood Forest Hospital, 2021 Streamlining internal transfers for nurses | NHS Employers that ;

- Internal transfer schemes contribute to reducing vacancy rates, staff turnover and have allowed employees to map their own career pathway within their own organisation.

- The internal transfer scheme helps with the retention of knowledge and talent, increased staff skills, shared knowledge between departments and specialities, improved quality of care for patients, and a reduction in the cost of recruitment and the time spent filling vacancies.

- The internal transfer scheme benefits employees developing their knowledge and skills, improving motivation and job satisfaction, reducing time spent searching and applying for vacancies, and an increased possibility of promotion.

Stay Together all Year (STaY) Event

Supervision Together all Year (STaY) 2022 was a Nurse retention initiative asking all new Nurses to meet their Chief Nurse and their Director of Nursing , explore well-being and understand Trust opportunities. This was held in November 2022 on both sites. Wolverhampton accommodated 70 Nurses and at Walsall there were 20. The event gave opportunities for useful 2-way discussions and feedback was positive. We plan to have a further 3 events this year to maintain the engagement and

positive momentum. Midwives will also be included in the next events and we will encourage staff from a further back start point to attend too. This will be advertised in advance to maximise uptake.

STaY Social Café

As an adjunct to the STaY event, February 2023 will see the pilot of the STaY Social Café commence to facitlitate scheduled or spontaneous dialogue with the Deputy Director of Nursing which will be open for all Nursing & Midwifery Staff with the aim of increasing engagement and turning comments into insights that can support retention.

Flexible working

We know that flexible working is a high impact action to support retention. This is important to all staff especially Generation Z , who are age up to 24, and represent our young and newly qualified workforce. In Autumn 2022 the Deputy Director of Nursing presented the flexible working requirements of this generation to both sites Senior Nurse and Midwifery leaders and both sites Matrons groups to raise awareness and encourage consideration of flexible working requests. It was also presented at the Trust Board as a development session for Board members. The Group Chief Nurse blog will also bring focus to this in Spring 2023.

Warm Welcome competition

All Nursing and Midwifery staff on both sites were invited to submit an application to the 'Warm Welcome' competition. This was created to raise awareness of the importance of getting the first few days of our staffs' employment with us right and we received 10 applications detailing how well they greeted their staff with their welcoming initiatives. The winners will be announced in January 2023, followed by a communication campaign showcasing the initiatives so that others may follow suit and utilise ideas. The competition will run again at the end of Summer 2023.

Preceptorship

Effective preceptorship outcomes are linked to improved recruitment and retention. The new National Preceptorship Framework was launched in September 2022 and we have self-assessed against the new gold standards criteria for both Trusts. The criteria is already met for most of the standards and this has been presented at Senior Nursing & Midwifery Leaders meetings and we are developing a robust Preceptor training programme that fulfils the requirements set out in the new framework. We plan to apply for the NHSE Interim Quality Mark Scheme for Preceptorship accreditation this Spring 2023.

Legacy Mentors

Legacy Mentoring facilitates experienced Nurses/ Midwives to offer support and expertise towards newly qualified Nurses and Midwives. The 2 main targeted outcomes of a legacy mentor service is to increase the retention of newly qualified practitioners joining our workforce and retaining Senior staff within the workforce. Our Midwifery service is in recruitment processes for a Legacy Mentor role and the Trust board has approved a cross -site Legacy Mentor 3 month pilot to test the concept in Nursing. The pilot will be evaluated after 3 months.

Professional Nurse/ Midwife Advocates (PNA/PMA)

PNA/PMAs are fellow clinical staff who have undergone training to enable them to provide service situated support to Nurses and Midwives in times of need thus increasing support in the workplace. Following the success within Midwifery where outcomes points to improved staff well-being and

retention the Trust adopted the role and model into nursing and health visiting in a structured way, using restorative supervision, to support nurses and health visitors' wellbeing, contribution to change and retain staff and became an early implementor of this role. We capture activity data within the Joint PNA Steering group. Please see below for current active roles.

	Total Number of registered PNA	On programme	Application in process	Waiting list
RWT	41	7	4	12
WHT	14	4	2	3

NHSE Position

In July 2022 NHS England wrote to Trust leads identifying the need to retain Nursing and Midwifery staff by the principles of;

- Targeted intervention for different career stages we know carries risk of staff leaving namely early and late careers stages.
- Bundles of high-impact actions are more effective than single actions to deliver sustained gains.

The letter prioritises the delivery of five high impact actions that will impact on early career, experience at work, and late career staff, maximising the retention and experience of our nursing and midwifery staff.

1. **Complete the Nursing and Midwifery retention self-assessment tool**
2. **Implement the National Preceptorship Framework**.
3. **Implement legacy mentoring scheme**.
4. **Encourage staff to attend national pension seminars and encourage Trusts to offer flexible retirement options.**
5. **Develop a menopause policy / guidance**

The Nursing and Midwifery retention self-assessment tool was completed by both organisations and submitted as a 'RAG' status to the Integrated Care Board (ICB) for oversight. This tool enabled us to undertake a self- assessment against the seven elements of the NHS People Promise plus key elements that support staff to deliver high quality care, enhancing job satisfaction and supporting the retention of Nurses and Midwives.

Workforce Retention data

HR colleagues report turnover and retention data via People and Organisational Development Committee (PODC) which has Deputy Director of Nursing representation on both sites and to Trust Board in a Monthly Workforce report.

END.

Appendix 2

Civility and Respect

NHS

Helping Hands Charter

What to expect when you are asked to support other areas:

- The staff member speaks with whoever is asking them to move in a respectful manner and vice versa
- Be given a rationale for the support being offered to another area
- Decision maker explores any fears, shows compassion and takes personal factors into consideration – for example, previous significant event (personal or work related) on ward they're being asked to go to and any reasonable adjustments put in place previously regarding health and well-being
- Be open and honest about any concerns you have regarding being moved and share any suggestions of what would help
- Although it can be daunting when asked to move, we must all appreciate the need to keep all areas as safe as possible – considering how it might feel to be the people in the area which is very understaffed

What to expect once you have moved to support another area:

- All staff to display kindness towards someone who has come to help, and express gratitude for skills they can offer
- Have a meet and greet with the nurse in charge to make clear who to escalate issues to
- Have an orientation to the ward (where to put belongings safely, shown where toilets are)
- To be included in conversations related to allocation of breaks and workload
- Review Ward Routine Checklist to support workload
- Share what you CAN do with the team and how to utilise your existing and additional nursing skills, as well as what they might find difficult
- If one person is busy then everyone is busy – share the load. This includes 1:1 duties as this should be rotated throughout the shift. It may mean reverting to doing a series of tasks

Adapted with permission from Chesterfield Royal Hospital NHS Foundation Trust.

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The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues Collaboration Communities

Civility and Respect

Helping Hands Charter

How to act if someone has moved to help your ward:

- All staff to display kindness towards someone who has come to help, and express gratitude for skills they can offer
- When staff member gets to receiving ward, they're welcomed and thanked for coming to help by ward staff – recognising that it can be nerve-racking to be out of their comfort zone and away from people they usually work with
- Try to provide a "buddy" for the member of staff that has been asked to move
- It is important that the staff member who has been moved is given the opportunity to state what they feel safe to do regardless of banding
- Staff may feel overwhelmed when moved. Consider whether the 'helper' could do an obs round for the whole ward, a medications round for the whole ward, do washes, help with feeding, patients transfers etc, and the experienced nurse(s) could then care for patients in a more specialist way
- Essentially – think about ways of working differently to get the best out of everyone in a difficult situation
- The banding of the person is not necessarily relevant to keep the ward running more smoothly
- Please thank them and allow the person to return to their base ward if they are no longer required to support the area

Wider Trust issues to address to improve staff movement:

- Ensure a Nurse in charge is identified every shift to be point of contact
- Every ward to have a Ward Routine Checklist to identify ward routine days and nights where possible to support new starters and those moving wards to support
- Potential to develop consistent system to prevent same people always moving / same people refusing to promote equality and equity

Adapted with permission from Chesterfield Royal Hospital NHS Foundation Trust.

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Walsall Healthcare NHS Trust

Care Colleagues Collaboration Communities

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Appendix 3

Back to the Floor -Thematic Report

Report Date	14th December 2022
Title	Back to the Floor Thematic Report.
Purpose of the Report	To provide a summary of themes from the Back to the Floor days.
Action required	**Receive for information and action**
Author + Contact Details	Martina Morris – Deputy Director of Nursing (interim) Email – m.morris16@nhs.net

1.0 Introduction

The concept of 'Back to the Floor' (BTTF) has been in existence for many years and utilised by a wide range of healthcare organisations across the United Kingdom. The aim of the BTTF concept is to improve patient experience through strengthened, visible, senior clinical nurse, midwife and Allied Health Professional (AHP) leadership. The concept supports the aims and objectives of an organisational Nursing, Midwifery and AHP strategy, which in the case of RWT and WHT, is the Clinical System Framework.

Evaluations of the Back to the Floor concept at other organisations have found that it has had a positive impact on staff and patients, for example, by improving senior team visibility, empowerment, learning together, professional networking, responding to problems collectively and effectively, strengthened communication and championing and implementing change effectively.

2.0 Process

The BTTF concept was implemented across the Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) on Friday 4th November 2022 and takes place every Friday.

All nursing, midwifery and AHP colleagues, who do not work in patient facing roles, are expected to participate in BTTF. When Fridays are not possible for colleagues, they are required to undertake their clinical day on another day.

As a rule, no critical meetings should be scheduled on the BTTF Fridays to enable colleagues to focus on being 'back to the floor'. However, it is recognised that some meetings may need to take place and colleagues are requested to schedule their clinical time around these meetings.

Feedback from observations at each BTTF day is provided immediately to the person in charge and shared with the matron and Head of Nursing/Midwifery/Service Lead for the area. Colleagues may also use an electronic feedback proforma which has been developed and launched on 2nd December 2022, to enable us to collate themes from the BTTF days and a collective understanding of positive aspects and areas for improvement and what actions may be required.

The Heads of Nursing (HoNs)/Midwifery (HoM)/Service Leads are required to maintain their own processes for ensuring that all relevant staff within their Divisions participate in the BTTF days, all areas are visited over time, feedback is provided and key themes and actions are captured.

3.0 Key Themes

The data included in this report relates to the clinical areas/services that have been visited, where written feedback has been shared with corporate nursing, via email of the newly launched electronic proforma.

Appendix 3
As the electronic feedback proforma is utilised over a longer period of time, this will enable us to provide a richer and more accurate data set (more thematically focused) and will enhance the way the data can be presented.

Based on the information received, 38 clinical areas and services have been visited across both trusts. From this number, 20 were at RWT and 18 at WHT. Please note some areas have been visited more than once.

The table below includes the areas that have been visited:

RWT	**WHT**
MLU	West locality team
Maternity Triage	Wound care clinic
A21, A23, PAU and paediatrics flow coordinators	Ward 4
Dermatology clinic	AEC
A9	Ward 10
Beynon	Hollybank
A5	Ward 20A
A6	Ward 23
A7	Ward 21
A8	PAU
A14	Ward 1
Emergency Department	Acute Pain Team
A14	Ward 9
CHU	Breast clinic
D7	ICU
Fairoak	Goscote Hospice
ICCU	
Ward 1 – West Park Hospital	

There were also 2 wards / clinical areas / services visited at WHT, which had no information of the exact location stated within the feedback proforma.

Based on feedback collated thus far, the key findings are as follows:

Positive areas:

- Clinical areas very busy but managed in a calm way.
- Patient centred care observed.
- Positive patient feedback received in most areas.
- Staff welcoming and compassionate towards the patients and visitors.
- Generally, clinical areas tidy and clutter free.
- Proactive approaches to maintaining safe staffing and mitigation of associated risks.
- Good multidisciplinary teamwork and support for new staff.
- Positive pain management practice.
- Deprivation of Liberty Safeguards application completed, and process followed correctly.
- Ongoing focus on quality improvement.
- Uniform / dress code compliance generally good, however please see below regarding the Infection Prevention and Control (IPC) non-compliance.
- Generally, patients had the items they needed, including the call bell within reach.
- Patients deemed at risk of falls were being cared for in appropriate areas, with falls prevention aids in situ.
- Same Sex Accommodation breach due to operational pressure managed in line with policy.

Areas for improvement:

- Medicines management non-compliance in some areas. Examples include, no controlled drug checks completed; drug trolley left unattended; not all medicines stored securely; ambient

Appendix 3

temperature checks not completed consistently and prescribing practice and correct completion of prescription charts challenges at WHT.

- Not all staff wearing name badges.
- Ongoing focus on IPC compliance required (bare below the elbow; wrist watches; jewellery)
- Storage challenges in some areas.
- Not all confidential information stored securely.
- Staffing challenges – some 1:1 shifts not filled; daily staffing challenges (with mitigations in place); staff expressed concerns regarding being frequently moved to other clinical areas; strained relationships between some colleagues on specific wards (this is being addressed).
- Delay in obtaining previous notes for patients when they are admitted to wards.
- Ongoing focus on strengthening handovers / safety briefs required, ensuring that all key aspects are handed over, including focus on improvement such as observations being completed on time.
- Environmental challenges in some areas – 'tired estate'.
- Improvement work required and in progress with regards to maternity triage at RWT.

4.0 Actions

- All colleagues as identified in the BTTF guidance to continue participating in the BTTF days.
- Feedback on observations and findings to be provided immediately to the person in charge and shared with the relevant matron and HoN/HoM/Service Lead for awareness and action as required.
- HoNs/HoMs/Service Leads to maintain their own processes for ensuring that all relevant staff within their Divisions participate in the BTTF days, all areas are visited over time, feedback is provided and key themes and actions are captured. The areas visited and key themes will be requested for the next BTTF thematic report.
- This report to be shared with all senior nursing, midwifery and AHP leaders and relevant forums/committees across both organisations.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Integrated Quality and Performance Report – December 2022
Action Requested:	Receive and Note: Current Progress
For the attention of the Board	
Assure	• All data reported with thorough validation checks and relevant departments are aware of any underperformance
Advise	• None in this report
Alert	• None in this report
Author + Contact Details:	Performance Manager ext 86746 Email: Lesley.burrows2@nhs.net Deputy Chief Nurse ext 85892 Email: c.wilson12@nhs.net Deputy Chief Nurse ext 85859 Email: m.morris16@nhs.net Director of Nursing ext 85889 Email: debra.hickman@nhs.net Director Strategic Planning and Performance ext 85914 Email: timothy.shayes@nhs.net
Links to Trust Strategic Objectives	1. To have an effective and well integrated health and care system that operates efficiently 4. Deliver a safe and high quality service 5. Operationally manage the recovery from Coronavirus to achieve national standards
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.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	None
Risks: BAF/ TRR	None
Risk: Appetite	None
Public or Private:	Public Session
Other formal bodies involved:	Trust Management Committee, Finance & Performance Committee and QGAC
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

The Royal Wolverhampton NHS
NHS Trust

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Wolverhampton
West Midlands
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Integrated Quality and Performance Report December 2022

Contents

Key to KPI Variation and Assurance Icons

Variation					Assurance		
 		 					
Special Cause of concerning nature or higher pressure due to (H)igher or (L)ower values		Special Cause of improving nature or higher pressure due to (H)igher or (L)ower values		Common Cause - no significant change	Pass variation indicates consistently - (P)assing of the target	Hit and Miss variation indicates inconsistently - passing and failing the target	Fail variation indicates consistently - (F)ailing of the target

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (**L**) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT performance. (**H**) is where the variation is upwards for a metric that requires performance to be below a target or threshold e.g. pressure ulcers or falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (**L**) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT. (**H**) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. pressure ulcers or falls.

Executive Summary

Obs on time: this indicator has seen slight deterioration during December 22. The Quality and Education team continues to support individual areas**.**

C.diff: 8 cases in month, C. difficile task and finish group met in January 23 to review the Trust C. difficile action plan and identify any further actions required.

MRSA: no cases during December 22.
Induction of labour: slight increase in month, remaining above target. A QI project is due to commence to determine appropriateness of IOL.
Smoking at delivery: deterioration seen in month, remains above target.

RTT incomplete pathway: performance has dipped slightly when compared with last month. In order to ensure our waiting lists are up to date and accurate the Trust will shortly be contacting patients in phases, by text message, asking them to let us know if they still need treatment, they only need to respond if they no longer wish to be seen. If we don't hear from this cohort of patients they will remain on the waiting list.
RTT 78+ week wait: this indicator has risen above the monthly trajectory (310), this is currently under review and plans are in place to reduce this number over the coming months, however, we will still need to treat long waiting and clinically urgent patients first.
Diagnostics: this indicator has deteriorated during December 22, this is as a result of the Trust now having to add planned patients who are overdue their seen by date to the 6 week wait. This has largely impacted Endoscopy performance. Ultrasound scans remain an issue due to the large backlog.
ED 4 hour: performance remains below the lower control limit, December was significantly challenged and was compounded by significant events - Paediatrics ED and Walk-In centres had significant pressure due to the Strep A outbreak. We continue to benchmark well both locally and nationally.
Cancer 2ww: referral numbers remain high and were 13% above pre-covid numbers during December 22.
Cancer 62 day: monthly performance remains fragile due to the backlog numbers, lengthy diagnostic process and high referral rates.

RIT referrals/patients accepted and seen: we continue to see a sustained rise in the number of referrals and increased activity during December 22. Both indicators remain above the upper control limit.
Virtual ward: is currently performing and managing its referrals within the current pathways.
Rapid access social care discharge (initial): Increased admissions due to expanding capacity. Increased End Of Life patients on the caseload.

Trust vacancy rate: Although we saw some decline in performance during December 22, this indicator remains within target.
Turnover (normalised): shown some improvement in month, however, this continues to exceed the target. All recruitment and retention metrics for medical staff are being met.
Retention (24 months): this remains below target.
Appraisals: remains below target. Divisions are developing actions plans to address this performance.
Sickness (monthly): remains above target. Considerable work has been done to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

Corporate Scorecard Summary

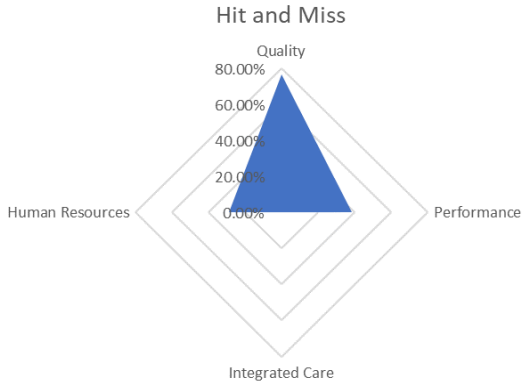
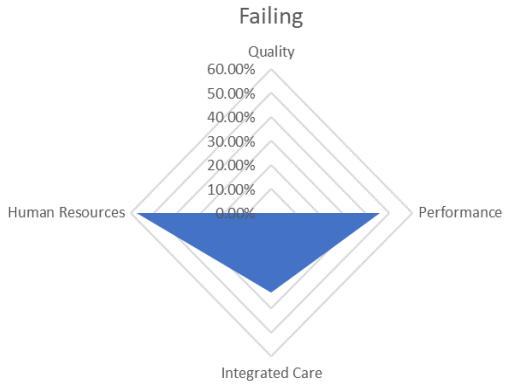
Quality				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Observations on time	>90%	72.20%		
Clostridioides difficile	4	8		
MRSA Bacteraemia	0	0		
Induction of labour	<33%	36.3%		
Smoking at delivery	<7%	13.3%		

Performance				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RTT - Incomplete Pathway	92%	55.03%		
RTT - 78+ Weeks	0	310		
Diagnostic 6 week wait	<1%	52.18%		
ED - 4 hour wait	95%	64.03%		
Cancer 2 week wait	93%	80.96%		
Cancer 62 day traditional	85%	22.73%		

Integrated Care				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RIT referrals received		1,471		
Patients accepted and seen		1,367		
Virtual Ward		153		
Rapid access social care discharge (initial)		62		

Human Resources				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Trust Vacancy Rate	6%	3.79%		
Turnover (normalised)	9%	11.49%		
Retention (24 months)	85%	80.45%		
Appraisals	90%	79.70%		
Sickness (monthly)	4.25%	5.75%		

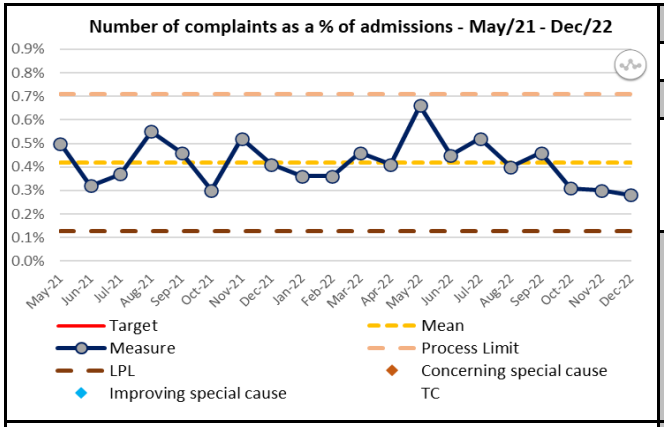
Indicator Summary

Consistently Passing	Hit and Miss	Consistently Failing
		
Quality - Duty of candour elements 1&2, Serious incidents reported within 48 hours & Midwife to birth ratio. **Performance** - Cancelled ops as % of electives, urgent cancelled ops for 2nd time, BADS Day Surgery & E-discharge summary **Integrated Care** - Patients offered HIV test & Crisis response **Human Resources:** mandatory training (generic)	**Quality** - Complaints against policy, obs on time, patient falls rate, C.diff, MRSA, medication incidents causing harm, never events, Care hours per patient day total & registered nurses, sepsis ED/inpatient, induction of labour & smoking at time of delivery. **Performance** - Cancelled ops not rebooked within 28 days, RTT 104+ waits, patient stay on Stroke Unit, stroke patients within 24 hours, Theatre utilisation, Cancer 2ww, Cancer 2ww breast, anti cancer drug, radiotherapy & 28 day FDS. **Human Resources:** vacancy rate & retention	**Performance** - RTT incomplete %, diagnostic waits, ED 4 hour wait, ED attend >12 hours, ambulance handover <15, <30 & >60 minutes, 31 day to treatment, 31 day sub-surgery, 62 day to treatment, screening & consultant upgrade. **Integrated Care** - Sexual health appointments offered **Human Resources:** turnover, appraisals, sickness rate monthly & sickness rate (rolling 12 months)

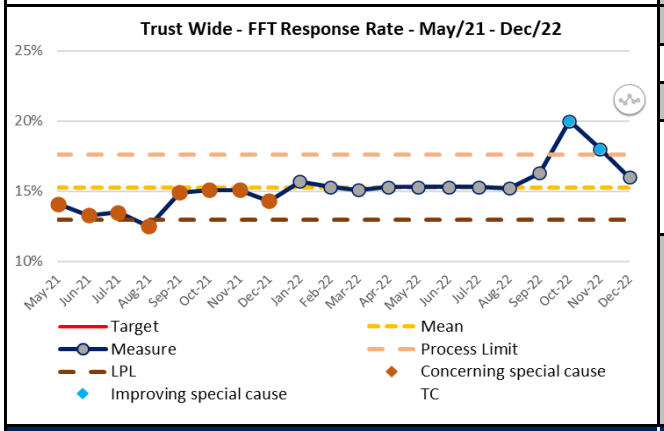
Quality

Metric - Patient Experience	Target	Variation	Assurance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Number of complaints as a % of admissions	Surveillance			0.52%	0.40%	0.46%	0.31%	0.30%	0.28%
Complaints response rate against policy	90%		?	95%	92%	97.5%	96.0%	96.0%	97.0%
FFT response rates - Trust wide	Surveillance			15.3%	15.2%	16.3%	20.0%	18.0%	16.0%
FFT recommendation rates - Trust wide		L		84.0%	84.5%	85.0%	82.0%	82.0%	77.0%
Observations on time (Trust wide)	>90%	L	?	73.25%	73.11%	73.98%	71.91%	74.71%	72.20%
Duty of Candour - Element 1: notifying patients and families of the incident and investigation taking place. Due 10 working days after incident is reported to STEIS	0		P	0	0	0	0	0	0
Duty of Candour - Element 2: sharing outcome of investigation with patients/relatives. Due 10 working days after final RCA report is submitted to CCG	0		P	0	0	0	0	0	0
Metric - Patient Outcomes	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Pressure ulcers - STEIS reportable cases	Surveillance			0	1	0	0	0	0
Pressure ulcers per 1,000 occupied bed days				1.25	1.37	0.67	1.30	1.06	1.71
Falls rate with harm per 1,000 occupied bed days				0.08	0.04	0.04	0.04	0.00	0.03
Patient falls - rate per 1,000 occupied bed days	<5.6		?	4.35	4.54	3.98	4.14	3.89	4.14
Crude mortality rate	Surveillance			1.86%	1.71%	1.68%	1.79%	1.71%	2.00%
RWT SHMI		L		0.9491	0.9382				

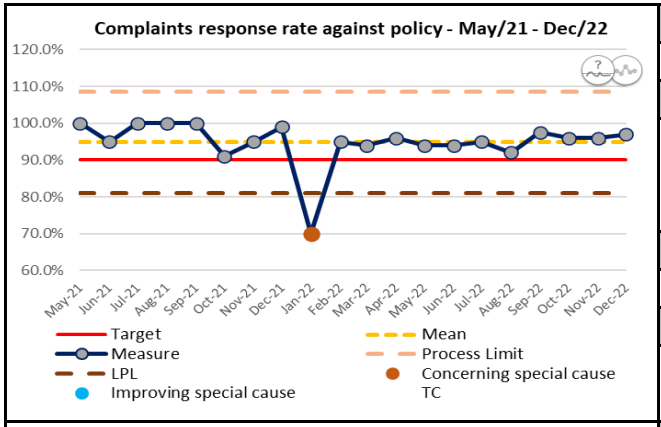
Metric - Patient Safety	Target	Variation	Assurance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Clostridioides difficile	4			7	2	2	9	3	8
MRSA Bacteraemia	0	L		0	0	0	0	0	0
E.Coli	Surveillance			26	17	25	18	21	18
Covid outbreaks				10	6	10	8	9	3
Medication error - incidents causing harm	0			0	0	0	0	0	0
Serious incident reporting - report incidences within 48 hours	0		P	0	0	0	0	0	0
Never events	0	L		0	0	0	0	0	0
Metric - Patient Safety (continued)	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Care hours per patient - total nursing & midwifery staff actual	>/= 7.6	L		7.4	7.5	7.6	7.5	7.6	7.7
Care hours per patient - registered nursing & midwifery staff actual	>/= 4.5	L		4.3	4.4	4.5	4.4	4.5	4.6
Midwife to birth ratio	</=30	H	P	29.0	29.0	30.0	30.0	30.0	30.0
Sepsis screening - ED	>/= 90%			90.0%	92.0%	98.0%	92.0%	88.0%	98.0%
Sepsis screening - Inpatients (reported quarterly)	>/= 90%			91.67%			90.00%		
Thrombus - Hospital acquired (VTE numbers) per 1,000 occupied bed days (reported quarterly 1 month in arrears)	Surveillance	H		0.63					
Metric - Maternity	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Induction of labour rate	<33%			34.2%	37.7%	33.5%	34.6%	33.3%	36.3%
Smoking at delivery	<7%			11.5%	7.2%	7.4%	10.1%	11.9%	13.3%
Babies being cooled (born here)	Surveillance			0	1	2	0	1	1



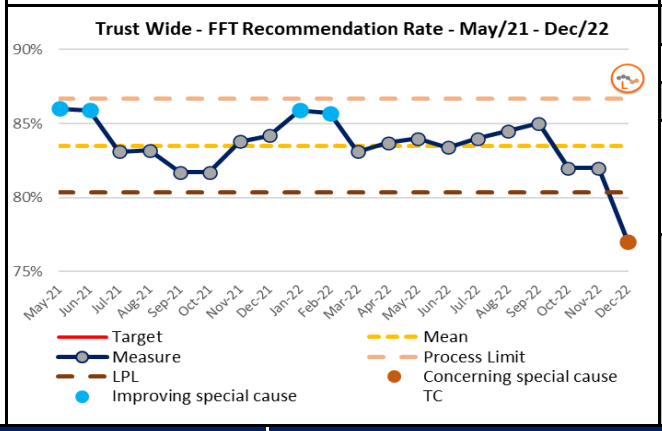
Dec-22
0.28%
Variance Type
Metric is showing common cause variation



Dec-22
16.0%
Variance Type
Metric is showing common cause variation

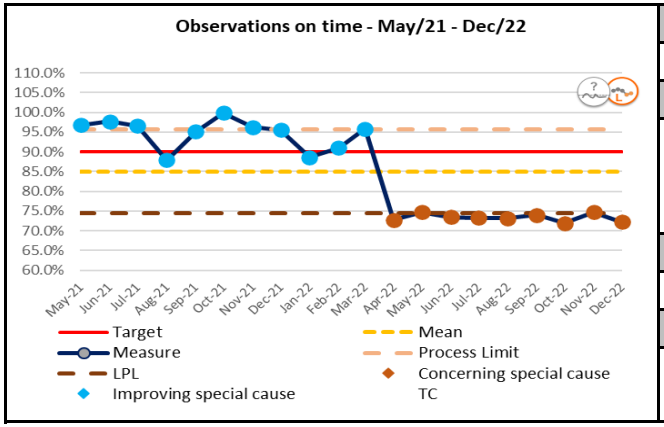


Dec-22
97.0%
Variance Type
Metric is showing common cause variation
Target
90.0%
Achievement
Metric is currently passing the target

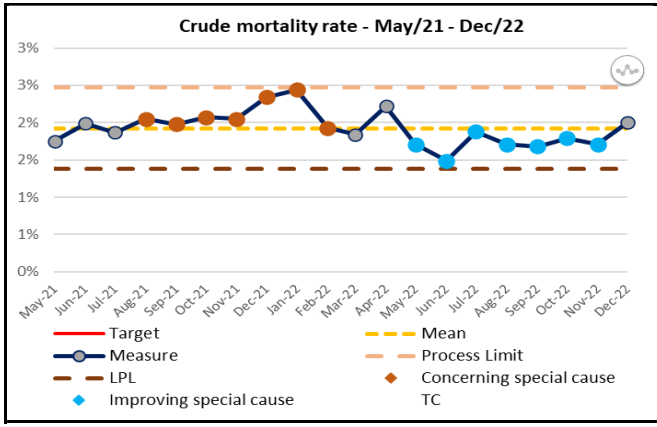


Dec-22
77.0%
Variance Type
Metric is currently showing lower cause variation (concern)

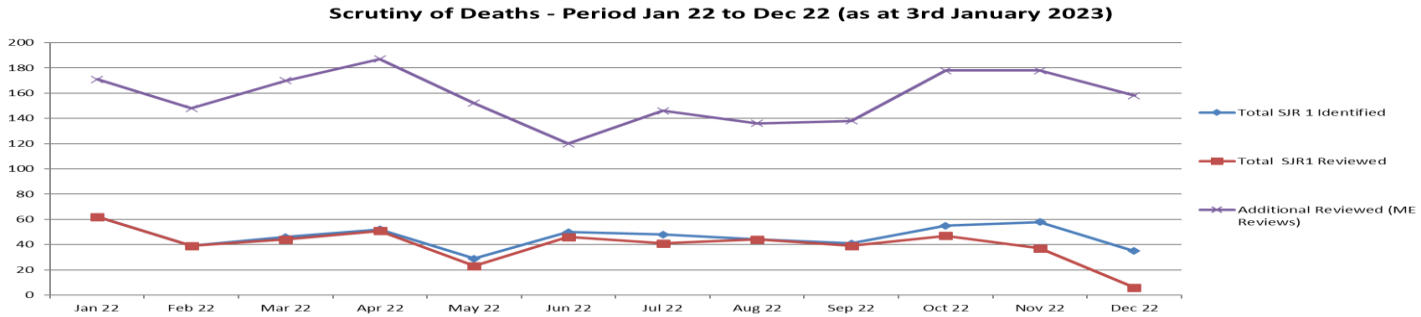
Summary	Actions	Assurance
Complaints: There were 30 formal complaints raised. It is noted that when compared to the same reporting period in 2021, there were 42 received. This represents a decrease of 28%. **Complaints Response:** There were 11 complaints which took longer than 30 days to complete, 10 of these did gain consent to breach from the complainant and 1 did not.	A decline in volume has been experienced which is not uncharacteristic for this time of the year. The team have been working with the operational teams to use this time to work to bring outstanding complaints outstanding to a closure. This is reflected in a reduction of the need for extensions to complaint response timescales.	Attendance at Divisional Governance meetings by the Patient Experience Team to discuss complaints and FFT performance, trend analysis and agree actions is custom and practice.
FFT: The overall Trust wide response rate for December 22 was 16% with 3,666 (77%) recommending the Trust and 792 (17%) not recommending the Trust.	The declining performance will be discussed in January 23 at the Patient Experience Group with operational staff, to include actions to improve performance.	



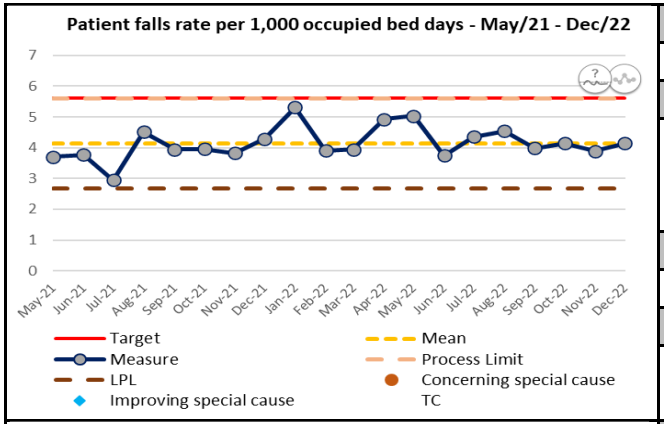
Dec-22
72.20%
Variance Type
Metric is currently showing lower cause variation (concern)
Target
90%
Achievement
Metric is currently failing the target



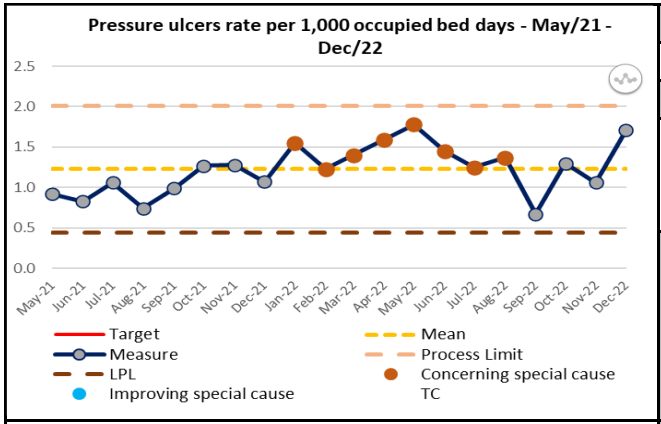
Dec-22
2.00%
Metric is showing common cause variation



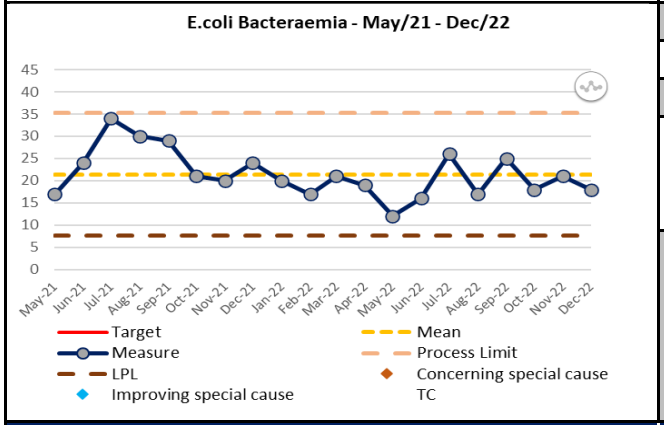
Summary	Actions	Assurance
Observations on time: There has been some slight deterioration in percentage scores in relation to patient observations completed on time, with the overall score of 72.2% for December 22 in comparison to 74.71% achieved in November 22.	Improvement actions remain in progress across the Trust, with some clinical areas utilising an 'observations on time prompt aid', to drive improvements. The Quality and Education teams continue to support individual areas with their improvements and this approach will continue.	Monitoring continues as part of corporate teams working with wards using Quality Improvement methodologies. Progress and additional interventions are discussed at the Deteriorating Patient Group and other relevant forums.
Mortality: The SHMI is 0.9382 and is within the expected range. At last reported position to MRG Chair as at 3rd January 2023 there were 67 outstanding SJRs for the period December 2021 to December 2022 (increased from 44 outstanding SJRs at previous time of reporting).	Of the SJRs completed during quarter 3 reported to MRG Chair on 9th January 2023, 6 cases in total were assessed where an element of poor care has been identified at the overall phase of care. The increase in numbers since previous reporting period is due to the Christmas period coupled with the clinical pressures being experienced by mortality reviewers within the hospital.	SHMI remains within expected range. There have been two additional mortality reviewers recruited, one of whom began undertaking reviews in January 2023 and the second will be undertaking reviews commencing March 2023.



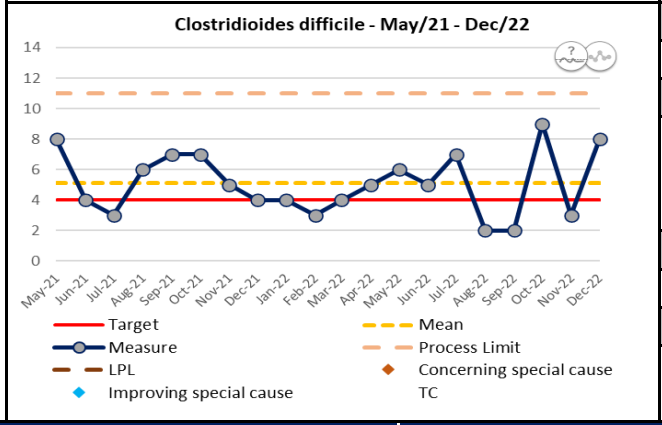
Dec-22
4.14
Variance Type
Metric is showing common cause variation
Target
<5.6
Achievement
Metric is currently passing the target



Dec-22
1.71
Variance Type
Metric is showing common cause variation

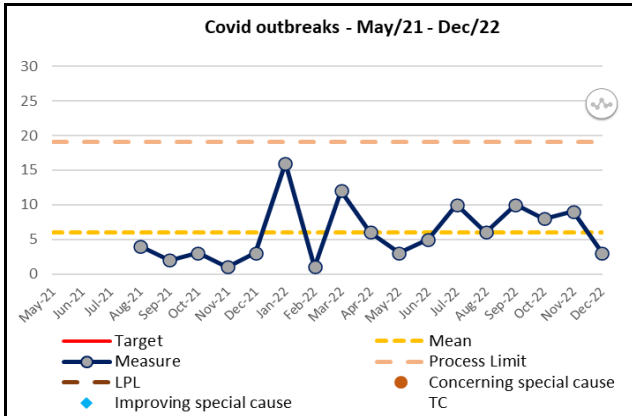


Dec-22
18
Variance Type
Metric is showing common cause variation

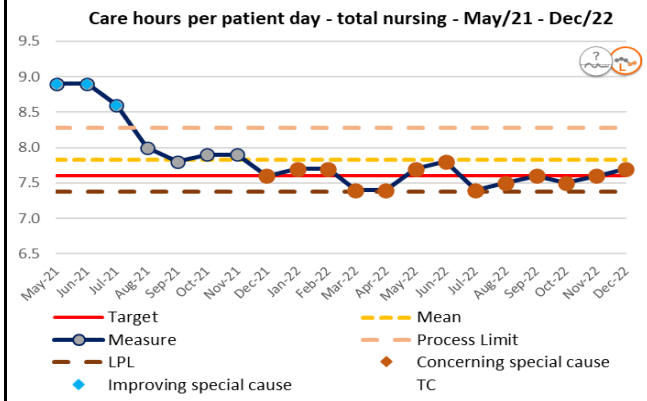


Dec-22
8
Variance Type
Metric is showing common cause variation
Target
4
Achievement
Metric is currently failing the target

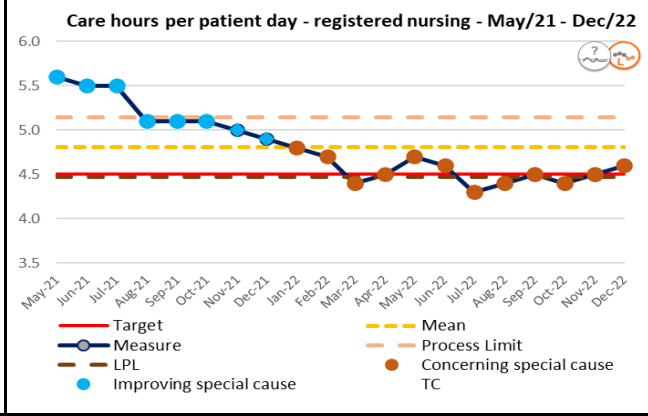
Summary	Actions	Assurance
HCAI: C.difficile saw 8 cases in month against a target of 4 during December 22. We are now 11 cases above the external trajectory at the end of month 9. There were no MRSA Bacteraemia cases during December 22.	IP team are involved in collaborative working groups with NHSE for Gram negative bacteraemia, C. difficile and surgical site infection. C. difficile task and finish group met in January 23 to review the Trust C. difficile action plan and identify any further actions required. NHSE will conduct an invited site visit at the end of January 23 to include a focus on documentation and board oversight. Weekly hydrogen peroxide decontamination of side-rooms with C. difficile patients are not achieved consistently due to capacity pressures. However, routine cleaning of isolation rooms is being achieved. The deep clean programme has been paused, however, Hotel Services continue to complete ad hoc deep cleans as possible.	An action plan is in place for Clostridioides difficile which includes, increased education for staff, increased audits including commodes, antimicrobial ward round is informed by the regional c.difficile collaboration work.



Dec-22
3
Variance Type
Metric is showing common cause variation

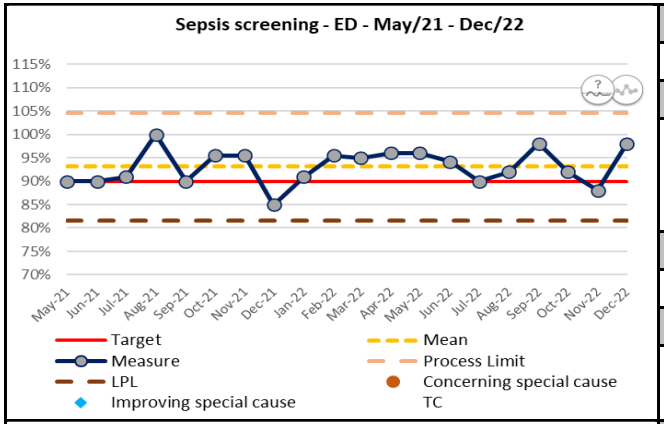


Dec-22
7.7
Variance Type
Metric is currently showing lower cause (concern)
Target
>7.6
Achievement
Metric is currently passing the target

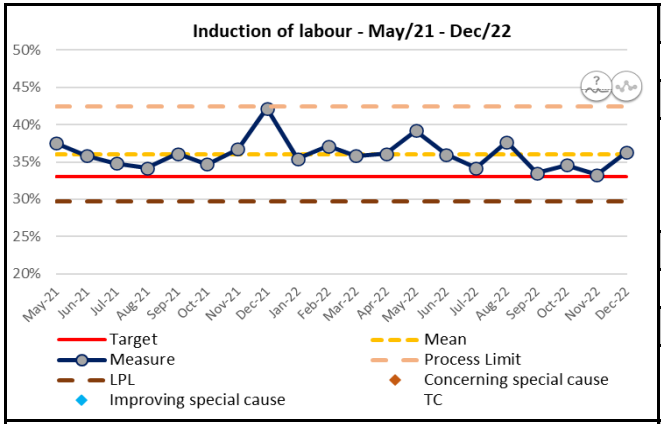


Dec-22
4.6
Variance Type
Metric is currently showing lower cause (concern)
Target
>4.5
Achievement
Metric is currently passing the target

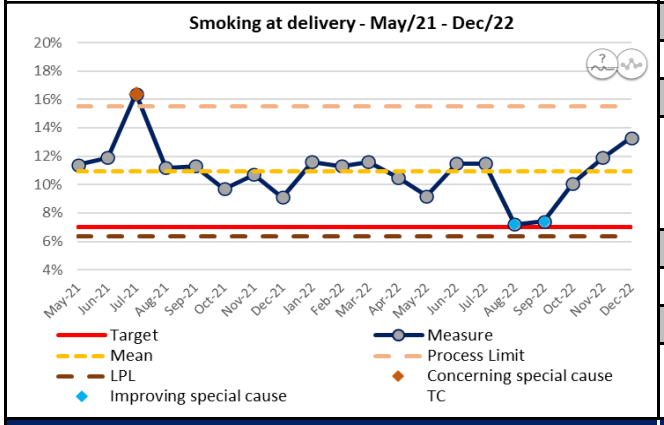
Summary	Actions	Assurance
Covid Outbreaks: Total of COVID outbreaks = 3 19 HCAIs were linked to outbreaks in December 22, with 11 not being linked to an outbreak.	ICB local outbreak procedure has been agreed, RWT are now following this reporting process. All the incidents and outbreaks have been reviewed at Grand Outbreak meetings which take place weekly on Tuesdays and Thursdays.	Occupational Health are maintaining a database of all COVID Positive staff. Outbreak management processes are in place as per Trust policy.
Care Hours per Patient Day (CHPPD): Trust average for December 22 was 7.7; the model hospital dashboard shows a national median to be 8.0 for August 22. Adult inpatient range between 4.5 - 10.2 (Mean 6.4) Critical care/Neonatal range between 27.8 - 29.0 (Mean 28.4) Emergency portal range between 7.2 - 7.7 (Mean 7.5)	Continue with monthly recruitment events. The next recruitment event is due to take place on 21st January 2023 at RWT for all 3 divisions. Prince's Trust recruitment continues with VCP's for unregistered vacancies.	Another 40 Clinical Nurse Fellows are due to arrive and start in posts at RWT (39 in January and 1 in February 2023). Local Pipeline – 133.91 (43.51WTE with start dates).



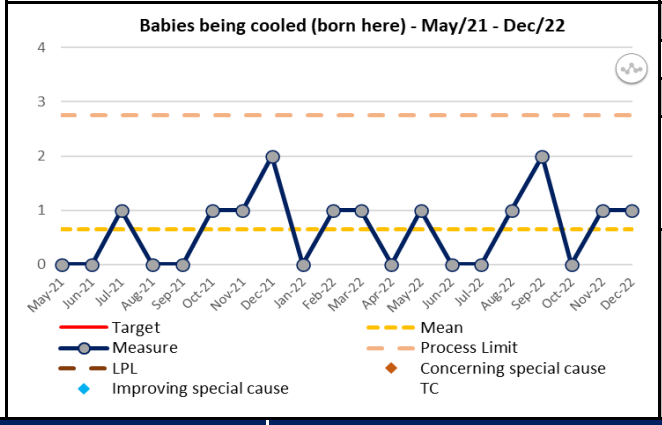
Dec-22
98.0%
Variance Type
Metric is currently showing common cause variation
Target
90%
Achievement
Metric is currently passing the target



Dec-22
36.3%
Variance Type
Metric is currently showing common cause variation
Target
<33%
Achievement
Metric is currently failing the target



Dec-22
13.3%
Variance Type
Metric is currently showing common cause variation
Target
<7%
Achievement
Metric is currently failing the target



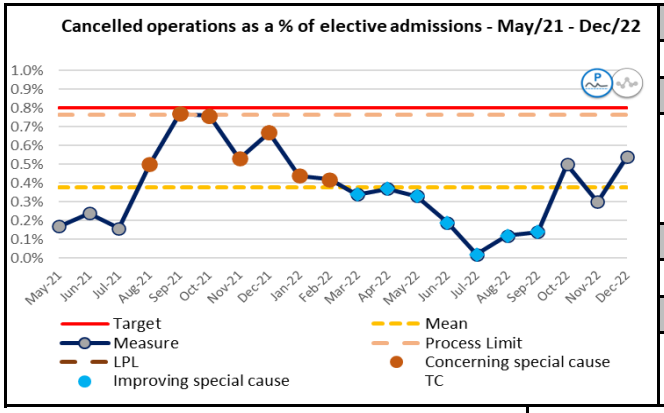
Dec-22
1
Variance Type
Metric is currently showing common cause variation

Summary	Actions	Assurance
Sepsis screening in ED: December 22 saw an increase. This performance is above target.		
Maternity: Induction of labour saw an increase during December 22.	Work is ongoing to monitor induction of labour (IOL) rates and a QI project is due to commence to determine appropriateness of IOL.	Bookings are being monitored closely to ensure birth rate trajectories are manageable in line with Birth to Midwife ratio's and capacity. Birth to Midwife ratio's 1:30 presently – recruitment taken place to bring in line with BR+ ratio of 1:27.
Maternity: Smoking times at delivery (SATOD) - showed an increase in month, this data is monitored by the Black Country Tobacco Treatment Steering Group.	Smoking at time of delivery rates are being monitored closely to ensure sustained reduction.	

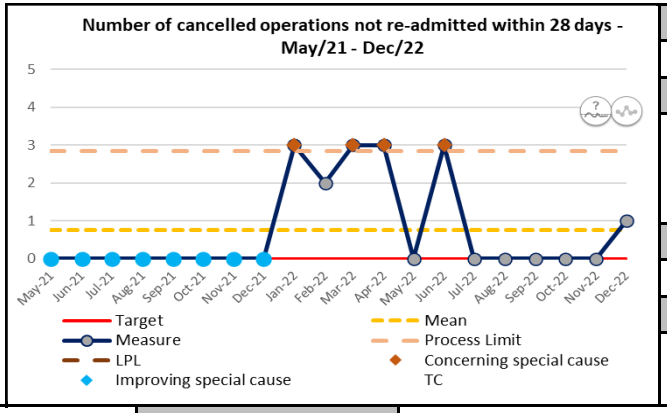
Performance

Metric - Patient Experience	Target	Variation	Assurance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Number of cancelled operations on the day of surgery for non-medical reasons				1	6	7	25	17	24
Cancelled operations as a % of elective admissions	<0.8%		P	0.02%	0.12%	0.14%	0.50%	0.30%	0.54%
Number of cancelled operations not re-admitted within 28 days	0		?	0	0	0	0	0	1
Number of urgent cancelled operations cancelled for a 2nd time	0		P	0	0	0	0	0	0
Number of patients who are medically fit for discharge				78	74	76	65	70	86
Metric - Waiting Times	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
RTT - % of patients on an incomplete pathway	92%	L	F	61.96%	61.67%	59.89%	59.88%	58.73%	55.03%
RTT - number of patients waiting 104+ weeks	0	L	?	0	0	0	0	0	0
RTT - number of patients waiting 78+ weeks		L		305	273	251	242	284	310
Total Incomplete Number		H		67,611	70,087	71,377	72,561	73,071	73,634
Diagnostic Test - % of patients waiting 6 weeks or more	<1%	H	F	44.23%	41.96%	45.40%	44.69%	42.95%	52.18%
Metric - Urgent Care	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Total time spent in ED (4 hours) - New Cross Hospital	95%	L	F	73.36%	71.76%	70.46%	70.82%	66.39%	58.29%
Total time spent in ED (4 hours) - Combined				80.92%	79.37%	79.06%	79.07%	73.29%	64.03%
% of ED attendances >12 hours	0	H	F	10.61%	10.50%	11.04%	10.38%	10.38%	12.76%
Ambulance handover within 15 minutes	65%	L	F	34.33%	34.13%	37.84%	29.57%	32.20%	24.96%
Ambulance handover within 30 minutes	95%	L	F	69.76%	68.81%	74.04%	68.07%	69.60%	58.98%
Ambulance handover >60 minutes	0%	L	F	14.37%	16.10%	11.45%	14.62%	14.47%	22.81%
% of emergency admissions via Emergency Department		H		37.65%	39.19%	39.82%	39.56%	38.89%	36.96%

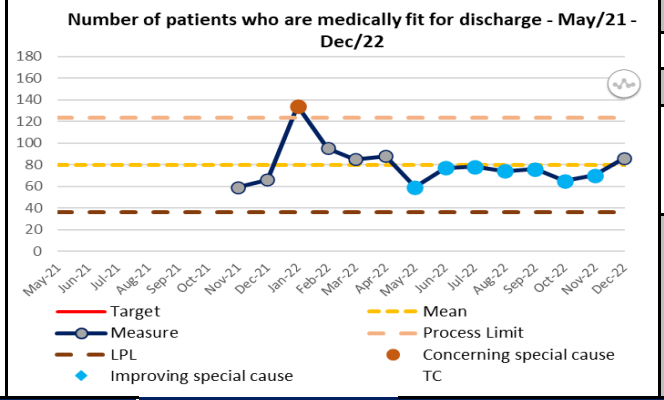
Metric - Stroke	Target	Variation	Assurance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Patients admitted with primary diagnosis of stroke should spend greater than 90% of their hospital stay on a dedicated stroke unit	80%			91.57%	95.60%	93.83%	92.59%	97.59%	85.53%
Stroke patients will be assessed and treated within 24 hours	60%			64.91%	67.95%	96.30%	63.23%	85.14%	84.93%
Metric - Organisational Efficiency	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Theatre Utilisation (Trust Wide)	>/= 90%			87.24%	88.24%	88.90%	89.34%	90.99%	87.73%
British Association of Day Surgery	>/= 75%			95.19%	95.25%	94.13%	95.17%	94.88%	95.83%
Electronic discharge summary within 24 hours of patient discharge	>/= 90%			92.90%	95.22%	94.79%	92.39%	92.74%	94.54%
Metric - Cancer Waiting Times	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
2 Week Wait - Cancer Referrals	93%			78.05%	79.21%	57.81%	75.00%	82.01%	80.96%
2 Week Wait - Breast Symptomatic Referrals	93%			97.83%	97.01%	51.46%	76.09%	90.00%	90.74%
31 Day to First Treatment	96%			77.59%	74.47%	70.07%	84.45%	77.33%	75.86%
31 Day Sub Treatment - Anti Cancer Drug	98%			86.89%	90.36%	79.80%	100.00%	90.16%	96.15%
31 Day Sub Treatment - Surgery	94%			44.12%	57.78%	63.27%	54.55%	44.44%	65.38%
31 Day Sub Treatment - Radiotherapy	94%			74.64%	76.67%	79.41%	85.79%	81.17%	93.65%
62 Day Wait for First Treatment	85%			49.77%	37.62%	40.23%	35.16%	32.48%	22.73%
62 Day Wait - Screening	90%			31.82%	29.41%	33.33%	36.36%	47.37%	31.43%
62 Day Wait - Consultant Upgrade (local target)	88%			66.89%	55.62%	53.11%	58.17%	51.70%	54.55%
28 Day Faster Diagnosis Standard	75%			65.56%	68.59%	68.00%	69.07%	68.52%	68.96%



Dec-22
0.54%
Variance Type
Metric is showing common cause variation
Target
<0.8%
Achievement
Metric is currently passing the target

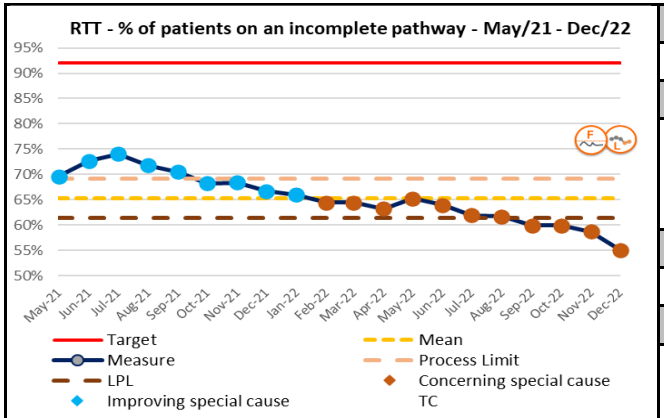


Dec-22
1
Variance Type
Metric is showing common cause variation
Target
0
Achievement
Metric is currently failing the target

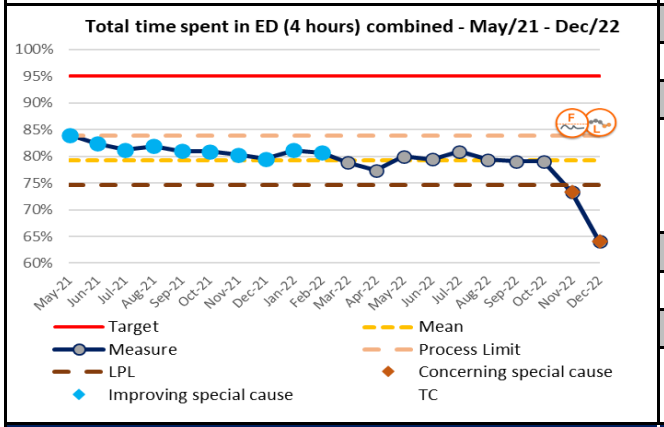


Dec-22
86
Variance Type
Metric is showing common cause variation

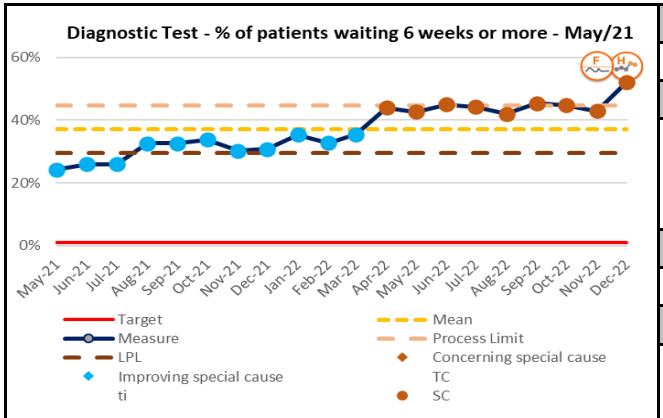
Summary	Actions	Assurance
Cancelled Operations: We saw an increase during December 22, however, this remains below target. There was 1 patient who had been cancelled that was not rebooked within 28 days this was due to the patient being covid +.	All cancelled operations on the day of surgery are reported daily and root cause analysis (RCA) is completed	RCA's are circulated to Deputy COO's on a weekly basis as part of the weekly performance meeting.
Patients who are Medically Fit for Discharge (MFFD): at the end of December 22 we had 86 patients in a hospital bed that were medically fit for discharge, this is an increase of 16 patients when compared with the previous month.	Daily medically fit for discharge meetings where every patient is reviewed. Daily escalation telephone calls to local authority and community teams.	The huddle tool is used internally to communicate between all departments.



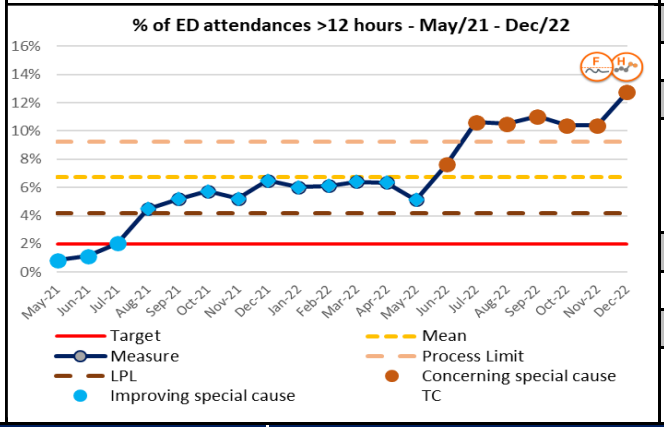
Dec-22
55.03%
Variance Type
Metric is showing lower special cause variation (concern)
Target
92%
Achievement
Metric is currently failing the target



Dec-22
64.03%
Variance Type
Metric is showing lower special cause (concern)
Target
95%
Achievement
Metric is currently failing the target

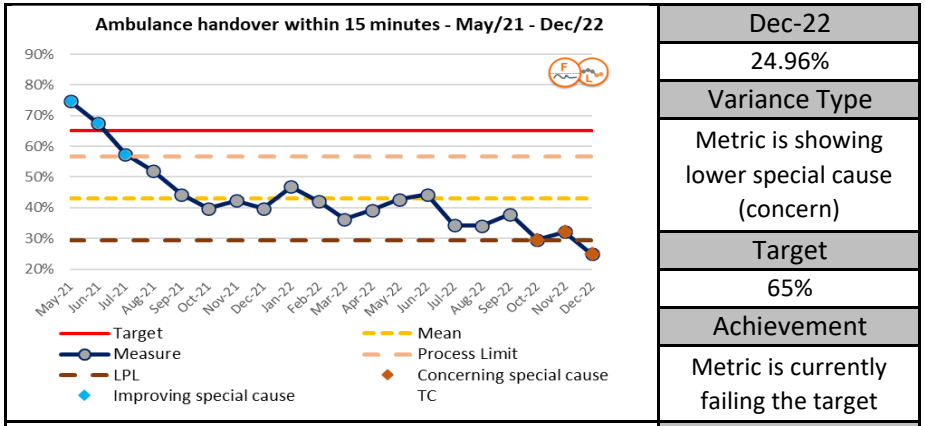


Dec-22
52.18%
Variance Type
Metric is showing higher special cause variation (concern)
Target
<1%
Achievement
Metric is currently failing the target

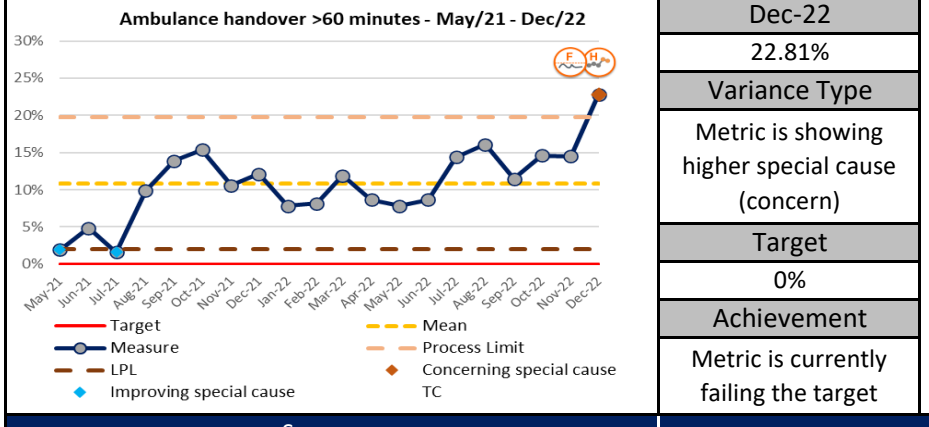


Dec-22
12.76%
Variance Type
Metric is showing higher special cause (concern)
Target
<2%
Achievement
Metric is currently failing the target

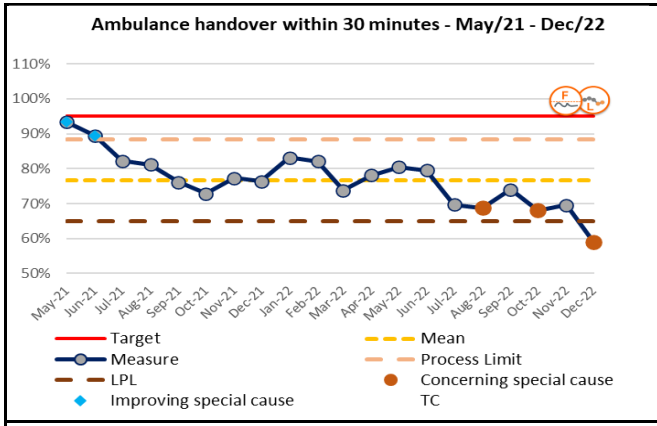
Summary	Actions	Assurance
RTT: 310 patients were reported as waiting 78+ weeks at month end. This remains above the monthly trajectory target of 211 by month end. This will be a challenge moving forwards as the trajectory reduces.	The Trust will shortly be contacting patients in phases, by text message, asking them to let us know if they still need treatment. Those who receive the message only need to let us know if they no longer need an appointment. If they still require an appointment they will remain on the Trust waiting list.	These patients are monitored on a weekly basis. The Trust is continuing to manage long waiting patients and utilise mutual aid where possible.
Diagnostics: December 22 performance showed deterioration in performance, this is as a result of us now having to include planned tests that are now overdue their seen by date.	U/S scans remain the biggest issue due to large backlog (overall performance excluding U/S is 40.04%). Endoscopy now also have high numbers due to the addition of the planned patients.	All modalities have an individual trajectory to work towards. This is monitored at the weekly performance meeting.
ED: Nationally RWT ranked 19th out of 110 Trusts for the month (compared with 18th in the previous month). Locally RWT we ranked 3rd out of 14 Trusts (static position when compared with the previous month).	December was significantly challenged and was compounded by significant events - Paediatrics ED and Walk-In centres had significant pressure due to the Strep A outbreak.	The Trust has maintained a strong position regionally and nationally. This indicator is monitored closely and discussed weekly at the Trust level performance meeting.



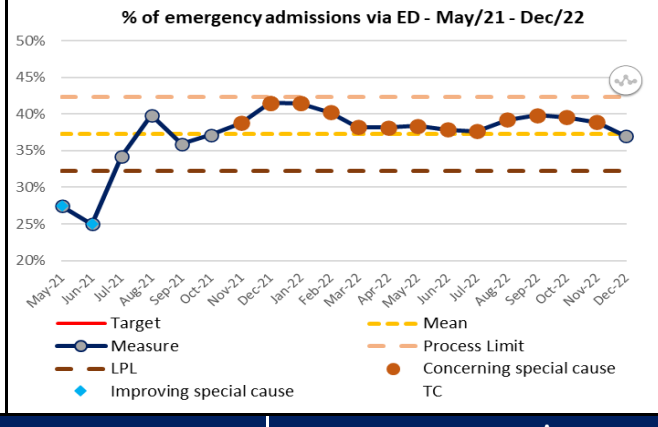
Dec-22
24.96%
Variance Type
Metric is showing lower special cause (concern)
Target
65%
Achievement
Metric is currently failing the target



Dec-22
22.81%
Variance Type
Metric is showing higher special cause (concern)
Target
0%
Achievement
Metric is currently failing the target

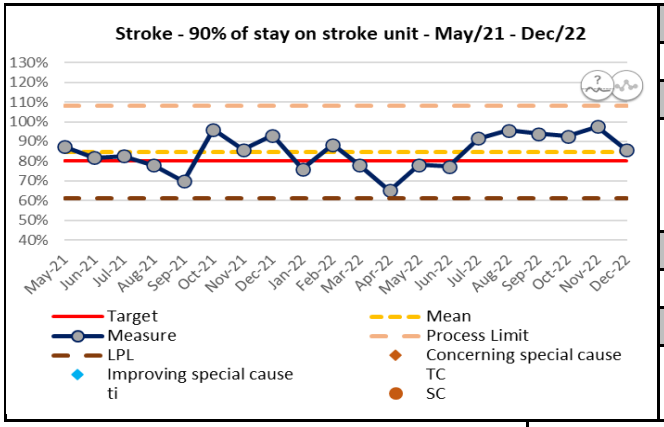


Dec-22
58.98%
Variance Type
Metric is showing common cause variation
Target
95%
Achievement
Metric is currently failing the target

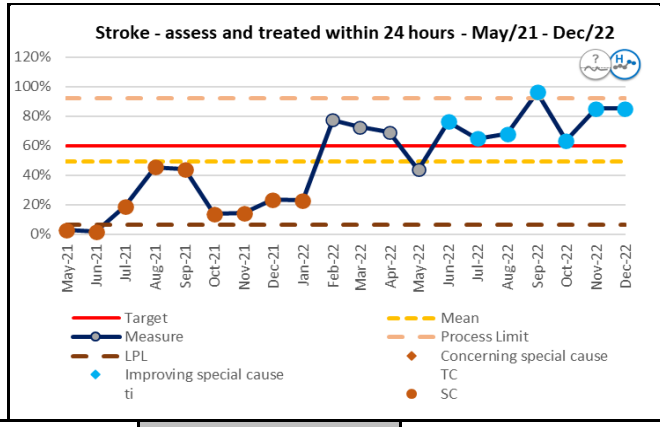


Dec-22
36.96%
Variance Type
Metric is showing common cause variation

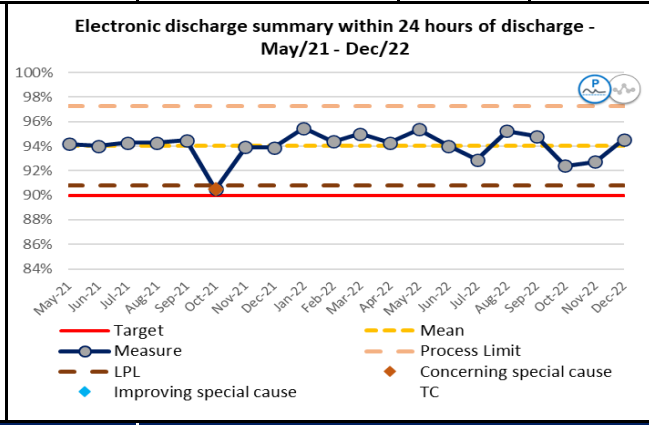
Summary	Actions	Assurance
Ambulance Handover: Deterioration was seen in all of the handover performance during December 22. Significant rise in patients who were medically fit for discharge in the organisation - resulting in lack of flow out of the Emergency Department.	Criteria Led Handover was implemented in Division 2 to expedite timely transfers. Push Pilot continued and is now extended where patients are pushed to every medical ward at 9:30 and 11:30 irrelevant of confirmed discharge. ARC is open and remains operational – AOA1 & 2 flexed as required.	The new ambulance receiving centre which has 17 additional offload spaces is now to open. An improved position has been seen since 5th January and is being maintained to date.
Emergency Admissions via ED: We saw further reduction in the emergency admission rate during December 22, the reduction has mostly been seen in SDEC to base wards. 56.4% of admissions are discharged home directly from SDEC, 6.6% are admitted to base ward via SDEC and the remaining 37.0% are admitted directly to a base ward.		Discussed in detail at the weekly performance meeting.



Dec-22
85.53%
Variance Type
Metric is showing common cause variation
Target
80%
Achievement
Metric is currently passing the target

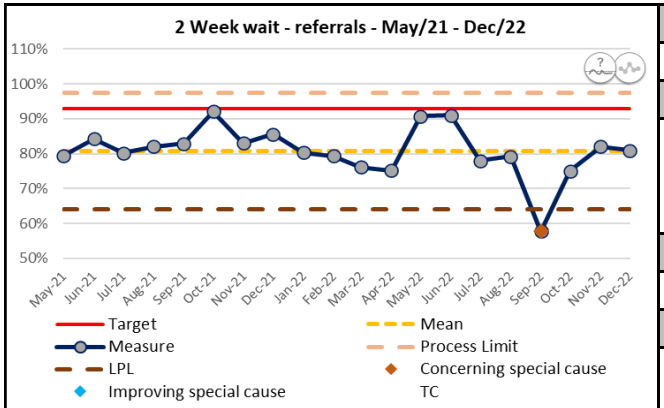


Dec-22
84.93%
Variance Type
Metric is showing higher special cause (improving)
Target
60%
Achievement
Metric is currently passing the target

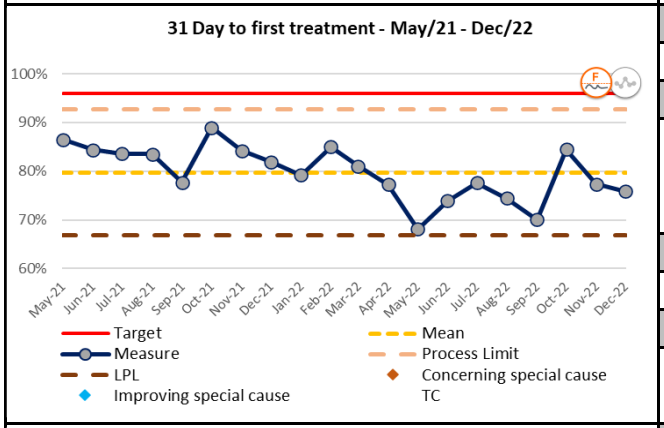


Dec-22
94.54%
Variance Type
Metric is currently showing common cause variation
Target
90%
Achievement
Metric is currently passing the target

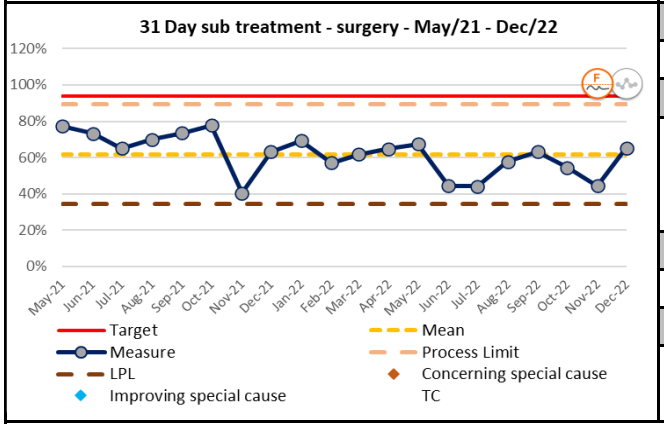
Summary	Actions	Assurance
Stroke: Patients spending 90% of time on a stroke ward has seen some slight deterioration during December 22, however, it remains above target.	Reasons for patients breaching the percentage of time on the stroke ward continue to be reviewed and recorded. This will used as part of the SSNAP report.	Continue to monitor outliers within the pathway, link discussion to pre-alert pathway and out flow model for stroke.
Stroke: Performance remained static during December 22 for patients being assessed and treated within 24 hours, this remains above target.	Weekly performance review of breach reasons by senior management team continues.	The service are undergoing demand and capacity modelling as a part of a wider action plan.
Electronic Discharge Summary: this remains above target.	Weekly ward level performance is circulated to all ward areas along with records that were not actioned on time for analysis and learning.	Continued weekly monitoring and reporting.



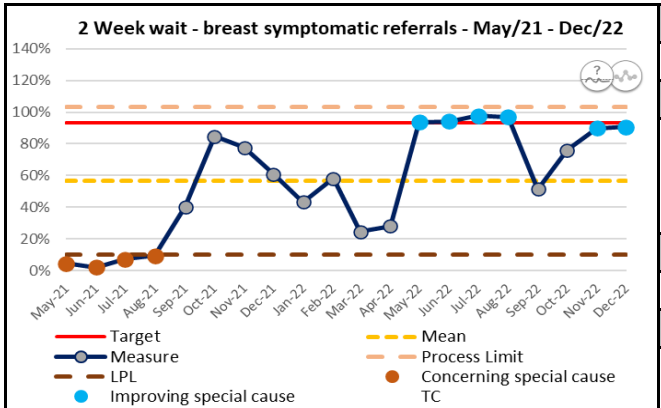
Dec-22
80.96%
Variance Type
Metric is showing common cause variation
Target
93%
Achievement
Metric is currently failing the target



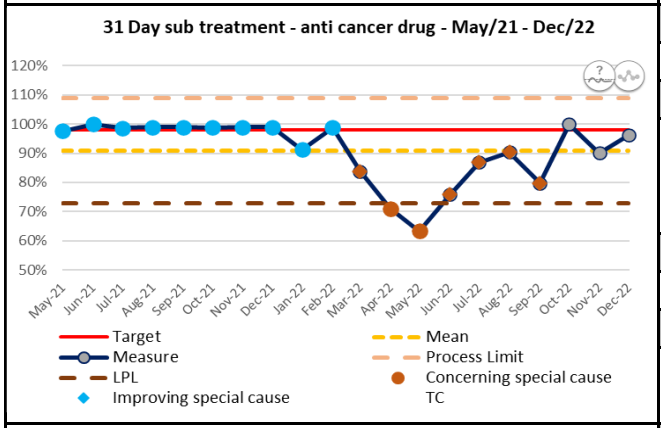
Dec-22
75.86%
Variance Type
Metric is showing common cause variation
Target
96%
Achievement
Metric is currently failing the target



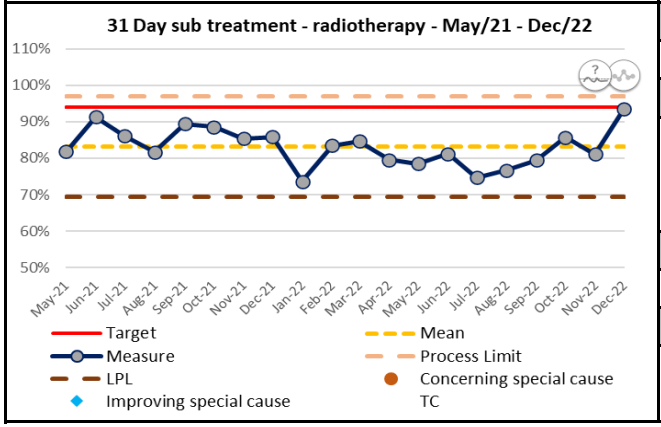
Dec-22
65.38%
Variance Type
Metric is showing common cause variation
Target
94%
Achievement
Metric is currently failing the target



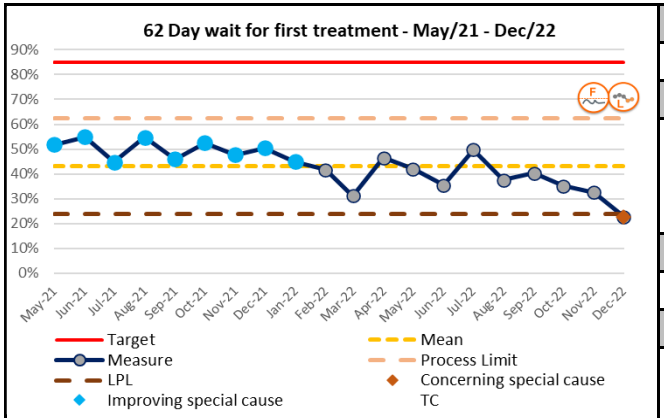
Dec-22
90.74%
Variance Type
Metric is showing common cause variation
Target
93.00%
Achievement
Metric is currently failing the target



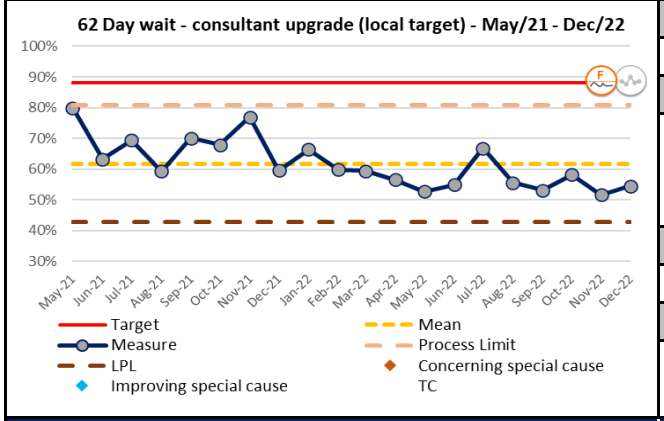
Dec-22
96.15%
Variance Type
Metric is showing common cause variation
Target
98%
Achievement
Metric is currently failing the target



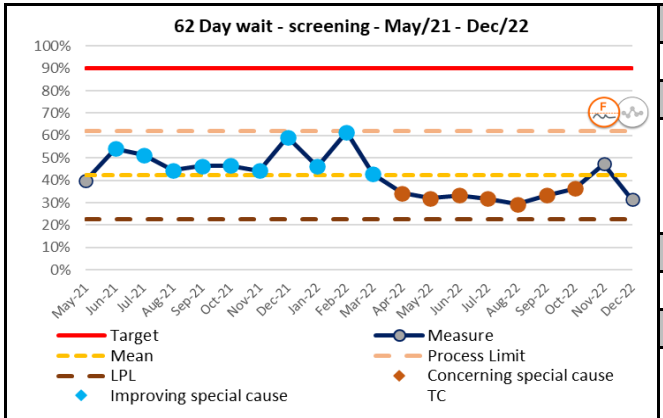
Dec-22
93.65%
Variance Type
Metric is showing common cause variation
Target
94%
Achievement
Metric is currently failing the target



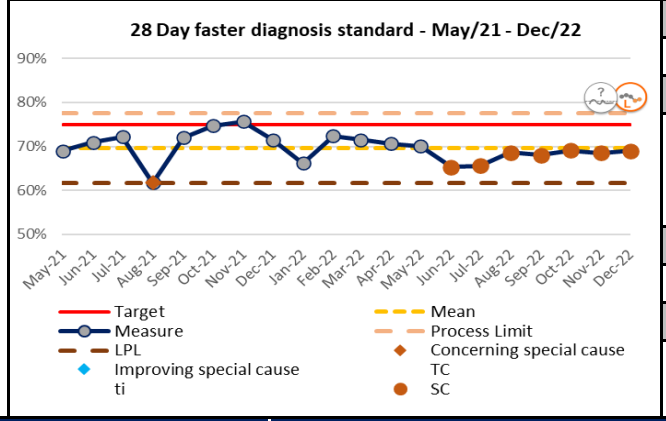
Dec-22
22.73%
Variance Type
Metric is showing lower cause variation (concern)
Target
85%
Achievement
Metric is currently failing the target



Dec-22
54.55%
Variance Type
Metric is showing common cause variation
Target
88%
Achievement
Metric is currently failing the target



Dec-22
31.43%
Variance Type
Metric is showing common cause variation
Target
90%
Achievement
Metric is currently failing the target

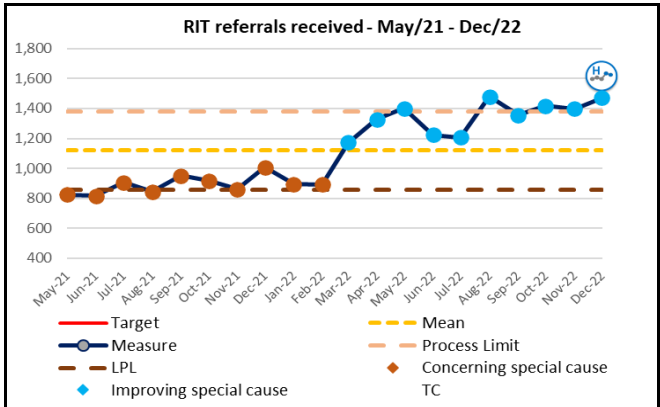


Dec-22
68.96%
Variance Type
Metric is showing lower cause variation (concern)
Target
75%
Achievement
Metric is currently failing the target

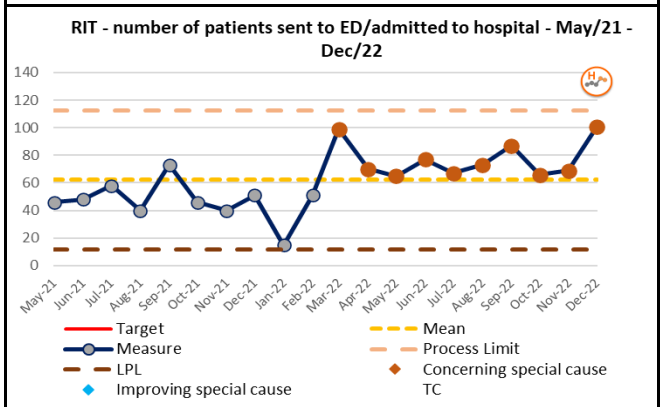
Summary	Actions	Assurance
Cancer: Overall high volumes of 2ww referrals have continued throughout December 22 and these were reported at 13% higher than pre-covid numbers. Achievement of these standards continues to be highly challenging, with high numbers of referrals alongside the number of patients in the 62 day backlog.	2ww waiting times continue to be monitored and discussed across the Black Country Trust's, skin and breast being the centre of discussions at the moment. Introduction of electronic pre-op for appropriate patients to reduce delays. Two new oncology consultants to start in March 2023, these will provide support for melanoma and urology.	All cancer indicators are monitored at the weekly Trust performance meeting along with a separate weekly PTL meeting focussing on individual pathways and patients.

Integrated Care

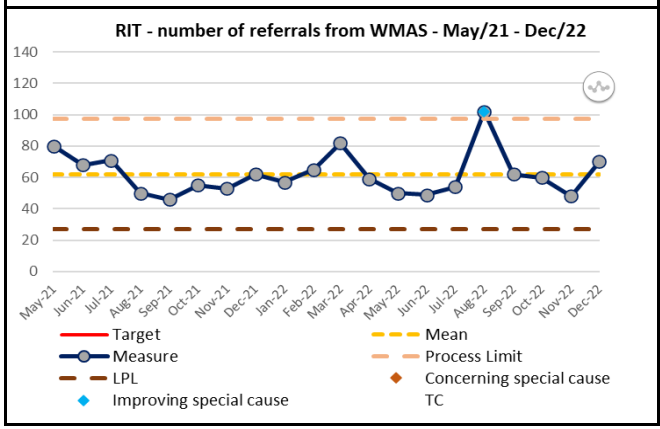
Metric - Sexual Health (a month in arrears)	Target	Variation	Assurance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Total number of appointments against block contract	>/=4,500		F	3,666					
% appropriate patients offered HIV test	>/=95%	H	P	99.8%					
Metric - Community Nursing (Rapid Intervention Team)	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Referrals received		H		1,207	1,481	1,355	1,417	1,397	1,471
Patients accepted and seen (actuals)		H		1,078	1,419	1,330	1,378	1,340	1,367
Number of patients sent to ED/admitted to hospital by RIT's		H		67	73	87	66	69	101
% of referred patients who are sent to ED/admitted				6.21%	5.14%	6.54%	4.75%	5.14%	6.86%
Number of referrals from West Midlands Ambulance Service				54	102	62	60	48	70
Night visiting service (initial)		H		167	168	212	214	243	271
Rapid response (initial)		H		850	993	958	935	928	1,017
Crisis response (within 2 hours)	>/=35%	H	P	66.2%	68.9%	64.3%	68.6%	69.7%	68.5%
Metric - Virtual Ward	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Oximetry at home (initial)		L		0	0	0	0	0	0
Virtual ward (initial)		H		98	109	91	145	132	153
Metric - Rapid Access Care (RASC & RASD)	**Target**	**Variation**	**Assurance**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Rapid access social care (initial)				36	29	39	60	49	62
Rapid access social care discharge (initial)		L		0	1	0	1	2	1



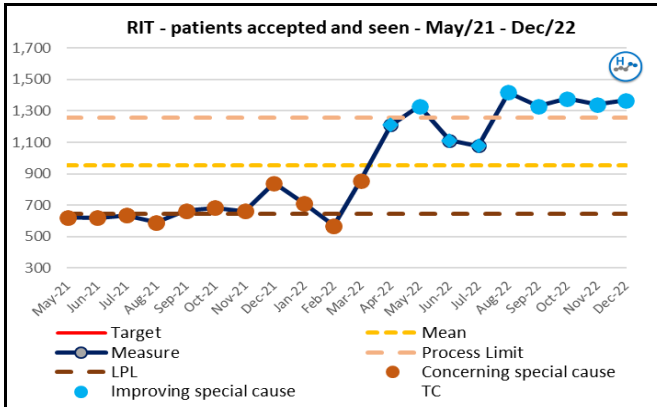
Dec-22
1,471
Variance Type
Metric is showing higher special cause (improving)



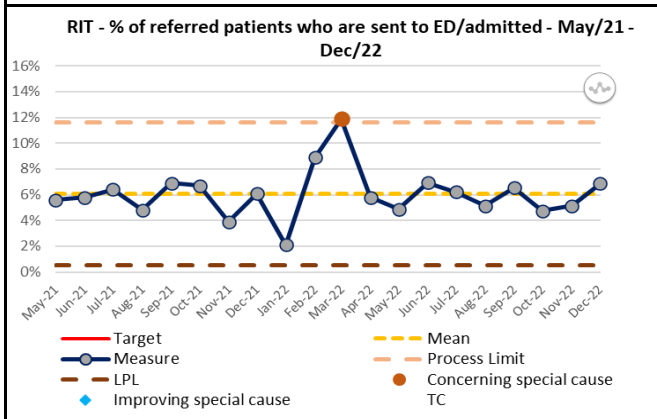
Dec-22
101
Variance Type
Metric is showing higher special cause variation (concern)



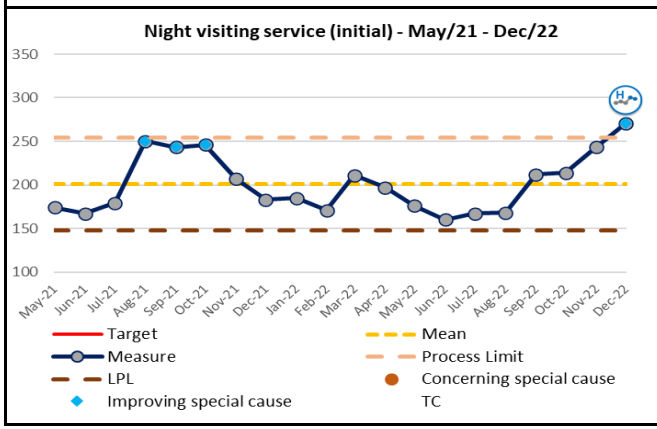
Dec-22
70
Variance Type
Metric is showing common cause variation



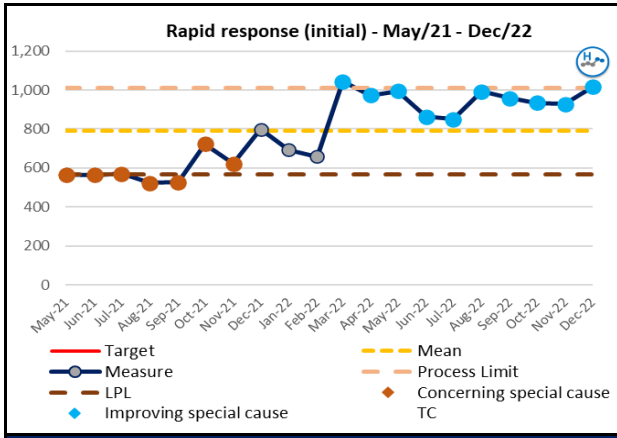
Dec-22
1,367
Variance Type
Metric is showing higher special cause (improving)



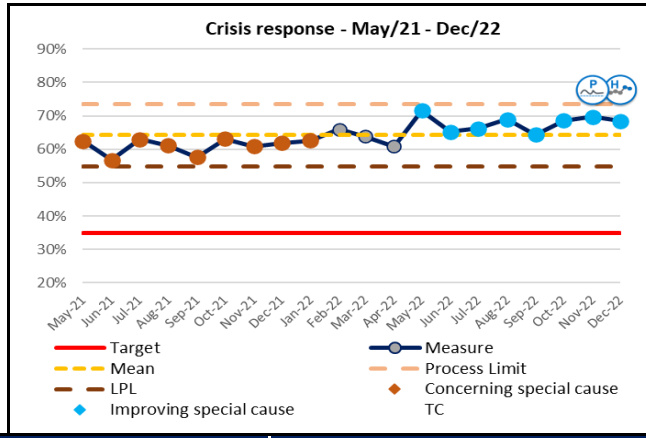
Dec-22
6.86%
Variance Type
Metric is showing common cause variation



Dec-22
271
Variance Type
Metric is showing higher special cause (improving)

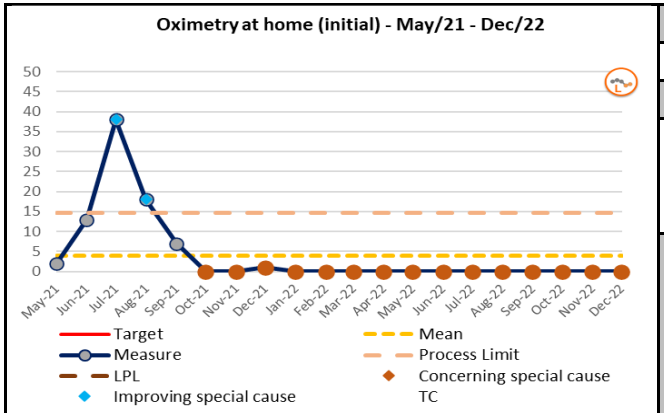


Dec-22
1,017
Variance Type
Metric is showing higher special cause (improving)

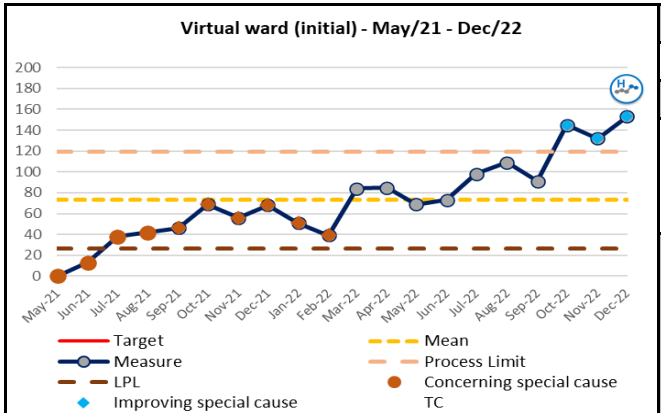


Dec-22
68.5%
Variance Type
Metric is showing higher special cause (improving)
Target
35.0%
Achievement
Metric is currently passing the target

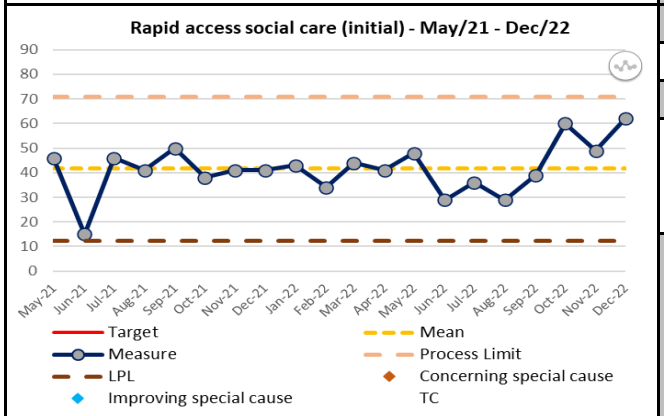
Summary	Actions	Assurance
Community Nursing (Rapid Intervention Team): We continue to see a sustained rise in the number of referrals and increased activity during December 22. Increased hospital admissions were due to high acuity of patient's and flu outbreaks within care home settings This remains above the upper control limit. We continue work with WMAS and care homes.	Ongoing promotional work with WMAS to maintain use of community pathways. Care homes encouraged to use the service when possible and appropriate.	WMAS DOS lead aware and continues to promote service and alternate pathways to crews. The RIT team are now covering 24 hour working.
Night Visiting Service: Increased admissions due to high District Nurse caseload.	Working towards a more collaborative working with the Rapid Intervention Team.	
Crisis Response within 2 hours: This service provides support for patients in their own home. We are continuing to facilitate discharges from hospital and accommodate End of Life patients.		Performance has remained consistently high and remains above target.



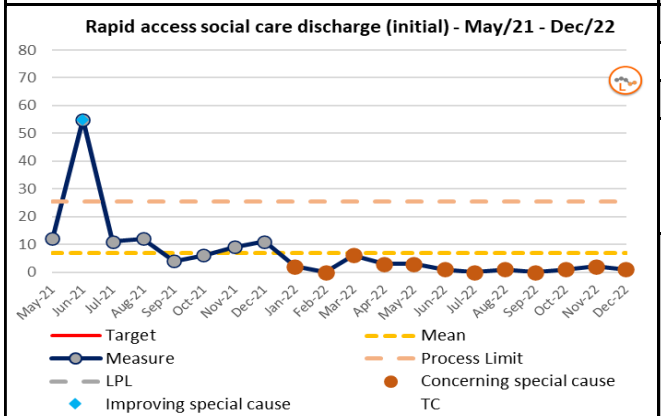
Dec-22
0
Variance Type
Metric is showing lower special cause variation (concern)



Dec-22
153
Variance Type
Metric is showing higher special cause (improving)



Dec-22
62
Variance Type
Metric is showing common cause variation

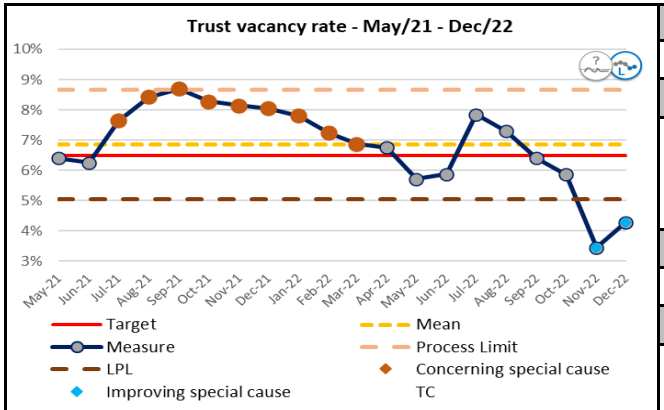


Dec-22
1
Variance Type
Metric is showing lower special cause variation (concern)

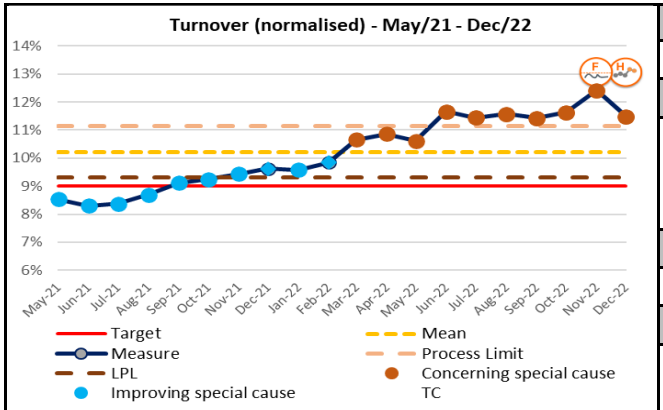
Summary	Actions	Assurance
Virtual Ward: is currently performing and managing its referrals within the current pathways. There is an expansion of pathways in line with nationally submitted plan.	Continual service developments and virtual bed expansion.	A dashboard is in development to monitor use against national submission, and evaluation of the impact, .
Rapid access to social care: Increased admissions due to expanding capacity. Increased End Of Life patients on the caseload. Handoff to Social Care continues to be an on-going cause for concern	Winter funding has been agreed. An escalation processes is in place for handover delays.	Capacity issues are reported in the bed meetings and D2A daily Performance monitored by Directorate and Division.

Human Resources

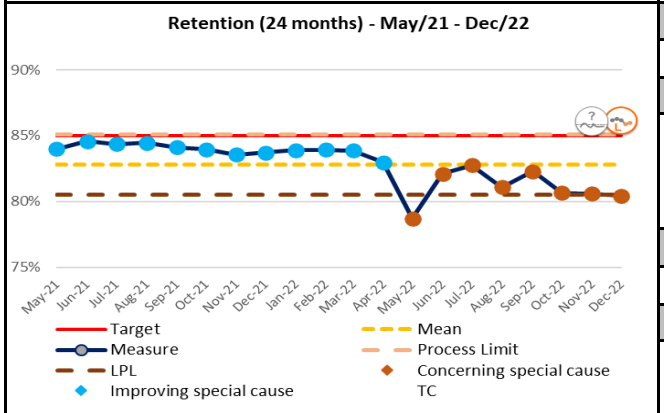
Metric	Target	Variation	Assurance	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Trust Vacancy Rate	6%	L	?	7.34%	6.79%	5.90%	5.37%	2.95%	3.79%
Turnover (normalised)	9%	H	F	11.44%	11.57%	11.43%	11.63%	12.41%	11.49%
Retention (24 months)	85%	L	?	82.76%	81.09%	82.30%	80.64%	80.60%	80.45%
Appraisals	90%		F	79.80%	80.20%	79.00%	78.80%	80.10%	79.70%
Mandatory Training (generic)	85%		P	96.50%	94.60%	94.60%	94.60%	94.70%	94.50%
Sickness (in month)	4.25%	H	F	6.38%	5.50%	5.36%	5.81%	5.75%	
Sickness (rolling 12 months)	4.25%	H	F	5.68%	5.68%	5.64%	5.62%	5.56%	



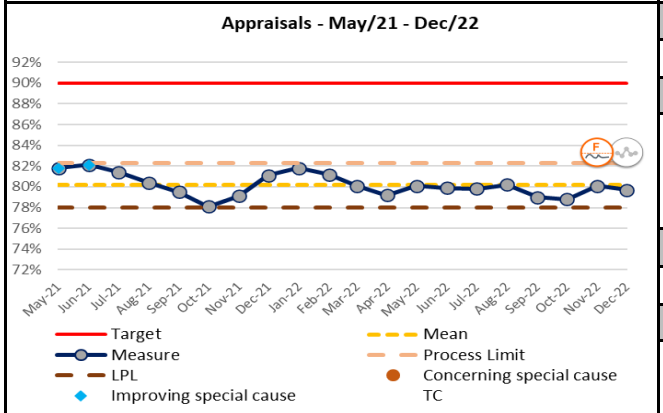
Dec-22
3.79%
Variance Type
Metric is showing lower special cause (improving)
Target
<6%
Achievement
Metric is currently passing the target



Dec-22
11.49%
Variance Type
Metric is showing higher special cause (concern)
Target
<9%
Achievement
Metric is currently failing the target

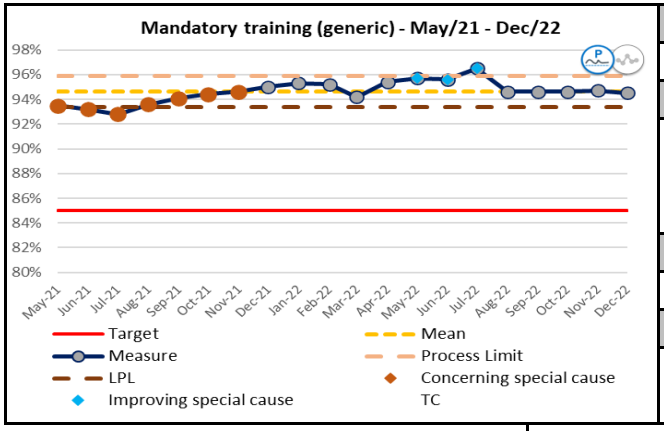


Dec-22
80.45%
Variance Type
Metric is showing lower special cause (concern)
Target
>85%
Achievement
Metric is currently failing the target

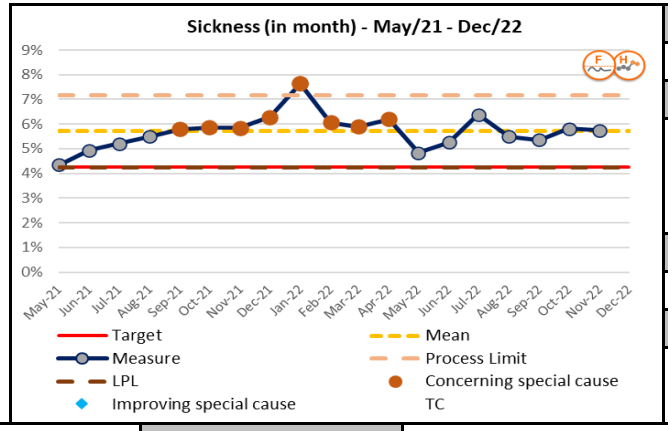


Dec-22
79.70%
Variance Type
Metric is showing common cause variation
Target
>90%
Achievement
Metric is currently failing the target

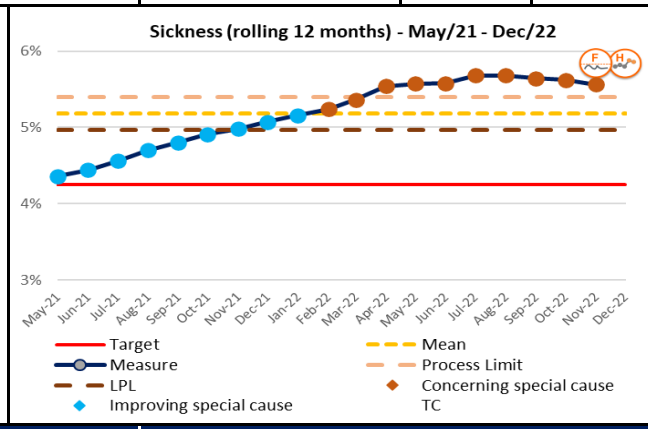
Summary	Actions	Assurance
Trust Vacancy Rate: Although we saw some decline in performance during December 22, this indicator remains within target.	Further work is underway to better understand and respond to the drivers of increased turnover among Nursing and Midwifery Staff and an deep dive will be brought to the Operational Workforce Group.	All recruitment and retention metrics for medical staff are being met. Temporary staffing arrangements are in place for vacancies where necessary to ensure services are appropriately staffed. Targeted recruitment continues in these areas as part of the work to identify and pro-actively recruit to hard to fill areas.
Retention/Turnover: Both indicators have shown improvement in month. Turnover continues to exceed the target at 11.49%. The Retention Rate at 24 months remains below target at 80.45%.		
Appraisals: compliance remains below target. This continues to be challenged by staff sickness and redeployment, making staff unavailable for appraisals.	Divisions will be asked to develop recovery plans for appraisals.	



Dec-22
94.50%
Variance Type
Metric is showing common cause variation
Target
>85%
Achievement
Metric is currently passing the target



Nov-22
5.75%
Variance Type
Metric is showing higher special cause (concern)
Target
<4.25%
Achievement
Metric is currently failing the target



Nov-22
5.56%
Variance Type
Metric is showing higher special cause (concern)
Target
<4.25%
Achievement
Metric is currently failing the target

Summary	Actions	Assurance
Mandatory Training (generic): compliance rates have remained static when compared with the previous month, they remain above target.		
Sickness: Performance remains above target. The rolling 12 month absence rate also remains above the Trust target of 4.25% as a result of continued elevated absence due to COVID-19 being represented across the full year in the figure.	HR teams continue to sensitively support the management of long and short term sickness absence cases as appropriate in the current circumstances. The attendance management structures will need to be revisited as part of the post COVID-19 recovery with the re-establishment of sickness absence workshops within the Divisions.	Considerable work has been done to develop the wellbeing support offer, including psychological and practical wellbeing support for staff. The Trust has vaccinated almost 90% of its workforce against COVID-19.

The Royal Wolverhampton NHS Trust

Trust Board Report (Public session)
Midwifery Services Report

Meeting Date:	7th February 2023
Title:	Midwifery Services Report
Action Requested:	Accept report
For the attention of the Board	
Assure	• To provide assurance that the maternity service is working towards key recommendations within the Care Quality Commission (CQC) report, conducted in October 2022 at The Royal Wolverhampton NHS Trust. • The Trust has received the final published CQC report. The Maternity Services 'Safe' domain has deteriorated from good to 'Needs improvement'. The Maternity Service has immediately focused on the 2 'must do's' for areas of improvement. • NHSR Maternity Incentive Safety Action 8 'Training' is now fully compliant. • All elements for the 10 safety actions within the MIS year 4 Technical Guidance have been quality checked internally by the Directorate prior to the external validation process by the Black Country Local Maternity and Neonatal System (BCLMNS) who were assured that Directorate on track to achieve all 10 safety actions by end of January 2023 would be achieved if progress continues as per plan.
Advise	• The Care Quality Commission (CQC) Overall summary of Maternity Services at The Royal Wolverhampton NHS Trust has remained 'Good'.
Alert	Alert the Board on the present position with implementation of CNST Maternity Incentive Scheme (MIS): year 4. Saving Babies Lives Care Bundle version 2 Safety action 6. • Compliance with CO monitoring at 36/40 gestation has now been achieved. • Internal validation by the directorate for this safety action has been completed. • External validation from the Black Country Local Maternity and Neonatal System has been completed.
Author + Contact Details:	Tracy Palmer Director of Midwifery and Neonatal Services X85267 tracypalmer@nhs.net

Links to Trust Strategic Objectives	4. Deliver a safe and high quality service .
Resource Implications:	Workforce
Report Data Caveats	
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	
Risks: BAF/ TRR	
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	Trust Board Public session
References Appendix	1. Care Quality Commission (CQC) Maternity Services Inspection report: October 2022.
	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	Midwifery Services Report
Item/paragraph **1.0**	**Maternity Services CQC inspection October 2022.** On October 24th 25th and 26th 2022 the Maternity Services at The Royal Wolverhampton NHS Trust received their CQC inspection. The service was the first to receive the inspection based on the new framework for inspections. The inspection took place over 3 days inspecting the safe and well led domains. The Trust has received the final report which has been published and within the public domain. The Maternity Services 'Safe' domain has deteriorated from good to 'Needs improvement. The Care Quality Commission (CQC) Overall summary of Maternity Services at The Royal Wolverhampton NHS Trust has remained 'Good'. The Maternity Service is focusing on the immediate recommendations of which there were two 'Must do's' areas for improvement. The improvement plan for Maternity Triage Unit has been devised to focus on the immediate recommendations for the Triage Unit detailed within the CQC inspection report (Appendix 1 and 2).

	The two 'must do's' from the inspection report are as follows: 1. The service must ensure women telephoning the triage service have rapid access to an initial assessment by suitably trained and qualified staff (Regulation 12 (2)). 2. The service must ensure they maintain safe staffing numbers in all areas of the maternity service (Regulation 18 (1)).
2.0	**NHSR: Maternity Incentive Scheme – CNST year 4 Progress update** As agreed at Trust Board in December 2022 delegated responsibility has been given to Quality Safety Assurance Committee (QGAC) prior to submission to Trust Board in February 2023. This arrangement was agreed to give the maximum timescales required to meet the safety standards, specifically for safety action 6 'Saving Babies Lives Care Bundle: Version 2' and safety action 8 'Training'. Submission for Trust Board declaration sign off for all ten safety actions has been extended until 2 February 2023. The Director of Midwifery presented overall compliance for all the 10 safety actions using The Trust Board declaration sign off document to QGAC in January 2023 (Appendix 3). The Trust is declaring full compliance with all 10 safety actions for NHSR Maternity Incentive Scheme Year 4.

The Royal Wolverhampton NHS Trust

Trust Board (Public Session)

Detailed Report – Midwifery Services Report February 2023	
Item 1.0	**<u>The Maternity Services Care Quality Commission (CQC) Inspection October 2022</u>** The Royal Wolverhampton NHS Trust is now in receipt of the CQC final report, which has been published and is available within the public domain. Overall ratings for Maternity Services at The Royal Wolverhampton NHS Trust remain 'good' however the 'safe' domain has deteriorated to 'requires improvement'. The inspection report highlighted some examples of good clinical practice, the inspection team fed back positively with regards to staff working together well for the benefit of women and, that leaders ran well led Maternity services at the Trust. However, the CQC inspectors identified that in some instances services did not have enough staff with the right skill to care for women and keep them safe. CQC inspectors also observed that women accessing the Maternity Triage Service did not always have timely telephone access to a Midwife. The report recommends that there are therefore two 'must do' actions to ensure that immediate improvement plans are in place to address the safety concerns highlighted from the inspection as stated below: **The maternity service must:** • Ensure women telephoning the triage service have rapid access to an initial assessment by suitably trained and qualified staff. (Regulation 12 (2)). • Ensure they maintain safe staffing numbers in all areas of the maternity service. (Regulation 18 (1)). The CQC also recommended the following: **The maternity service should:** • Ensure that all staff complete mandatory training and role specific training in a timely way. • Ensure all emergency equipment checks are carried out in line with Trust policy. • Ensure the emergency buzzer is audible in every area. • Ensure the ventilation system in the consultant led delivery suite complies with the standards set out in the Healthcare Technical Memorandum and that all risks from waste aesthetic gasses are adequately mitigated. • Ensure all medicines are always stored safely. • Ensure there is a continued improvement in the system of review for all cardiotocography fetal monitoring, including appropriate documentation of Fresh Eyes checks.

	• Ensure policies and guidelines are updated and available to staff within agreed timescales. Local guidelines differing from national guidelines should have been risk assessed. Senior leaders within the Directorate were already working towards an improvement plan for The Maternity Triage Unit prior to the CQC inspection however, the action plan had now been strengthened incorporating the recommendations from the CQC inspection set out within the report. Following the inspection improvement plans were expedited regards telephone access to The Maternity Triage Unit. An automated telephone service has been installed to ensure women are directed to the appropriate place or person to reduce waiting times on the telephone. Workforce plans are also in place to recruit to Birth Rate Plus and The Ockenden recommendations. Ongoing recruitment into vacant clinical midwifery post are being supported by Trust Board whilst the business case is being is finalised by the Directorate Management Team. The Chief Midwifery Officer (CMO) at NHSE/I for Midlands has met with the Director of Midwifery (DoM), Chief Nursing Officer (CNO), Director of Nursing (DoN) at The Royal Wolverhampton NHS Trust (RWT) to discuss the CQC inspection report. The Senior Responsible Officer (SRO) for the Integrated Care Board (ICB) was also present at the meeting. To discuss inclusion of the Trust into the national Maternity Safety Support Programme (MSSP) launched in September 2017. Maternity services are formally entered onto the programme if they are rated 'requires improvement' or 'inadequate' in the well led and/or the safe domains by the Care Quality Commission. It was concluded that all present were in agreement this was not required and should be monitored via the Local Maternity Network. The CMO for NHSE/I informed that she would be presenting the proposal in her report at the next National Quality Board at NHSE/I at the end of January. The Director of Midwifery will present the full CQC Quality Improvement plans to Trust Board in April 2023.
2.0	**<u>NHSR: Maternity Incentive Scheme – CNST year 4 Progress update.</u>** As agreed at Trust Board in December 2022 delegated responsibility has been given to Quality Governance Assurance Committee (QGAC) prior to submission to Trust Board in February 2023. This arrangement was agreed to give the maximum timescales required to meet the safety standards, specifically for safety action 6 'Saving babies Lives Care Bundle: Version 2' and safety action 8 'Training'. The Senior Directorate Team have met to review and validate the evidence for each safety action. The Senior Directorate team have declared full compliance with each safety action. This was approved by the Director of Nursing on 30th January 2023 (Appendix 3). In addition the Directorate received an external confirm and challenge / scrutiny review by the Local Maternity and Neonatal System (LMNS). The purpose of this

review meeting was to provide external scrutiny and a 'fresh eye' to the evidence for each safety action.

The LMNS ware also assured that the Maternity Service was fully compliant with each safety action and satisfied with the plan to achieve safety action 6.

The Director of Midwifery presented the Board Declaration position to QGAC in January 2023.

Table 1:
Maternity Incentive Scheme year 4: CNST compliance
January 2022/23 Internal and External Validation scores.

Safety Action	Standard	Internal Validation Directorate	External Validation LMNS
Safety Action 1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Fully compliant with all elements. NHSR will cross reference with MBRRACE-UK/PMRT	Agreed by LMNS
Safety Action 2	Are you submitting data to the Maternity Services Data Set to the required standard?	Fully compliant with all elements. Cross referenced NHSE/I criteria 2 - 7 with NHS digital data	Agreed by LMNS
Safety Action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Fully compliant with all elements.	Agreed by LMNS
Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Fully compliant with all elements.	Agreed by LMNS Agreed by LMNS
Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Fully compliant with all elements	Agreed by LMNS
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?	Internal Validation process continues for CO monitoring: Audit in progress. Refer to SBLCB dashboard Table 2.	Agreed by LMNS
Safety Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Fully compliant with all elements	Agreed by LMNS

Safety Action 8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Fully compliant with all elements. Refer to table 3.	Agreed by LMNS
Safety action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Fully compliant with all elements	Agreed by LMNS
Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	Fully compliant with all elements. Cross referenced against HSIB NNRD NHSR	Agreed by LMNS

Table 2:
The Saving babies Lives Care Bundle 2022/23 dashboard compliance: December 2022

RWT - Saving Babies Lives Care Bundle Dashboard - Version 2 - 2022/2023

Element 1 - Co monitoring		Jul	AUG	SEPT	OCT	NOV	DEC	Jan	FEB	March
co monitoring % compliance at booking	over 95% -	81.80%	91.40%	90.60%	90.70%	92.60	91.2	86.80%		
Co Monitoring compliance rate at 36 weeks	> 80% and < 95% < 80% -	82.50%	82.40%	70.70%	73.50%	81.6	85.80%	94.1%		
% of women with a CO>4 ppm at booking	No Parameters	7.20%	7.50%	10.70%	10.70%	11.6	8.6	9.7		
% of women with a CO>4 ppm at 36 weeks		7.30%	6.60%	6.80%	10.90%	28.9%	6.9	8		
%co level >4ppm and have a co< 4ppm		7	7	9	14	11	29.2	45.2		
RWT Referal pathway to stop smoking in pregnancy	Yes or No									
Element 2 - FGR										
% FGR at booking	over 95% - > 80% and < 95%	96.60%	97.90%	96.60%	96.90%	97.4%	96.7	96.6		
% FGR at the 20 week scan	< 80% -			77.40%	84.60%	87.8%	87%			
women BMI> 35kg/m2 are offered a growth scan	Yes or No									
High risk of FGR offered UAD completed by 24 weeks	Yes or No									
14 audit % babies born<3rd centile > 37+6 weeks	Yes or No					in progress				
% PNMRT cases for 2021reviewed in relation to FGR	Yes or No									
Multiple pregnancy - risk assessment & growth complies	Yes or No									
Element 3 - Reduced Fetal Movements										
% women who receive RFM Leaflet	over 95% -	83.50%	87.60%	85%	86.20%	89.8%	97	87.9		
% of women who attend woth RFM have a computerised CTG	> 80% and < 95% < 80% -	87.60%	88.20%	98.50%	97.80%	98.8%	100	97.4		
Element 4- CTG Compliance										
Guidelines SIA & Fetal monitoring in date	Yes or No									
% eligible staff attended Fetal monitoring day	over 90%	48%	59%	59%	73%	95%	93%			
Element 5 - Preterm birth										
% of single live births < 34 weeks receiving a full course of steriods	No Parameters	36.40%	100%	66.60%	87.50%	71.4%	70	55.6		
% of single live births occuring more than 7 days after completion of their first course of steriods	No Parameters	0	0	0	0	0	0	0		
% of singleton births < 30 weeks receiving magnesium sulphate within 24 hours prior to birth	No Parameters	42.90%	66.70%	77.50%	75%	100%	40	50		
% of women giving birth in an appropriate seting for gestation	level 3	100%	100%	100%	100%	100%	100	100		
Lead consultant for pre term birth	Yes orNo									
Acess of women to a preterm birth clinic	Yes or No									
Audit of 40 women assessed at birth for preterm risk - low, intermediate or high at booking	Yes or No									
Risk assessment and management of multiple pregnancy complies with Nice	Yes or No									

Key : Rag status

over 95% - Green	PASS
> 80% and < 95% Amber	Action Plan
< 80% - Red	Automatic Fail

3.4 Element 1 – CO monitoring

Monitoring of audits have determined compliance with CO monitoring at 36 weeks gestation. Non-compliance during September and October was due to a national shortage of CO straws. This was escalated to NHSR at the time.
Trusts will meet the standard if compliance is over 80% as an average over 4 consecutive months. An action plan to achieve 95% compliance in line with recommendations for Saving Babies Lives Care Bundle Version 2 and The Maternity Incentive Scheme year 4 is in place within the Directorate.

Element 2 – Fetal growth Restriction (FGR)

The Maternity Service is compliant with the recommendations for Element 2: Detection of Fetal Growth Restriction. Trusts compliance indicator must be 80% with an action plan to achieve >95%. An action plan to achieve 95% compliance is in place within the Directorate.

High women at risk of FGR receiving Umbilical Artery Doppler (UAD) at 24/40 – this is not a pathway that has been fully established yet within the Maternity Services however, there is appropriate mitigation in place to ensure that high risk women at risk of FGR are receiving serial scans. This has been accepted by NHSR as reasonable mitigation until the full pathway can be embedded. The risk of not having a fully established UAD pathway for these cohorts of women was reported to Trust Board by The Director of Midwifery in the Midwifery Services report in October 2022.

The risk (5849) remains on the Divisional Risk Register as a high amber risk at present and is due to Ultrasonography workforce challenges.

Table 3: Compliance against Safety action 8 – 'Training'

Workforce challenges within the Medical and Midwifery workforce over the last year has meant that Safety Action 8: 'Training' was a concern in terms of achieving full compliance within the timescales specified by NHSR.

Proactive planning for training sessions by the Directorate Practice Development Teams has proven successful; therefore, full compliance for attendance at The Practical Obstetric Multi-Professional Training Day (PROMPT) for all staff groups has now been achieved.

Table 3 below demonstrates full compliance with safety action 8.
January – December 2022

In house training PROMPT	Numbers of staff	Dec 2022
Obstetric Consultants	15	100%
Obstetric Registrar	21	100%
Anaesthetic Consultant	10	90%
Anaesthetic Staff Grade/CF/Trainee	22	95%
Anaesthetic General Cons On Call	27	93%
Midwives	219	94%
IP Support Staff Del Suite and MLU	24	100%

Neonatal Life Support (NLS)	Numbers of staff	Dec 2022
Midwives	219	92%
NN Consultants	8	100%
NN Junior Drs	21	100%
ANNP's	6	100%
NNU Nurses	145	92%

Immediate & Essential Action 1: Inadequate staffing for Maternity Triage Unit					
Outcome Required	**Action**	**Lead (Job Title)**	**Timescale**	**Progress RAG**	**Evidence / Comment**
1. 1 Safeguard minimum midwifery staffing levels. Ensure 2 midwives (11.02 WTE) are working in Maternity Triage 24/7 as per Birthrate + requirements	1.1.1 Maintain midwifery staffing according to Birthrate + requirements Design and develop an Escalation Flow Chart. Include in Staffing Guideline Disseminate to Delivery Suite Coordinators and Maternity Managers on Call	Matrons	End March 2023		Business case to be agreed to reflect BR+ Continue recruitment for core triage midwives
1.2 Consider 1 additional midwife for peak time of workload (usually 10am-7pm, 7 days per week) 2.06 WTE Minimum requirement B6/7 as per RCOG/RCM Good Practice Draft Paper (see Appendix 1).	1.2.1 Business Case to increase midwifery staffing as per RCOG/RCM Good Practice Draft Paper.	Head of Midwifery/Group Manager	End February 2023		Business case to be agreed to reflect RCOG/RCM Good Practice Paper
1.3 Dedicated 1 WTE MSW (band 3) per shift (2.7wte)	1.3.1 Business case to increase band 3 MSW budgeted establishment for top floor.	Head of Midwifery / Group Manager	End March2023		Core MSW in addition to BR+ for MTU

1.4 Safeguard minimum medical staffing levels (See Appendix 1) as per RCOG/RCM Good Practice Draft Paper. Ensure ST3 or equivalent 'in hours.	1.4.1 Business Case to increase medical staffing as per RCOG/RCM Good Practice Draft Paper	Clinical Director/Group Manager	End February 2023		Discuss with CD and Group Manager and add to business case
1.5 Review current admin cover for emergency portal areas (including delivery suite/ maternity triage / MLU / FAU/ Community midwifery calls).	1.5.1 Business case – resource to be advised by directorate team	Group Manger / Assistant group manager / digital midwife / matrons	End February 2023		Review admin team cover for service in progress

Immediate & Essential Action 2: Prompt risk assessment under the current telephone Triage system					
Outcome Required	**Action**	**Lead (Job Title)**	**Timescale**	**Progress RAG**	**Evidence / Comment**
2.1 No call is un-answered and is answered by an appropriate qualified professional	2.1.1 Implement a queueing system for maternity triage and a redirection system to the most appropriate department.	Digital Midwife	January 2023		21/12/22 System went live 29/12/22
	2.1.2 Telephone queuing system is also required for FAU and MLU	Assistant group manager	February 2023		In progress
	2.1.3 Adequate admin cover to support the redirection of calls	TBC	February 2023		Review admin team cover for service in progress

Immediate & Essential Action 3: Unable to evidence current advice and appropriate risk assessment provided over the phone. This will have medical legal implications.					
Outcome Required	**Action**	**Lead (Job Title)**	**Timescale**	**Progress RAG**	**Evidence / Comment**
3.1	3.1.1 Audio recording and archiving of all external calls into Maternity	Digital Midwife	March 2023		
	3.1.2 Audit appropriateness of advice given	Maternity Triage Manager	July 2023		
	3.1.3 Comms campaign to raise awareness the Maternity Triage Unit is an emergency portal and women are redirected appropriately	Digital Midwife	End February 2023		Implementation of BSOTS Triaging system on FAU and MLU in progress training commenced 24/1/23
	3.1.4 Electronic patient recording also needed for FAU and MLU	Ward Mangers and Digital Midwife	End February 2023		

Immediate & Essential Action 4: Training and Competency Assessment concerns on BSOTs.					
Outcome Required	**Action**	**Lead (Job Title)**	**Timescale**	**Progress RAG**	**Evidence / Comment**
4.1 All staff on the third floor trained and competent	4.1.1 Develop and implement a training package	Professional Development Team /Maternity Triage Manager	April 2023		Update TNA Training Plan
4.2 New starters to area trained and competent	4.2.1 Develop and implement a training package	College Tutor	January 2023		Part of induction for all new starters Completed January 2023
4.3 All junior medical staff trained and competent	4.3.1 Incorporate BSOTs and Triage Training into the SHOOT Course for medical staff during their induction	College Tutor	January 2023		Part of induction for all new starters Completed Jan 2023
	4.3.2 Update TNA to include training and competency requirements.	Professional Development Lead	April 2023		
	4.3.3 Audit and monitoring of patient wait time on arrival to Maternity Triage Unit	Maternity Triage Manager	November 2022		Peer audits being completed

	4.3.4 Audit and monitoring of BSOTs utilisation	Maternity Triage Manager	April 2023		Set up and implement audit process
Immediate & Essential Action 5: Inappropriate activity currently being managed on Maternity Triage Unit.					
Outcome Required	**Action**	**Lead (Job Title)**	**Timescale**	**Progress RAG**	**Evidence / Comment**
5.1 Increase antenatal bed capacity on ward D9 to assist with flow of patients from maternity triage	5.1.1 This will require minimum midwifery staffing levels – 2wte midwives (11.02 wte band 5/6 midwives) plus 2.7wte band 3 MSW. Review current staffing on ward D10 and redistribute staff to cover D9.	Inpatient matron	March 2023		Change of establishment forms for D10 and D9
5.2 B7 Antenatal ward manager required for leadership of area.	5.2.11 wte band 7 ward manager Business Case	HOM / Group Manager	March 2023		Awaiting VCP approval
5.3 Review antenatal emergency pathways for all emergency portal areas within maternity	5.3.1 Essential to ensure the correct patients are directed and admitted to the most appropriate care setting Review antenatal pathways and criteria for each area.	Clinical Director / Matrons	February 2023		CD & Matron to discuss and review criteria for all areas

5.4 Ensure Maternity Triage is used as an emergency portal only	5.4.1Review our demand and capacity modelling and current utilisation.	Digital Midwife / Matron / Maternity Triage Manager	February 2023		Reviewing criteria of women suitable for MTU

1. Immediate & Essential Action 6: Centralised maternity triage call centre for both RWT & WHT (located outside the triage departments).					
Outcome Required	**Action**	**Lead (Job Title)**	**Timescale**	**Progress RAG**	**Evidence / Comment**
6.1 Review 'labour line' model used by Southampton / Portsmouth	6.1.1 Staff site Visit	Matrons	March 2023		
6.2 Source suitable location of call centre	6.2.1 Agree location	DOM / HOM at RWT & WHT	TBC		Ongoing discussions are taking place to determine plan for implementation with WHT.
6.3 Minimum staffing requirements; 5.4 wte (band 6/7 midwife) to operate 1 wte midwife 24/7	6.3.1 Business case Staffing establishments contributing from RWT & WHT in addition to birthrate plus.	Group Mangers – RWT & WHT	TBC		Ongoing discussions are taking place to determine plan for implementation with WHT.

Appendix 1	**Table 1. Recommendations for minimum staffing levels for maternity triage departments from Good Practice Draft Paper RCOG/RCM 2022**	
Maternity unit (births/year)	**Midwifery staffing (Band 6 and 7)**	**Medical staffing (Seniority equivalents)**
3000-4500	1 midwife 24/7 1 additional midwife for peak time of workload (usually 10am–7pm)	ST1-2 in department 'in hours' ST1-2 available (usually on-call LW team) ST3-7 available (usually on-call LW team) Obstetric consultant available
4500-6000	2 midwives 24/7 Consider 1 additional midwife for peak time of workload (usually 10am–7pm)	ST1-2 in department 'in hours' Additional ST1-2 available (usually on-call LW team) ST3-7 available (usually on-call LW team) Obstetric consultant available

MIDWIFERY SERVICE
WORKFORCE ACTION PLAN

	GOAL
	To provide assurance that RWT are continuously working through strategies to future proof the workforce and improve current staffing levels within the maternity unit.
	BENCHMARKS FOR SUCCESS
	Achieve Midwifery workforce establishments as outlined in the Birth Rate plus report 2022.

	STRATEGIC ACTION DESCRIPTIONS	PARTY / DEPT RESPONSIBLE	DATE TO BEGIN	DATE DUE	CURRENT STATUS	POTENTIAL HAZARDS AND HAZARD MITIGATION	DESIRED OUTCOME
1.	Review the international workforce – which countries provide midwifery care and which countries employ practicing midwives. Once identified, ensure that midwives are supported to undertake Objective Structured Clinical Examination (OSCE's), English Language Test for Study (ILETS) and CBT exams and support with migrating to the UK	International Recruitment Lead Midwife	2020	Ongoing	Four internationally educated midwives working at the Trust currently and undertaking intensive induction period. A further seven internationally educated midwives to join the Trust in Spring 2023.	Recruits will require enhanced induction packages, lasting at least 6 months whereby the midwife works under a supernumerary status. Two, full time Practice Educators employed to support overseas midwives in the clinical areas.	Following supernumerary period, the midwives will be working autonomously and will be counted in the midwifery staffing establishments.
2.	Midwifery Apprenticeships	Workforce and Education lead Midwife	January 2021	Ongoing	Two apprentice midwives commenced the BSc	Nil – apprentice midwives will have student midwife status and will be supported by assessors and supervisors as per the	Qualified midwives who have worked at the Trust as Maternity Support Workers who have gone on to be supported

					Midwifery course in September 2021 and a further two apprentice midwives commenced in September 2022. Expressions of Interest for 2023 in progress. RWT's implementation of HEE Maternity Support Worker Framework supports career progression pathways. Continued joint partnership working with the University of Wolverhampton lead for the apprenticeship programme.	Supervisor Assessor Standards (SSSA)	through Midwifery training. The desired outcome is that they remain part of the Trust and work here as qualified midwives.
3.	Improve community midwifery staffing by showcasing service – recruitment video filmed incorporating bespoke homebirth study day. Department focused on staff wellbeing – access to a psychologist and immersive wellbeing sessions bimonthly. In addition, good development programme for those wishing to enter management roles.	Matron for Community services	April 2021	Ongoing	Rolling adverts – adverts live for 2 weeks, shortlisting within 2 days and those suitable to interview are interviewed within 2 weeks. Regional recruitment event with the Local Maternity and Neonatal System utilised to showcase Community Midwifery at RWT and on the day	Delay in recruitment process delays the start dates for candidates. Monthly meetings with resourcing lead to address any issues with delays in recruitment. Inpatient areas offering 12-hour shifts – unable to facilitate on community, therefore, looking an alternative way of working	Community Midwives in permanent posts and succession planning into leadership roles.

					interviews and appointments.	– 4 longer days to support work life balance. Reluctance from staff due perceived drop in pay due to lack of unsociable hours - plan to educate staff on pay and ensure that they are aware of other income streams on community, i.e., on call payments, milage. Review rotation plans and ensure they is built into preceptorship program.	
4.	Maternity Support Worker Transformation Programme – RWT are aware of the difficulties in recruitment of midwives, therefore, each healthcare support worker was given the opportunity to be upskilled from a band 2 Healthcare Assistant to a band 3 Maternity Support Worker – this transformation has given maternity tasks to the MSWs, releasing midwives to undertake specific midwifery clinical elements.	Maternity support worker programme lead Midwife Workforce and Education lead Midwife	January 2021	Management of change completed in June 2022.	Management of change process began in January 2022 and was completed in June 2022. All staff were interviewed, and successful candidates have been mapped against the framework set out by Health Education England.	Staff reluctant to move to alternative areas within the service, therefore, MSW lead midwife in post to support rotations and transitions to new areas. A regional competency document (Skills Passport) is being used to document the upskilling of staff, along with an accompanying training programme, provided by the PD Team, MSW Lead and Specialist Midwives.	All HCAs develop into maternity support worker's and ultimately, go on to undertake further training to become midwifery associates and future midwives through the Midwifery Apprenticeship
	Recruitment of band five and band six midwives to work within acute services	Workforce and Education lead Midwife	June 2022	Ongoing	Twenty midwives joined the Trust in between September and December 2022. Fifteen were newly	All local trusts are recruiting from the same pool of midwives – risk that some midwives may decline	Permanent Midwifery staff and succession planning into leadership and specialist roles.

5.					qualified midwives. A further four midwives are expected to commence in post between January and March 2023. Enhanced support packages in place including robust local induction plans and psychological support. Two full time Practice Education Facilitators have been recruited to provide local induction and supernumerary support in the clinical areas to increase staff retention. Ongoing recruitment for Band 5 and Band 6	offers of appointments at the last minute. To mitigate this risk, workforce service leads have increased contact with all new recruits during the onboarding process. In addition, career discussions have been introduced to all Midwives particularly those that are considering leaving the organisation or profession to establish reasons for leaving. The discussions will include exploring desired career pathways and signpost staff to further career development and educational opportunities. Exit interview information to be utilised to recognise any retention issues and themes.	
	ADDITIONAL NOTES						
	The workforce plan is reviewed by the Workforce Lead Midwife monthly with maternity matrons and/or line managers to acknowledge any current workforce deficit and any upcoming vacancies so that we have a robust recruitment strategy. A monthly workforce report will be submitted to the Head of Midwifery / Director of Midwifery. Regular contact is maintained with the Local Maternity and Neonatal System (LMNS) Workforce Lead to keep abreast of the regional recruitment and retention issues with an aim to formalise a regional recruitment strategy. Monthly meetings with the Trust Head of Workforce – Nursing, to update on Maternity staffing issues. Author: Workforce Education Lead Midwife Version 2						

NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name Royal Wolverhampton Hospitals NHS Trust
Trust code T359

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			-	

Sign-off process:

Electronic signature Sally Roberts - Chief Nursing Officer, Black Country Integrated Board

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Electronic signature Sally Roberts - Chief Nursing Officer, Black Country Integrated Board

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Electronic signature Sally Roberts - Chief Nursing Officer, Black Country Integrated Board

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature Sally Roberts - Chief Nursing Officer, Black Country Integrated Board

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Electronic signature

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Confirming that:
There are no reports covering either **this year (2022/23) or the previous financial year (2021/22)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature Sally Roberts - Chief Nursing Officer, Black Country Integrated Board

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Electronic signature Sally Roberts - Chief Nursing Officer, Black Country Integrated Board

For and on behalf of the board of Royal Wolverhampton Hospitals NHS Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering

Name: David Loughton
Position: Cheif Exectutive Officer
Date: 01/02/2023

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Pharmacy and Medicines Optimisation Report
Action required:	Receive and note
For the attention of the Trust Management Committee	
Assure	• Patient harm from medication incidents remains low and no new trends have been identified. • In response to the increase in streptococcal A infections and a serious shortage of antibiotics, RWT promptly issued prescribing guidance and antibiotic supply to RWT patients was maintained. RWT supplied antibiotics to community pharmacies to prevent patients being referred to ED / UTC's.
Advise	• All pharmacy sectors report recruitment challenges and hard to recruit to posts. Anecdotally RWT has less difficulty recruiting pharmacy staff than other Trusts within the Black Country. • 50% of the RWT pharmacist workforce are prescribers, increasing to 85% by the end of 2024. All newly qualified pharmacists are offered the prescribing qualification which supports successful recruitment. • Lloyds Pharmacy have announced the closure of >200 pharmacies nationally, whilst in Wolverhampton there has been a 10% reduction in community pharmacies since 2018 with further closures expected. Closure of community pharmacies will result in increased pressures on other healthcare services. • Work is being undertaken to align the RWT and WHT Medicines Management Groups and form joint sub-groups. • A business case has been submitted to C&C to increase the pharmacy service to the admissions portals, including the introduction of a weekend and bank holiday clinical service. If approved this will drive improvements in patient safety and flow.
Alert	• Safe and secure storage of medicines and management of controlled drugs in some areas (mainly inpatient wards and theatres) continues to be below the standards expected. The Exec Team are well sighted on this risk. • Lack of ambient temperature monitoring and temperature control of medicines and fluid storage areas was included in the CQC report of maternity services.
Author + Contact Details:	Angela Davis, Clinical Director of Pharmacy and Medicines Optimisation, Controlled Drugs Accountable Officer Email angela.davis15@nhs.net

Links to Trust Strategic Objectives	Care Collaboration
Resource Implications:	None
Report Data Caveats	This is a standard report using previous months data. It may be subject to cleansing and revision.
CQC Domains	Safe
Equality and Diversity Impact	None
Risks: BAF/ TRR	Risk 5448: Safe Medicines Management, Amber 12 Risk 5030: Aseptic Unit – Facility, Amber 12 (Pending approval to TRR)
Public or Private:	Public
Other formal bodies involved:	• Medicines Management Group report received by QSAG January 2023 • Report received by Trust Management Committee January 2023
References	Professional Standards for Hospital Pharmacy (rpharms.com) Guidance on Pharmacy Services and Medicines Use within Virtual Wards _including Hospital at Home (1).pdf (hee.nhs.uk)
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value Accountability through local influence and scrutiny

Pharmacy and Medicines Optimisation Report

1.0 Introduction

The purpose of this report is to:

- Provide strategic context and horizon scanning on national and local pharmacy and medicines optimisation issues that will impact the Trust.
- Provide the Trust Management Committee and Trust Board with assurance around pharmacy services and medicines, highlighting exceptions, risks, and mitigating actions.

2.0 Strategic Context and Horizon Scanning

2.1 Pharmacy Workforce

GPhC data shows that the number of registered pharmacists is increasing year on year, however despite this, all pharmacy sectors are reporting recruitment challenges. This is thought to be due to:

- Demand exceeding supply. The Additional Roles Reimbursement Scheme (ARRS) in Primary Care has created a significant number of new posts for pharmacists and pharmacy technicians. Growth in hospital pharmacy and covid services has also contributed.
- Increase in the number of pharmacy professionals who are choosing to work part-time or opting for portfolio working.
- Little growth in the number of registered pharmacy technicians.

	NHSE and HEE have funded systems within the Midlands to trailblaze the formation of Pharmacy Faculties to address workforce issues at ICS level. RWT is hosting the Black Country Pharmacy Faculty and Angela Davis is the SRO. The Black Country Pharmacy Faculty reports to the Black Country People Board, and workstreams include: • Development of a Black Country pharmacy workforce plan • Supporting supervision and mentoring within the profession to improve retention Anecdotally RWT has less difficulty recruiting pharmacy staff than other Trusts within the Black Country. On paper the acute hospital pharmacy team at RWT is fully established, however in reality there are 20 vacancies in various stages of recruitment, which is equivalent to a 10% vacancy rate. There are some hard to recruit to posts including trained aseptic personnel; ward-based pharmacy technicians; and highly specialist pharmacist posts e.g., paediatrics, cancer, ophthalmology. In the RWT PCN there are several pharmacist vacancies, and a recruitment campaign is to be launched. Changes to the standards for the initial education and training of pharmacists has introduced major reforms which will ensure pharmacists are able to play a much greater role in patient-facing clinical care from their first day on the register, including prescribing. MPharm courses are in the process of being accredited for the new standards. For RWT there has been 2 significant consequences: • The introduction of tariff-based clinical placements for MPharm students. From September 2022 we have had agreements in place with Wolverhampton University and Birmingham University to take undergraduates pharmacy students. • By 2026 Pharmacy graduates will be prescribers and between now and then we need to 'bridge the gap'. 50% of our current pharmacist workforce are prescribers and we have a plan to increase this to 85% by the end of 2024. From September 2022 we have offered all newly qualified pharmacists the prescribing qualification in year 2 of their pathway and this has contributed to successful recruitment.
2.2	**Community Pharmacy** Every day 1.6M people in England visit a community pharmacy without an appointment. As well as dispensing and over the counter medicines, community pharmacy services include vaccinations, UTI treatments, oral contraception, minor ailment schemes, smoking cessation, community pharmacy consultation services (CPCS) and discharge medication services (DMS). Between 2016 and 2019 there were funding cuts to community pharmacy, and in 2019 a 5 year flat-funding deal was agreed. Un-renumerated services include filling of compliance aids and prescription home delivery. Medicines shortages can result in pharmacies purchasing medicines at higher rates than they are reimbursed for. With reducing income and rising costs many pharmacy contractors have been forced to review the viability of their business. Nationally Lloyds Pharmacy have announced the closure of over 200 Sainsbury's pharmacies, whilst in Wolverhampton there has been a 10% reduction in community pharmacies since 2018 with further closures expected.

	Staff recruitment and retention has been negatively impacted by financial pressures and increasing workload. Due to ARRS in Primary Care there is a significant demand for pharmacists and pharmacy technicians, and many community pharmacy staff are leaving to work in Primary Care Networks. Closure of community pharmacies will result in increased pressures on other healthcare services. NHSE have recently funded a senior pharmacist post in each ICS to lead community pharmacy services and join the ICS pharmacy leadership team. From a provider perspective we can support community pharmacies locally be maximising communication and commissioned services e.g., DMS.
2.3	**Virtual Wards** Most patients entering a virtual ward service will be taking medicines and therefore pharmacy support and input is vital. In September 2022 NHSE published guidance on Pharmacy Services and Medicines Use within Virtual Wards and following-on from this there was a regional event, which included a presentation from RWT Principal Pharmacist for Community Services, Mary Virdee. WMAHSN have established a community of practice for pharmacy teams who provide services to virtual wards as it is recognised as a challenging and fast developing area, with potential risks relating to medicines safety. At RWT there are 1.8 WTE prescribing pharmacists who work across virtual ward and care coordination. It is anticipated that pharmacy input into virtual wards and care in the community will continue grow.
2.4	**Black Country Acute Collaborative** Pharmacy and medicines is the 10th workstream in the Acute Collaborative. Projects being progressed by the Pharmacy Teams from RWT, WHT, DGFT and SWB are: • Better Value Medicines – working with the Ophthalmology Network to deliver efficiencies relating to adoption of biosimilars (Lucentis) and new technologies. • Aseptic Service – developing a Black Country business continuity plan for aseptic services and benchmarking our current services to identify opportunities for collaborative working. • Workforce –retention of pharmacy professionals within our organisations. • Formulary – development of a single Black Country Joint Prescribing Formulary.
2.5	**Collaboration with WHT** The Hospital Pharmacy Standards describe quality pharmacy services or 'what good looks like'. The standards were updated in November to reflect new and increasingly integrated models of care. The Pharmacy Team will be benchmarking against the updated standards over the next 6 months and have committed to working with colleagues at WHT to develop a joint Medicines Optimisation Strategic Plan under the Trusts Joint Quality and Safety Strategy. Work is being undertaken to align the RWT and WHT Medicines Management Groups and as a result: • RWT and WHT will retain their own MMG's, but the MMG's will have the same TOR's.

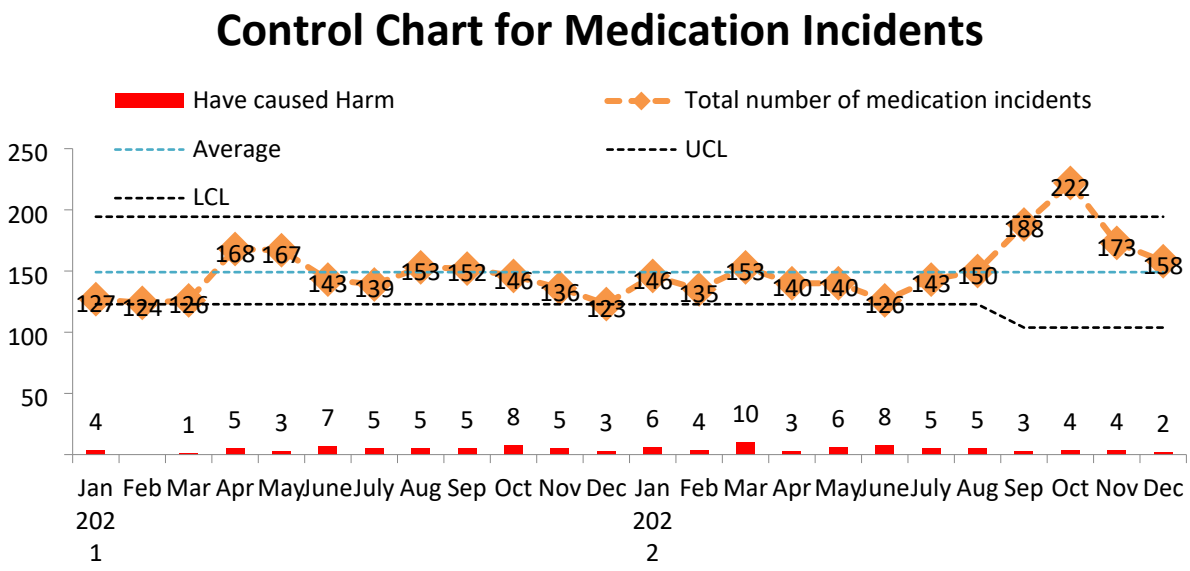
- The role of the MMG's will change to provide a greater focus on receiving and providing assurance on medicines.
- Task-based work e.g., formulary requests, will be devolved to subgroups.
- Joint RWT / WHT subgroups will be established for medicines safety, formulary/new medicines, and PGD's.

3.0 Assurance

3.1 Medication Incidents

Medication incidents were greater than the upper control limit in October and came back within control limits in November and December (Figure 1). In October there was an increase in reporting across all medication incident types with no cause identified. Patient harm from medication incidents remains low and no new trends have been identified.

Figure 1: Medication Incidents



3.2 Safe Medicines Practice

The Pharmacy Team leads the Trusts multidisciplinary approach to safe and effective use of medicines, this includes monitoring of metrics relating to the safe prescribing, administration, and storage of medicines. The position in December was:

- Medication Storage (at least annually): 145/162 (90%) areas scored >80%, 27 audits overdue. Internal improvement target - all areas to score >80% and no overdue audits.
- Controlled Drugs (quarterly): 48/58 (83%) areas scored >80%, 39 audits overdue. Internal improvement target - all areas to score >80% and no overdue audits.
- Omitted Doses (monthly): 5096 (3.8%) doses of critical medicines omitted on EPMA wards. Target - 0 omitted doses.
- Patient Group Directions (monthly): 132/144 in date (92%), 12 expired. Target - all PGD's to be in date.
- Prescription Chart Audit of non-EPMA wards (at least annually) – scheduled to be reported to MMG in February.

	• Pharmacy Intervention Audit (at least annually) – scheduled to be reported to MMG in March. • Pharmacy staffing capacity issues have resulted in overdue audits (Datix 5875 Clinical Pharmacy Service Staffing (9 Amber)). Safe and secure storage of medicines and management of controlled drugs in some areas (mainly inpatient wards and theatres) continues to be below the standards expected (Datix 5448 Safe medicines management (Amber 12)). Actions being progressed to improve compliance include: • The introduction of Pharmacy Medicines Management Assistants into the ward-based pharmacy team. • A secondment to a Medicines Safety Nurse due to commence February 2023. • Development of Trust wide standards for clinical rooms, fluid rooms, medicines trollies and patient lockers. • Refurbishment of the clinical rooms on C22 and C21 as blueprints for optimal medicines storage. • A review of medicines training provided to HCSW's, nurses, doctors, AHP's and pharmacy. • Inclusion of medicines standards in the proposed ward accreditation scheme. The recent CQC review of Maternity Services found that 'The service used systems and processes to safely prescribe, administer, and record medicines. Not all medicines were stored safely.' There was one should do action related to medicines: 'The service should ensure all medicines are always stored safely', which was due to medicines and fluids being stored in rooms without ambient temperature monitoring and the rooms being warm. The pharmacy team are supporting all areas to put in place risk assessments and identify corrective actions e.g., air conditioning, where ambient temperatures exceed those recommended for medicines storage (Datix 5269 Ambient temperature monitoring of medicines storage areas external to Pharmacy (6 Yellow)).
3.3	**Clinical Pharmacy Services - Medicines Reconciliation** NICE Guideline 5 *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes*, recommends that in the acute setting medicines reconciliation should be undertaken within 24 hours of admission. This enables early action to be taken when discrepancies between lists of medicines are identified and prevents medication-related patient safety incidents. Furthermore, discharges are generally processed faster when medication errors have been corrected on admission, rather than at the point of discharge. RWT performance for January – December 2022 was an average of 46% drug histories taken by pharmacy were confirmed within 24 hours of admission. The greatest contributors towards this shortfall are: not all areas have pharmacy cover, pharmacy staffing constraints (particularly in the admissions portals), and the lack of a weekend clinical pharmacy service. In October 2022, Pharmacy allocated 29 additional hours of senior prescribing pharmacist time to AMU as part of a pilot project to assess the impact of additional pharmacy resource (Monday-Friday). During this time the pharmacist prescribed 157 medicines unintentionally

	omitted from inpatient prescriptions and made 101 medication safety interventions, of which 58 were deemed high risk/critical. A business case has been submitted to C&C to increase the pharmacy service to the admissions portals, including the introduction of a weekend and bank holiday clinical service.
3.4	**Medicines Availability** In December there was an increase in the number of streptococcal A infections. There was a sudden increase in demand for oral antibiotics which resulted in a serious shortage of solid and liquid dose forms of several antibiotics including penicillin. RWT promptly issued prescribing guidance for clinicians and antibiotic supply to RWT patients was maintained. RWT also supplied antibiotics to community pharmacies in Wolverhampton open over the Christmas and New Year holidays to prevent patients being referred to ED or the UTC's. Theatres in particular continue to be affected by a large number of medicines shortages, although these are well-managed to minimise patient impact (Datix 5319 Medicines Shortages (Amber 9)).
3.5	**Aseptic Services** A new Aseptic Unit is to be built on the ground floor of Wrekin House with a scheduled go-live of Q3 24/25. The current Aseptic Unit has surpassed its original intended lifespan by 8 years and there is a risk that the facility will fail to meet the requirements of Good Manufacturing Practice (GMP) thus forcing it to close. The consequence of the unit closing would be that chemotherapy treatments would not be available or would be delayed. There would also be a financial impact of outsourcing treatments. The Directorate Risk has been escalated for acceptance on the Trust Risk Register due to a water leak within the unit in October and the requirement for the roof to be replaced to prevent further leaks (Datix 5030 Aseptic Unit – Facility (Amber 12)). The roof replacement is on the Estates workplan.
3.6	**Antimicrobial Stewardship** Local antibiotic audit results demonstrate that over the last 2 years: • We are using more IV antibiotics • Patients are staying on IV antibiotics for longer This trend is reflected nationally and as a result there is an NHSE CQUIN in 2023/24 to promote IV to oral antibiotic switches. Internally there are antimicrobial guidelines and antimicrobial ward rounds to provide advice on appropriate antibiotic course lengths. Co-amoxiclav is the second most prescribed antibiotic within the Trust. Reclassification of antibiotics against the WHO AWaRe categories will mean that in 2023/24 hospitals, including RWT, will be required to reduce consumption of co-amoxiclav. The out-patient parenteral antimicrobial therapy (OPAT) service has provided antibiotics to 117 patients from January- December 2022, saving an estimated 3231 bed days. The OPAT service is scoping the introduction of 24-hour antibiotic pumps which will enable more antibiotics to be administered via the service and therefore more patients will be eligible.

4.0	**Summary** This report provides an account of key strategic developments and assurance activities relating to pharmacy and medicines optimisation. Through this report the Trust Management Committee and Trust Board are sighted on pharmacy and medicines issues and receive assurance that medicines are managed within an effective governance framework.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Infection Prevention and Control Report
Purpose of the Report:	For assurance that avoidable infections are being proactively managed as part of the Trust's patient safety priority
Summary:	• Ongoing COVID-19 pandemic; symptomatic testing in place in the hospital • 47 cases of toxin positive *Clostridium difficile* (externally attributable) to end December 2022 against a target of 43 • 25 RWT-attributable Methicillin-susceptible *Staphylococcus aureus* (MSSA) bacteraemia to end December 2022 against an internal target of 18 • 33 Methicillin-resistant *Staphylococcus aureus* (MRSA) acquisitions to end December 2022, against internal target of 27 • 44 Device related hospital acquired bacteraemia (DRHABs) to end December 2022, against internal target of 36 • Compliance with mandatory training is below 95% for Infection Prevention and Hand Hygiene competency.
Recommendation:	Accept report
Action required:	**Receive for assurance**
Assure	Below internal targets for *C. difficile*. Below or at external targets for *E. coli* and Klebsiella bacteraemia. Carbapenemase Producing Enterobacteriaceae (CPE) screening continues to pick up patients and reduce the risk of spread – total of 43 new patients identified from April 2022 to date
Advise	Ongoing COVID-19 pandemic requires ongoing monitoring of patients and outbreaks and increases pressure on side-rooms. From early December influenza cases rose rapidly, with 66 positive inpatients at the end of December. Numbers have fallen steadily since early January. Above external *C difficile* target with 47 to date (target to date 43) Above external target for *Pseudomonas aeruginosa* bacteraemia Above internal targets for MSSA bacteraemia, MRSA acquisition and DRHABs Compliance with infection prevention-related mandatory training below 95% at end December 2022 (93% for IP mandatory training, 89% for Hand Hygiene).
Alert	CPE with the same enzyme isolated from screening samples from two patients on critical care in November.
Clinical implications and view	Monthly data and detailed actions discussed at The Infection Prevention and Control Group.
Patient, carer, public impact and views	MRSA bacteraemia, *Clostridium difficile* and *E Coli* bacteraemia available publicly via Public Health England

Author + Contact Details:	Director: Debra Hickman, Director of Nursing Tel 01902 698259 Email Joanna.macve@nhs.net
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. **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.
Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Links to Assurances	None
Resource Implications:	None
Report Data Caveats	The previous month's data may be subject to change following scrutiny of RCAs.
Public or Private	Public
Equality and Diversity Impact	None
Risks:	Trust reputational risk if infections increase
Risk register reference:	None
Other formal bodies involved:	CCG, Public Health contract Infection Prevention services from RWT
References	The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (2015)

Report Details

1

Clostridium difficile Infection

The annual objective for *Clostridium difficile* toxin positive cases has been set as 58 cases for the year, based on case numbers in the year to November 2021. At the end of December 2022 there were 47 cases, against a trajectory of 43. Polymerase Chain Reaction (PCR) (non-toxin) cases are also monitored as patient outcomes can be just as harmful to patient safety. To the end December 2022 there were 87 PCR positive cases against our internal trajectory of 90 (see Appendix 1). In mid-October the *C. difficile* laboratory testing protocol was changed due to the introduction of PCR testing of all stool samples. This reduces the time to a positive result. Using PCR as the screening test for *C difficile* is more sensitive so may result in an increase number of positive samples detected.

MRSA Bacteraemia

The national objective for MRSA bacteraemia is zero for all NHS organisations. To the end of December 2022 there has been one RWT-attributable MRSA bacteraemia (in May 22); this was thought to be related to an infected pressure sore.

Monthly totals and number externally attributable to RWT

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
21-22 (RWT)	1 (1)	0 (0)	0 (0)	1 (0)	1 (0)	0 (0)	0 (0)	0 (0)	2 (0)	0 (0)	0 (0)	0 (0)
22-23	0	1	0	0	1	0	1	0	1			

(RWT)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)			

MSSA bacteraemia

MSSA is externally monitored by Public Health England (PHE) but targets are set internally. MSSA bacteraemia is a good proxy for MRSA bacteraemia and may be avoidable therefore a local target is applied and cases investigated. To end December 2022 there have been 25 internally attributable cases, against a trajectory of 18 (see Appendix 1).

Monthly totals and number internally attributable to RWT

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
20-21	3	6	4	8	7	7	7	8	1	7	4	4
(RWT)	(0)	(2)	(1)	(2)	(4)	(3)	(4)	(4)	(0)	(1)	(3)	(2)
21-22	9	17	3	3	4	4	6	8	4	8	8	7
(RWT)	(4)	(7)	(2)	(1)	(1)	(1)	(3)	(0)	(0)	(1)	(4)	(4)
22-23	8	1	5	3	6	9	10	8	8			
(RWT)	(2)	(1)	(2)	‘(2)	(2)	(3)	(7)	(2)	(4)			

MRSA Acquisitions

There were 33 MRSA acquisitions to end December 2022, against our internal trajectory of 27 (see Appendix 1).

DRHABS

Bacteraemia (any organism) related to a medical device is surveyed and acted upon, within an internal target of 48 per year. To end December there were 44 DRHABs against a trajectory of 36 (see Appendix 1).

Gram negative bacteraemias

Gram negative bacteraemias include but are not limited to bacteraemias caused by *Escherichia coli*, Klebsiella species and *Pseudomonas aeruginosa*. Externally attributable bacteraemias include those that occur on day 2 or more of admission, or within 28 days of discharge. Trajectories for 2022-23 are 103 for *E. coli*, 35 for Klebsiella spp. and 18 for *P. aeruginosa*. To end December 2022 there were 75 *E. coli* bacteraemias against a trajectory of 75, 25 Klebsiella bacteraemias against a trajectory of 26, and 13 *P. aeruginosa* bacteraemias against a trajectory of 12.

Carbapenemase producing Enterobacteriaceae

These multi-antibiotic resistant organisms have caused large outbreaks in UK Trusts, putting patients at risk and causing organisational disruption. To end of December, 43 new patients were found to be carrying a CPE (see Appendix 1), 36 of these were by rectal screening. To end December 2022 three of the new positive patients were inpatients who were identified on a clinical sample.

It is likely that we will continue to see rising numbers of patients with these multi-resistant organisms that are often resistant to all available antibiotics. In addition to increasing screening in line with current national guidelines, which has not been possible to progress due to the need for ICB agreement, reducing spread from positive patients requires en-suite side-rooms, meaning that more of these will be needed going forward.

Blood culture contaminants
The blood culture contamination rate April to end December 2022 had an average of 1.98%, which is below the nationally recommended maximum of 3%.

Outbreaks and Incidents – November-December 2022

C. difficile Periods of Increased Incidence (PIIs), SIs and Outbreaks

There was one *C. difficile* incident since the previous report in November. This was not a new incident, but the fine (MLVA) typing for two of the cases on C21 demonstrated that transmission had occurred. Further audits were completed and the action plan from the original SI meeting was reviewed, with actions from the previous meeting having been completed.

COVID-19
There were multiple COVID- 19 outbreaks since the previous report in November. In the period of November to December there were 100 probable or definite cases of hospital acquired COVID-19. Almost all asymptomatic screening, apart from for clinically vulnerable patients and for patients being discharged to care homes, has ceased in line with national guidance. There have also been outbreaks and cases in local care homes and RWT infection prevention are providing support and advice.

Influenza A PII
Two patients who were co-located tested positive for Influenza A on a medical ward. Themes included environmental issues including dust on equipment and also over-usage of Personal Protective Equipment (PPE).

CPE on critical care
Two inpatients who were co-located on critical care screened positive for the same CPE enzyme (KPC). A meeting was held and screening of contacts undertaken – no further positive cases were found. Typing demonstrated that the organisms that carried the enzymes were not linked. While this is encouraging, it does not entirely rule out possible transmission because the genes for the enzymes can cross into different organisms,

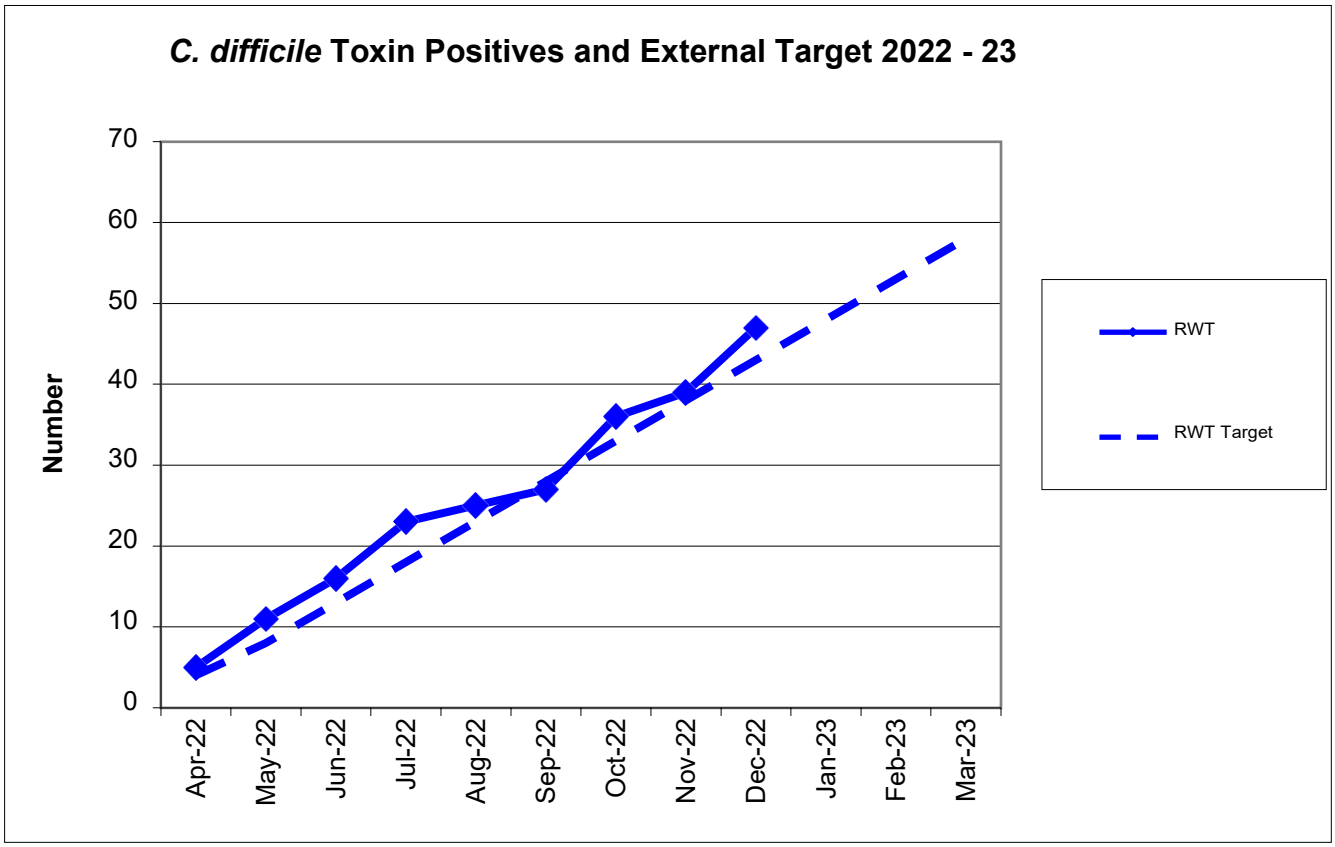
COVID-19 Pandemic
This is ongoing. Universal mask wearing in the Trust has been stepped down, as has asymptomatic testing of staff, and asymptomatic testing of patients, other than for certain at-risk groups.

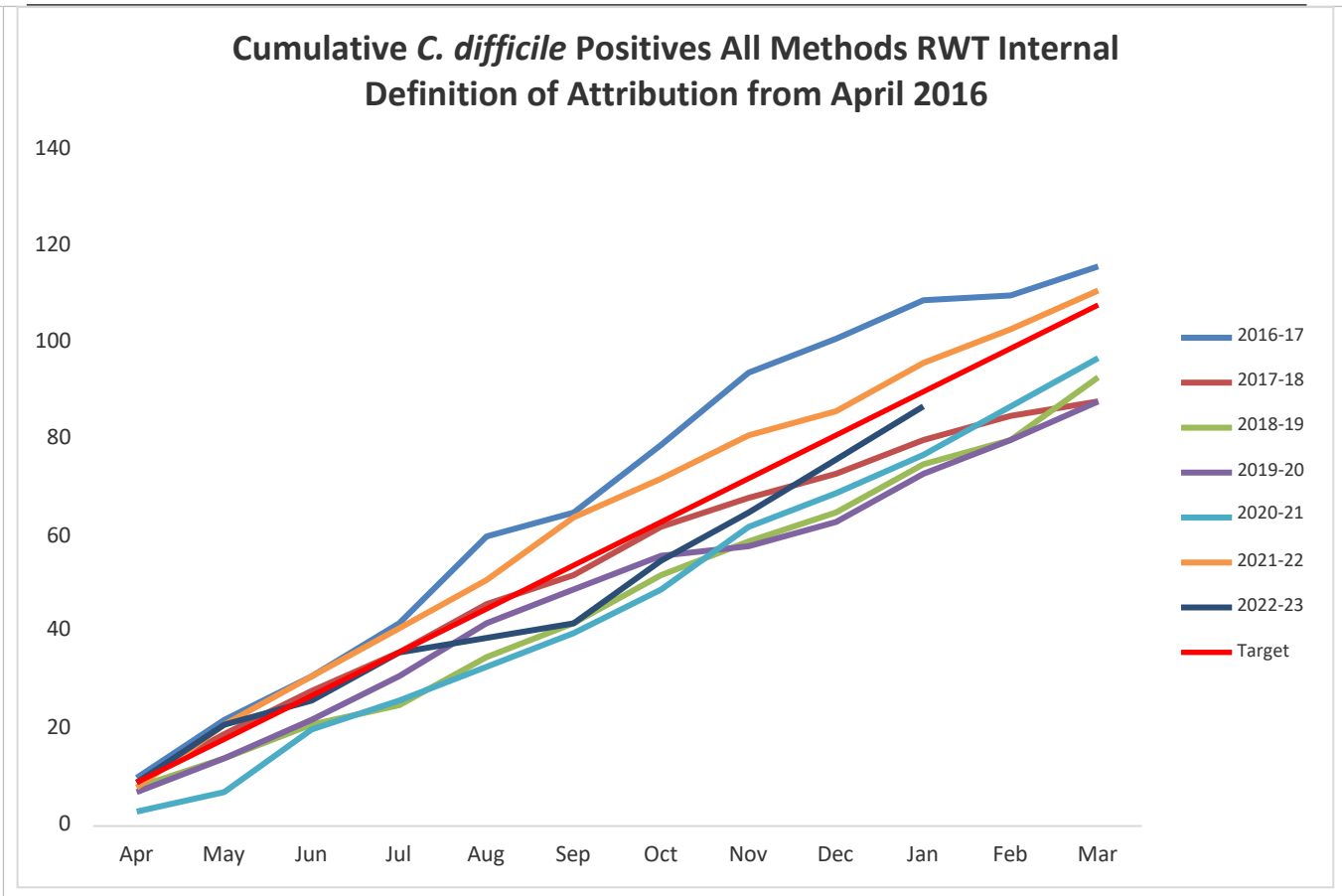
Influenza
The Trust has seen increased influenza cases in this winter season, following two years with very little influenza. From early December influenza cases rose rapidly, with 66 positive inpatients at the end of December. Numbers have fallen steadily since early January, down to a handful of cases at the time of writing.

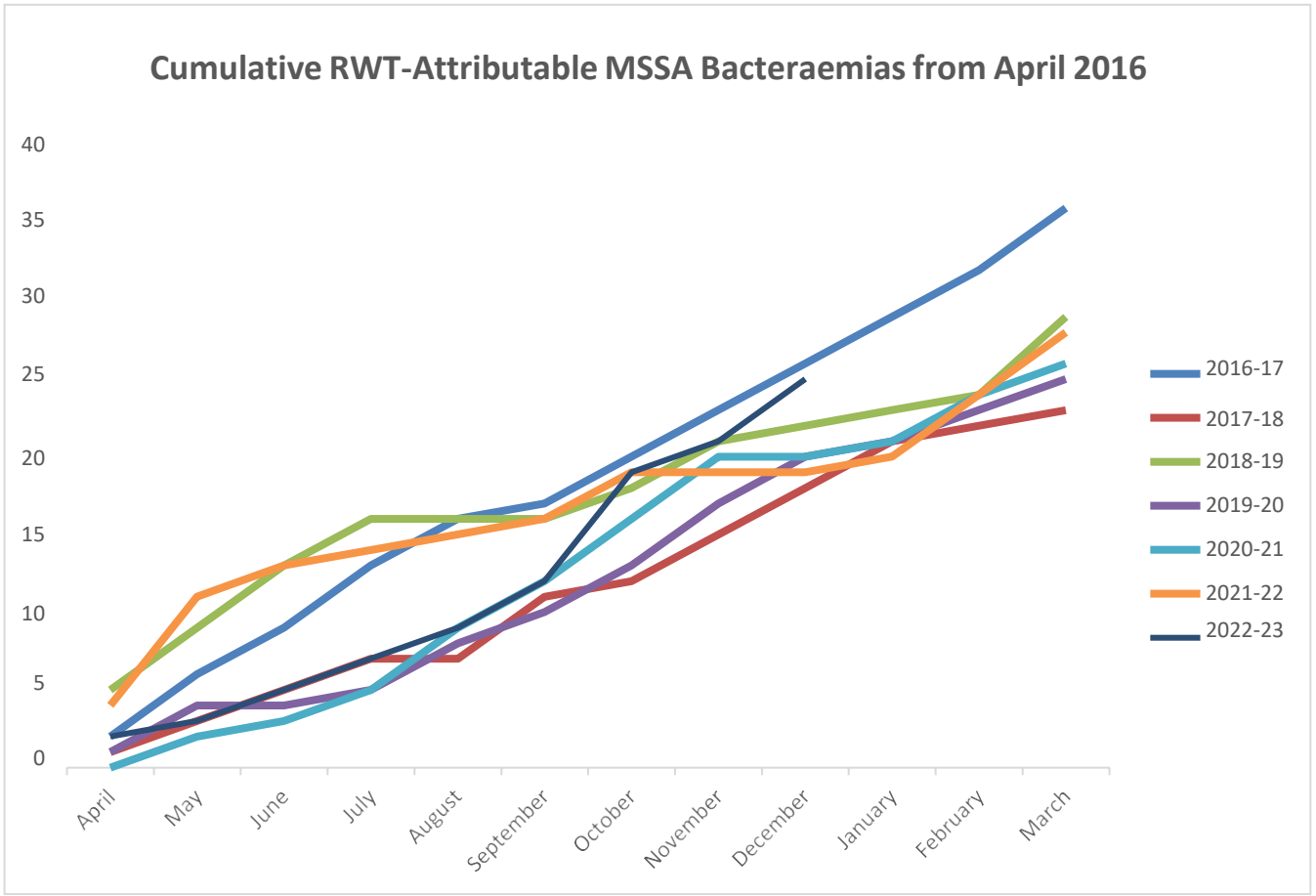
Objectives for 2022/23
CDI – 58 cases
MRSA bacteraemia - 0
Flu vaccination – CQUIN with 70% requirement for minimum payment and 90% requirement for maximum payment.
E. coli bacteraemia – 103
Klebsiella bacteraemia – 35
Pseudomonas aeruginosa bacteraemia – 18

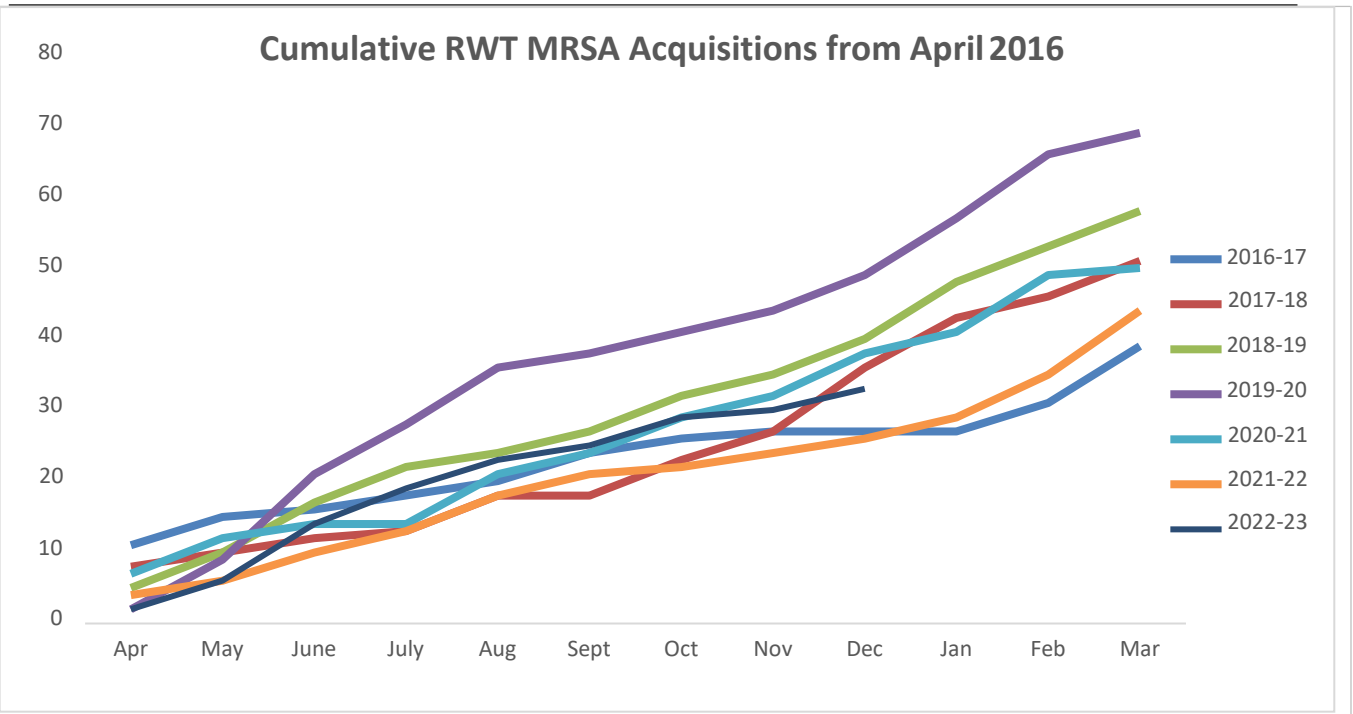
Appendices

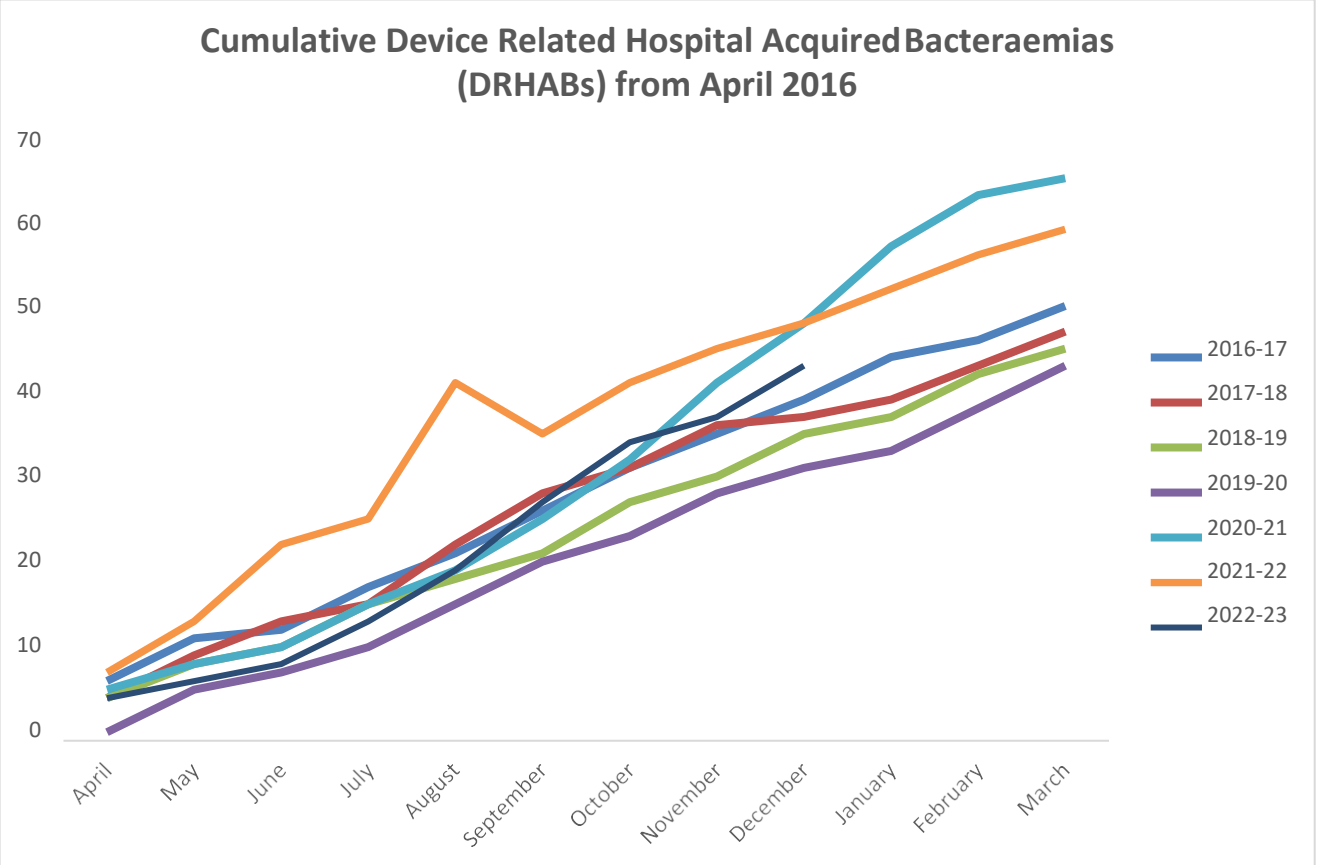
1 **Appendix 1 – Illustrative charts of Infection data**




Cumulative C. difficile Positives All Methods RWT Internal Definition of Attribution from April 2016
140
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
Target


Cumulative RWT-Attributable MSSA Bacteraemias from April 2016
40
35
30
25
20
15
10
5
0
April
May
June
July
August
September
October
November
December
January
February
March
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23


Cumulative RWT MRSA Acquisitions from April 2016
80
70
60
50
40
30
20
10
0
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23


Cumulative Device Related Hospital Acquired Bacteraemias (DRHABs) from April 2016
70
60
50
40
30
20
10
0
April
May
June
July
August
September
October
November
December
January
February
March
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23

Number of new patients colonised with CPE identified (hospital and community). The three most common types of CPE enzymes are New Delhi Metallo-betalactamase (NDM), OXA-48, and Klebsiella pneumoniae carbapenemase (KPC). Some patients may have more than one enzyme.

	NDM	OXA-48	KPC	Others	Total
2015-16	4	1	7	0	12
2016-17	6	2	9	1	18
2017-18	19	6	9	2	34
2018-19	15	3	2	0	20
2019-20	26	34	5	2	56
2020-21	6	11	4	0	18
2021-22	10	14	4	0	27
2022-23	19	26	5	0	43

Healthcare associated COVID summary tables – September to October 2022

Table 1. Summary of Healthcare acquired cases of COVID 19 July to August 2022 Includes probable healthcare acquired (>8 days from admission) and definite healthcare acquired (>14 days)

Month	Number of HCAI COVID
April	99
May	13
June	25
July	62
August	31
September	58
October	83
November	46
December	54

Table 2. Summary of outbreaks (externally reported) in September to October 2022

Date of Outbreak	Ward/Department
02/11/22	C14
11/11/22	CHU
11/11/22	Deanesly
13/11/22	C16
15/11/22	C25
23/11/22	WP2
28/11/22	C39
30/11/22	A7
30/11/22	A8
13/12/22	WP1
16/12/22	C21
29/12/22	A5

Infection Prevention and Control board assurance framework V1.11 September 21st 2022

1.Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**	**Action date**	**Review Date**	**RAG**
Systems and processes are in place to ensure:							
A respiratory plan incorporating respiratory seasonal viruses that includes:							
Point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services	Point of care testing (POCT)is available in ED for COVID screening and is used for all symptomatic patients POCT for FLU/RSV will commencd from 21/11/22	Testing of Flu/RSV POCT equipment will take place from 21/11/22		Division 2/POCT Team	30/11/2022	16/01/2023	
Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g clinically immunocompromised.	Flowcharts are in place to enable staff to segregate and move patients to the most appropriate bed. Infection Prevention and Capacity teams work together to ensure patients are placed appropriately Elective surgery is housed in separate buildings Joint RWT/WHT Respiratory virus risk assessmnet document		Red/Green areas SafeHands system for tagging positive and contact COVID patients and other respiratory infections Joint RWT/WHT Respiratory virus risk assessmnet document	Deputy COOs/Heads of Nursing/Infection Prevention/Capacity Team	14/10/2022	16/01/2023	
A surge/escalation plan to manage increasing patient/staff infections.	A Winter Plan has been written and agreed by Trust Board with an escalation plan included			Deputy COOs/Heads of Nursing/Infection Prevention/Capacity Team	14/10/2022	16/01/2023	
A multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.	Work completed to increase single room capacity within the Respiratory Directorate (x2 en-suite single rooms in wards C14 and C26. For future new builds/refurbishments isolation rooms is on the Agenda			Deputy COOs/Heads of Nursing/Infection Prevention	30/11/2022	16/01/2023	
Organisational /employers risk assessments in the context of managing infectious agents are:							
Based on the measures as prioritised in the hierarchy of controls.	A joint RWT/WMH risk assessment is in place and updated accordingly following national guidance updates All IP risks are present on the Risk Register, escalated and discussed at Infection Prevention and Control Group (IPCG) monthly Departmental/Ward and individual staff risk assessments are in place and updated accordingly Updates provided to all RWT staff via Communications Team using e mail and social media Ventilation Group established and meet quarterly Emergency Preparedness Team update Executives and forward any communications		Compliance is monitored through Trust audits monthly e.g. Environment, Fresh Eyes	Head of Nursing Corporate Support Services/ Human Resources/Matrons/Infection Prevention Team	14/10/2022	16/01/2023	
Applied in order and include elimination; substitution, engineering, administration and PPE/RPE							
Further reassessed where there is a change or new risk identified eg. changes to local prevalence							

Criterion 1

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
The completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	All risk assessments are reviewed at Governance meetings and updated accordingly The joint RWT/WMH risk assessment is reviewed at Executive lead COVID-19 Restrictions group and at Infection Prevention and Control Group			Head of Nursing Corporate Support Services/ Human Resources/Matrons	14/10/2022	16/01/2023	
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents.	Risk assessments are completed by a multi-disciplinary team			Directorate Teams/Health and Safety/Human Resources/Infection Prevention Team/Capacity Team	14/10/2022	16/01/2023	
Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	Patients are transferred to different areas if their condition dictates. CEV patients are screened for COVID prior to transfer to reduce the risk of transmission			Directorate Teams/Infection Prevention Team/Capacity Team	14/10/2022	16/01/2023	
Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	Audits are completed at least monthly for Hand Hygiene, Environment, PPE, Fresh Eyes to include all staff and all areas		Audit results are all collated in MyAssure	Directorate Teams/Infection Prevention Team	14/10/2022	16/01/2023	
The application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs	Policies are in place and audited at least 2 yearly Audits are completed at least monthly for Hand Hygiene, Environment, PPE, Fresh Eyes to include all staff and all areas Waste audits are completed annually by the Waste Management team		Environment and Waste audit results are discussed at the Environment Group monthly All other audits are presented at IPCG as they have been completed	Directorate Teams/Infection Prevention Team/Waste Management Team	14/10/2022	16/01/2023	
The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	Presented at IPCG monthly, Trust Management Committee and Trust Board bi-monthly			Head of Nursing Corporate Support Services/Senior Matron IP	14/10/2022	16/01/2023	
The Trust Board has oversight of incidents/outbreaks and associated action plans.	All incidents/outbreaks and action plans are included in the Chief Nurse Report and the Intergrated Quality Performance Report monthly which are presented at Trust Board			Senior Matron Infection Prevention	14/10/2022	16/01/2023	
The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	More than one mask type is available and all appropriate staff are fit tested on at least 2 with hoods being a 3rd choice Compliance data is available on the Mandatory training reports	Jan 23 - In response to FFP3 Resilience in Acute Trusts - proportionate response to focus on high risk areas. Compliance mapping process in commenced.		Clinical Skills/Procurement/FFP3 fit testers/EPRR	14/10/2022	16/01/2023	

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2.Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**	**Action date**	**Review Date**	**RAG**
Systems and processes are in place to ensure:							
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at Board level	RWT has implemented the National Standards of Healthcare Cleanliness following agreement at Trust Board. Monitored through the Trust Environment Group which reports to IPCG			Head of Hotel Services	14/10/2022	16/01/2023	
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room	The Trust has some methods in place to identify and communicate changes in relation to the functionality of areas/rooms: Comms information via the Intranet, Trust groups diseminating information, IP team providing advice on a 7 day basis	Lacks robust process for informing Estates, requires a systematic process to be developed		Head of Estates/Head of Estates Development	30/11/2022	16/01/2023	
Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Non-clinical areas cleaned at least daily. Posters are in place ensuring that staff are cleaning their work surfaces and equipment at the start and end of their shift. Cleaning standards are audited through Hotel Services and reported to Environment Group and IPCG monthly		Regular communications Trustwide regarding maintaining cleaning standards	Head of Hotel Services/Communication Team	14/10/2022	16/01/2023	
Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	All areas continue to have a chlorine based clean daily and any outbreak areas/cohort wards have enhanced cleaning including touchpoints			Head of Hotel Services	14/10/2022	16/01/2023	
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Initial and refresher training logs/documents	External contractors in some GP practices	Environment audits are completed in all RWT areas monthly	Head of Hotel Services/IP Team/GP Managers	14/10/2022	16/01/2023	
For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: - patient isolation rooms - cohort areas - donning & doffing areas – if applicable - Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. - where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea and/or vomiting.	Housekeeping is following the national specification document on frequency of toilet/bathroom cleaning. Specifically, 2 x full clean and 1 x spot clean daily for high risk (wards) and 1 x full clean and 1 x spot clean for significant risk (clinics) daily Daily Chlorine (Sochlor) clean on all positive wards/bays On the wards, "frequently touched" surfaces is part of the daily specification. In communal areas, our re-deployed staff were used to clean touchpoints throughout the day. This is now completed by ward staff. Electronic equipment decontamination is performed by individual staff in departments it is part of the cleaning strategy, assured through monthly environment audits. Areas are cleaned as per the national specification document. Dirty Utilities are cleaned twice daily. Assured through technical cleaning audit. Environmental audits completed monthly by clinical teams and uploaded to Health Assure. Technical audits completed by Hotel Services		Environment and Technical cleaning audits completed monthly If scores are low then feedback to team is undertaken and any gaps in training/service provision discussed. Low scoring areas are discussed at Environment Group and any that require escalation are reported to IPCG.	Head of Hotel Services/IP Team/GP and Ward Managers	14/10/2022	16/01/2023	
The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	Cleaning responsibilities are identified in the Cleaning Strategy http://intranet.xrwh.nhs.uk/pdf/policies/ST_Cleaning_Strategy.pdf			Head of Hotel Services/Ward Managers	14/10/2022	16/01/2023	

Criterion 2

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
A terminal clean of inpatient rooms is carried out: - when the patient is no longer considered infectious - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). - following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Chlorine based solutions are used for decontamination An electronic system - Teletracking - is in place at RWT and bed cleaning monitoring is recorded on this system Hotel Services supervisors are responsible for the terminal cleans following outbreaks RAG cleaning process and posters in place		In GP practices, clinicians decontaminate equipment between patients using appropriate wipes In the event of a symptomatic patient attending the room willl be cleaned and ventilated as directed Environment audits are completed in all RWT areas	Head of Hotel Services/GP and Ward Managers/IP Team	14/10/2022	16/01/2023	
Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing, or repair equipment.	Trust Policy HS12 Decontamination of re-useable medical devices in in place and current Green (I am clean) stickers are available and in use		Included in Environment audit and Annual IPS audit	IP Team/Ward Staff	14/10/2022	16/01/2023	
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	All areas have a daily cleaning schedule and responsibilities used by patients		IP audits are completed monthly by ward staff and quarterly or following outbreaks by IP Team	IP Team/Ward Staff	14/10/2022	16/01/2023	
Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	Ventilation systems currently in place comply Critical care and respiratory wards are compliant	Not all areas have mechanical ventilation available	Free standing ventilation units have been introduced in some areas Air purification units installed in ED in April 2022	Head of Estates/Head of Estates Development	31/12/2022	16/01/2023	
Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	A quarterly ventilation group has been established	A Trustwide ventilation assessment needs to be completed - External resource		Head of Estates/Head of Estates Development	31/12/2022	16/01/2023	
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Window posters available in all areas advising the importance that windows are opened for 10 minutes every hour			Ward/Department Managers	14/10/2022	16/01/2023	

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3.Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**	**Action date**	**Review Date**	**RAG**
Systems and process are in place to ensure:							
Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	Consultant Microbiologist is the AMS lead Group includes Antimicrobial Pharmacists and Infection Prevention Nurses Meetings held quarterly			Antimicrobial Pharmacist/Microbiologist/IPN	14/10/2022	16/01/2023	
NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 IS implemented - Antimicrobial Stewardship: systems and processess for effective antimicrobial medicine use	Pharmacists are continuing to screen prescriptions to check that antimicrobial prescribing is appropriate, including COVID-19 positive patients Audits completed and presented routinely through IPCG Weekly antimicrobial ward rounds are completed			Antimicrobial Pharmacist/Microbiologist/IPN	14/10/2022	16/01/2023	
The use of antimicrobials is managed and monitored: - to optimise patient outcomes - to minimise inappropriate prescribing - to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed	Pharmacy audits completed and presented quarterly through IPCG Weekly antimicrobial ward rounds are completed by Consultant Microbiologist, Antimicrobial Pharmacist and IPN			Antimicrobial Pharmacist/Microbiologist/IPN	14/10/2022	16/01/2023	
Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: - total antimicrobial prescribing; - broad-spectrum prescribing; - intravenous route prescribing; adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	Microbiology and Pharmacy work closely with ICCU AND AMU to ensure antimicrobial guidelines are appropriate and adhered to and the use of bacterial infection markers such as Procalcitonin are used to aid antimicrobial stewardship		Antimicrobial prescribing compliance is reported to IPCG Quarterly	Antimicrobial Pharmacist/Microbiologist/IPN	14/10/2022	16/01/2023	

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4.Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**	**Action date**	**Review Date**	**RAG**
Systems and processes are in place to ensure:							
IPC advice/resources/information is available to suport visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use	Posters are located throughout the Trust both inside and outside Information is available on the External Intranet and social media Information has been added to all correspondence to patients Easy read information is available thorugh Mencap e link and communicated via comms			Communications Team/IP Team	14/10/2022	16/01/2023	
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Visiting is in place Visiting Hub was set up March 2022 whereas visitors can book a slot online or by telephone Upto 2 visitors for 1 hour per day			Patient Experience Lead/Heads of Nursing	14/10/2022	16/01/2023	
National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard National guidance on visiting patients in a care setting is implemented	SOP is available regarding face to face visiting and video calls			Patient Experience Lead/Heads of Nursing	14/10/2022	16/01/2023	
Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.	1 other person is allowed in these areas to support patients if they choose to			Patient Experience Lead/Heads of Nursing	14/10/2022	16/01/2023	
Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	Decision is made once an outbreak has been declared and the Visiting Hub is informed			DIPC/Microbiologist/IP Team	14/10/2022	16/01/2023	
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	Risk assessments are in place for the use of face masks Posters are in place around the Trust informing not to visit if suffering from respiratory illnesses and diarrhoea and vomiting			Communications Team/IP Team	14/10/2022	16/01/2023	
If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.	Visitors are made aware if attending an infectious patient or a cohort area Face masks are available at entrances to the Trust and also entrances to wards Risk assessments are in place for essential/purposeful/compassionate visiting			Senior Sisters/Charge Nurses/Heads of Nursing/Patient Experience Lead	14/10/2022	16/01/2023	
Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.	Discussions are held with relatives prior to visiting Appropriate IP precautions are put in place to ensure that purposeful/compassionate visiting can take place if the visitor is feeling unwell/symptomatic Risk assessments are in place for essential/purposeful/compassionate visiting			Senior Sisters/Charge Nurses/Heads of Nursing/Patient Experience Lead	14/10/2022	16/01/2023	

Criterion 4

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	Hoods are available if the visitor is required to remain at the bedside but in most instances they will be asked to leave until after the procedure			Senior Sisters/Charge Nurses	14/10/2022	16/01/2023	
Implementation of the supporting excellence in infection prevention and control behaviours implementation toolkit has been adopted where required https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf	This document has been diseminated across the Trust		Several resources are in use from this toolkit including key messages, posters etc	Communications Team/IP Team	14/10/2022	16/01/2023	

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5.Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Systems and processes are in place to ensure:							
All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	All patients are risk assessed in Emergency Portals and if they present with any of the identified symptoms then a point of care test (POCT) is taken followed by a PCR for COVID-19 and Influenza		Patients are isolated in side rooms if POCT or PCR positive	Emergency Portals/Matrons/Senior Sisters/Charge Nurses/Department Managers	14/10/2022	16/01/2023	
Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	Posters and pull ups are in place across all sites			Communications Team	14/10/2022	16/01/2023	
The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	Teletracking/SafeHands records the infection status of the patients for internal use The transfer (SBART) document is completed between ward/hospital moves Discharge summary is completed and sent to GP electronically The D2A form includes infection status Datix of non-compliances are encouraged			Divisions/Capacity Team	14/10/2022	16/01/2023	
Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.	All emergency portals are aware of the symptoms for respiratory illnesses and triage accordingly All cubicles with ED have doors Other departments isolate patients in side rooms until POCT/PCR results are available			Emergency Portals/Matrons/Senior Sisters/Charge Nurses/Department Managers	14/10/2022	16/01/2023	
Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated.	Face masks are available on all wards and are encouraged			Senior Sisters/Charge Nurses/Matrons	14/10/2022	16/01/2023	

Criterion 5

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	All cubicles with ED have doors Other departments isolate patients in side rooms until POCT/PCR results are available Face masks are encouraged			Emergency Portals/Matrons/Senior Sisters/Charge Nurses/Department Managers	14/10/2022	16/01/2023	
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	All cubicles with ED have doors Other departments isolate patients in side rooms until POCT/PCR results are available Face masks are encouraged	Limited number of side rooms available in the Trust which results in some patients with alert organisms nursed in bays with appropriate PPE (risk 5682)	Isolation matrix is available with IP policy to guide staff.	Matrons/Senior Sisters/Charge Nurses/Department Managers/Capacity Team/IP Team	31/01/2023	16/01/2023	
Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	Clinicall extremely vulnerable (CEV) patients are nursed away from positive patients and in a side room if available	Difficult to identify all CEV patients as not tagged on Teletracking	Exploring the use of TeleTracking to support this process.	Senior Sisters/Charge Nurses/Matrons	31/12/2022	16/01/2023	
If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Patients are individually assessed for the need for treatment or admission			Divisions/Medical Directors	14/10/2022	16/01/2023	
The use of facemasks/face coverings should be determined following a local risk assessment.	Local risk assessments are in place and stored on the Trust database			Divisions	14/10/2022	16/01/2023	
Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	Guidance for outpatient areas is available Patients are seen and discharged in a timely manner Social distancing of 1 metre is maintained in waiting rooms Outpatient areas have completed local risk assessments			Heads of Nursing/Directorate Managers/Department Managers	14/10/2022	16/01/2023	
Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	Staff vaccinations for COVID-19 and seasonal flu are available through Occupational Health All staff are encouraged to take the vaccines at the earliest opportunity between September and February			Occupational Health and Wellbeing	14/10/2022	16/01/2023	

Criterion 5

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	Protocol in place Datix completed and raised as a Serious Incident if appropriate (RWT follows approved Black Country System COVID-19 Serios incident reporting process) Outbreak meetings take place on Tuesdays and Thursdays if required and is chaired by either the DIPC, Deputy Director of Nursing, Head of Nursing Corporate Support Services or Senior Matron Infection Prevention External partners are invited to attend as well as the management team of the area affected A Consultant Microbiologist, Hotel Services, Occupational Health, Health and Safety reps are invited			Matron Infection Prevention	14/10/2022	16/01/2023	

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6.Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Systems and processes are in place to ensure:							
IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	IP education is available through Trust Induction and Mandatory training Additional education is available on the Intranet Updates are provided on social media as required Leaflets are available for patients and visitors Specific section of intranet for COVID-19 information	IP COVID-19 guidance on the Intranet is currently being reviewed and updated		Communications Team/IP Team	30/11/2022	16/01/2023	
Training in IPC measures is provided to all staff, including: the correct use of PPE	IP education is available through Trust Induction and Mandatory training Videos are available regarding donning and doffing of PPE Fit testing is provided by Clinical Skills or Fit testers in the clinical areas			Clinical Skills/Nurse Education/IP Team	14/10/2022	16/01/2023	
All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);	Trust Induction, IP Level 1 and Level 2 Mandatory training, Hand Hygiene competency assessed Posters and Videos available for PPE selection, donning and doffing			Clinical Skills/Nurse Education/IP Team	14/10/2022	16/01/2023	
Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk	PPE audits are completed monthly by ward staff or ad hoc by IP Team if ward involved in outbreaks and recorded on HealthAssure			Matrons/Senior Sisters/Charge Nurses/Department Managers/IP team	14/10/2022	16/01/2023	
Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Standard Precautions Policy and Glove Policy are available on the Intranet PPE audits are completed monthly or ad hoc if required to ensure compliance			Matrons/Senior Sisters/Charge Nurses/Department Managers/IP team	14/10/2022	16/01/2023	
Hand hygiene is performed: - before touching a patient. - before clean or aseptic procedures. - after body fluid exposure risk. - after touching a patient; and - after touching a patient's immediate surroundings.	Hand Hygiene audits are completed monthly by ward staff or ad hoc by IP Team if ward involved in outbreaks and recorded on HealthAssure			Matrons/Senior Sisters/Charge Nurses/Department Managers/IP team	14/10/2022	16/01/2023	
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)	All clinical rooms and patient WCs in clinical areas have paper hand towels in the Trust Some public WCs and staff WCs have either hand dryers or paper towels		Survey completed and no hand dryers in clinical areas	Head of Estates/Hotel Services	14/10/2022	16/01/2023	
Staff understand the requirements for uniform laundering where this is not provided for onsite.	Trust Dress Code policy is available on the Intranet Re-iterated in communication e mails to all users	No formal evidence of staff comprehension	Nil planned	Communications Team/All staff	14/10/2022	16/01/2023	

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7. Provide or secure adequate isolation facilities

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Systems and processes are in place to ensure:							
That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Patients are advised on admission to wear facemasks if tolerated Wards monitor compliance locally			Senior Sisters/Charge Nurses/Matrons	14/10/2022	16/01/2023	
Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM.	Symptomatic patients are seen in clinic rooms or side rooms Patients are nursed in side rooms/cohort bays/cohort wards There are Red and Green pathways			Senior Sisters/Charge Nurses/Matrons/Capacity Team/IP Team	14/10/2022	16/01/2023	
Patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	Positive patients are nursed in side rooms/cohort bays/cohort wards AMU have a process to isolate in side rooms until a bed is available on the base wards There are Red and Green pathways			Senior Sisters/Charge Nurses/Matrons/Capacity Team/IP Team	14/10/2022	16/01/2023	
Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings	Standard Precautions and Glove Policies are available on the Intranet PPE and Hand Hygiene audits are completed monthly by ward staff and ad hoc by IP for assurance			Senior Sisters/Charge Nurses/Matrons/Capacity Team/IP Team	14/10/2022	16/01/2023	
Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	Policy available on the Intranet			Senior Sisters/Charge Nurses/Matrons/Capacity Team/IP Team	14/10/2022	16/01/2023	

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8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
There are systems and processes in place to ensure:							
Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	Competency documents for all methods are available within the department BMS staff are HCPC registered The micro management team does not roster staff in an area where they have not been competency assessed and keep an up to date record of all assessments The department is UKAS accredited, although COVID 19 testing is not currently within this scope as it is such a new test.			Pathology Service Manager	14/10/2022	16/01/2023	
Patient testing for infectious agents is undertaken promptly and in line with national guidance.	Time for in-house testing is 24 hours An outstanding worklist is completed twice a day to ensure that there are no issues, any requests exceeding the 24hours are investigated and resolved POCT is available for use in ED and is operational		Testing for symptomatic patienst in line with national guidance.	Pathology Service Manager	14/10/2022	16/01/2023	
Staff testing protocols are in place for the required health checks, immunisations and clearance	National and regional guidance changes for symptomatic staff COVID-19 testing RWT aligned to this and documented and approved via combined RWT/WHT COVID-19 Risk Assessment (Sept 22). All OHWB information available on the Intranet			Occupational Health and Wellbeing	14/10/2022	16/01/2023	
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	Protocols in place in the Lab			Pathology Service Manager	14/10/2022	16/01/2023	
Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. COVID-19 Specific	Patients are screened on development of COVID-19 symptoms			Senior Sisters/Charge Nurses	14/10/2022	16/01/2023	
Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)	All patients discharged to a care home have a COVID-19 PCR test If patient has been COVID positive within 90 days an LFT can be requested	No compliance data	Community IP Team get informed if a resident has been transferred without a recent swab result	Senior Sisters/Charge Nurses/IP Team	14/10/2022	16/01/2023	
For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Testing protocols are transcribed onto a poster which is available in all clinical areas			Senior Sisters/Charge Nurses/IP Team	14/10/2022	16/01/2023	

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9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**	**Action date**	**Review Date**	**RAG**
Systems and processes are in place to ensure that:							
Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	There is an annual programme of work which includes reactive and proactive work and an audit programme A progression report is presented at IPCG quarterly All audit reports are also presented at IPCG as they are completed Audit reports are also uploaded to the Trust Audit database Quality peer reviews are completed in all clinical areas monthly			Head of Nursing Corporate Support Services/Senior Matron Infection Prevention	14/10/2022	16/01/2023	
Staff are supported in adhering to all IPC and AMS policies.	IP Team are allocated to all areas to support and educate wards IP Ambassadors/Link Staff identified locally			Senior Sisters/Charge Nurses/Matrons/IP Team	14/10/2022	16/01/2023	
Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Outbreak policy in place and accessible on Trust intranet PII and SI meetings have associated documents (agenda, minutes/actions)			Head of Nursing Corporate Support Services/Senior Matron Infection Prevention	14/10/2022	16/01/2023	
All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	Compliant Waste Manager responsible Waste guidance posters around organisation			Waste Manager/Senior Sisters/Charge Nurses/Matrons/IP Team	14/10/2022	16/01/2023	
PPE stock is appropriately stored and accessible to staff when required as per NIPCM	Stored appropriately and accessible			Senior Sisters/Charge Nurses/Matrons	14/10/2022	16/01/2023	

Infection Prevention and Control board assurance framework V1.11 September 21st 2022

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Appropriate systems and processes are in place to ensure:							
Staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.	All information is available on the Intranet.			Occupational Health and Wellbeing Manager	14/10/2022	16/01/2023	
Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.	All RWT staff follow same advice and policies			Workforce	14/10/2022	16/01/2023	
Staff understand and are adequately trained in safe systems of working commensurate with their duties.	Policies, Videos, clinical practices are in place to support staff		Mandatory training records, My Academy	All staff	14/10/2022	16/01/2023	
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit testing takes place on all FFP3 masks and respirators that are available in the Trust Fit testers are available in most clinical areas (c 400 fit testers at RWT) Clinical Skills perform initial training for fit testers	Jan 23 - In response to FFP3 Resilience in Acute Trusts - proportionate response to focus on high risk areas. Compliance mapping process in commenced.		Clinical Skills Department	14/10/2022	16/01/2023	
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: -- lead on the implementation of systems to monitor for illness and absence. - facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. - lead on the implementation of systems to monitor staff illness, absence and vaccination. - encourage staff vaccine uptake.	Track & trace system in place via the covid helpline where PPE compliance is assessed and staff advised to isolate as necessary if deemed risk Discussed at Grand Outbreak meetings if required Vaccintion programme (COVID-19 and Influenza) is in place			Occupational Health and Wellbeing Manager/Matron Infection Prevention	14/10/2022	16/01/2023	
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM	All staff continue to follow all IPC precautions			Senior Sisters/Charge Nurses/Matrons/IP Team	14/10/2022	16/01/2023	
A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. - A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. - that advice is available to all health and social care staff, including specific advice to those at risk from complications. - Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. - A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Covid risk assessment devised by OHWB in collaboration with public health. Risk Assessment tool in place across the organisation.	Compliance/ uptake of risk assessments not 100%.	Review of risk assessment tool through COVID Restrictions Review Group. Reports provided to Divisions on a weekly basis to ensure risk assessments in place for all staff.	Senior Sisters/Charge Nurses/Matrons/Workforce	14/10/2022	16/01/2023	
Testing policies are in place locally as advised by occupational health/public health.	All testing procedures are available on the Intranet			Occupational Health and Wellbeing Manager/Matron Infection Prevention	14/10/2022	16/01/2023	
NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	All information is available on the Intranet for staff screening and isolation			Occupational Health and Wellbeing Manager	14/10/2022	16/01/2023	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Completed by	Action date	Review Date	RAG
Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records.	Video available on the intranet for each type of respirator Compliance data stored on Sharepoint and through My Academy	Jan 23 - In response to FFP3 Resilience in Acute Trusts - proportionate response to focus on high risk areas. Compliance mapping process in commenced.	My Academy data is available	All staff	14/10/2022	16/01/2023	
Staff who carry out fit test training are trained and competent to do so	Clinical Skills Team and a group of staff across RWT are recognised Fit Testers		My Academy data is available	Clinical Skills/Senior Sisters/Charge Nurses	14/10/2022	16/01/2023	
Fit testing is repeated each time a different FFP3 model is used.	Clinical Skills Team and a group of staff across RWT are recognised Fit Testers		My Academy data is available	Clinical Skills	14/10/2022	16/01/2023	
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Clinical Skills Team and a group of staff across RWT are recognised Fit Testers	Jan 23 - In response to FFP3 Resilience in Acute Trusts - proportionate response to focus on high risk areas. Compliance mapping process in commenced.	My Academy data is available	Clinical Skills	14/10/2022	16/01/2023	
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.	A record is kept on the individuals My Academy and they will be offered a powered hood if required		My Academy data is available	Clinical Skills/Recognised fit tester/Senior Sister/Charge Nurse	14/10/2022	16/01/2023	
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	Hoods and reuseable respirators are available if fit testing fails			Senior Sisters/Charge Nurses	14/10/2022	16/01/2023	
Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	Redeployment opportunities are available within RWT			Senior Sisters/Charge Nurses/Matrons/HR	14/10/2022	16/01/2023	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	These are held in personal files			Senior Sisters/Charge Nurses/Matrons/HR	14/10/2022	16/01/2023	
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	The results are recorded on My Academy and a monthly report is generated			Education and Training Department	14/10/2022	16/01/2023	
Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	Staff absence is managed according to the Wellbeing Policy and supported by the individuals manager and HR			Senior Sisters/Charge Nurses/Matrons/HR/Occupational Health and Wellbeing	14/10/2022	16/01/2023	

1.Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**	**Action date**		**RAG**
Systems and processes are in place to ensure:							
A respiratory plan incorporating respiratory seasonal viruses that includes:							
A multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.	Work is in progress to increase single room capacity within the Respiratory Directorate For future new builds/refurbishments isolation rooms is on the Agenda			Deputy COOs/Heads of Nursing/Infection Prevention	30/11/2022	16/01/2023	

2.Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**	**Action date**	**Review Date**	**RAG**
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room	The Trust has some methods in place to identify and communicate changes in relation to the functionality of areas/rooms: Comms information via the Intranet, Trust groups diseminating information, IP team providing advice on a 7 day basis	Lacks robust process for informing Estates, requires a systematic process to be developed		Head of Estates/Head of Estates Development	30/11/2022	16/01/2023	
Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	Ventilation systems currently in place comply Critical care and respiratory wards are compliant	Not all areas have mechanical ventilation available	Free standing ventilation units have been introduced in some areas Air purification units installed in ED in April 2022	Head of Estates/Head of Estates Development	31/12/2022	16/01/2023	
Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	A quarterly ventilation group has been established	A Trustwide ventilation assessment needs to be completed - External resource		Head of Estates/Head of Estates Development	31/12/2022	16/01/2023	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people							
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Completed by**		**Date**	**RAG**
Systems and processes are in place to ensure:							
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	All cubicles with ED have doors Other departments isolate patients in side rooms until POCT/PCR results are available Face masks are encouraged	Limited number of side rooms available in the Trust which results in some patients with alert organisms nursed in bays with appropriate PPE (risk 5682)	Isolation matrix is available with IP policy to guide staff.	Matrons/Senior Sisters/Charge Nurses/Department Managers/Capacity Team/IP Team	31/01/2023	16/01/2023	
Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	Clinicall extremely vulnerable (CEV) patients are nursed away from positive patients and in a side room if available	Difficult to identify all CEV patients as not tagged on Teletracking	Exploring the use of TeleTracking to support this process.	Senior Sisters/Charge Nurses/Matrons	31/12/2022	16/01/2023	

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7 February 2023
Title:	Director of Assurance Report - Trust Risk Register (TRR)
Action Requested:	**Receive for assurance and note**
For the attention of the Board	
Assure	• Monthly risk register updates are conducted at Directorate, Divisional and Trust levels.
Advise	• 23 TRR risks are open and ongoing • Risk Registers are produced monthly for Directorate, Divisional and Trust level review and reporting. • Risk descriptions are reviewed to ensure these are clearly represented – for understanding and assurance. • A revised Risk Register review group carries out oversight review and challenge to support regular risk update and accountability. • A Risk Register update guide has been developed to standardised the update of risks in the system • There will be ongoing development of the heat map to accompany the Trust Risk Register reported bi-monthly. • Risk updates may periodically be adversely impacted by operational pressures and staff availability but there is improvement noted. • The following risks are more than 3 years old: - Risk 1984 – 2008 - Risk 4596 – 2016 - Risk 4900 – 2017 - Risk 5058 – 2018 - Risk 5748 – 2016
Alert	• 4 new risks are added to the register in December 22 • 8 red risks remain open (5849, 5802, 5246, 5610, 4900, 5667, 4596, 5388). • 2 Risks have been removed (5681, 4472) • 1 Risk has been downgraded from red to Amber (1984) Ophthalmology Review Risk • 1 Risk has been upgraded from amber to red: • 5849 – Reduced scan capacity in Fetal Medicine Dept
Author + Contact Details:	Michelle.metcalfe7@nhs.net
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment in patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	Nil.
Report Data Caveats	Nil
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	No adverse impact on personal protected characteristics.
Risks: BAF/ TRR	See TRR risk detail below.
Public or Private:	Public

NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details

Brief/Executive Summary Title:

Trust Risk Register – Updates December 22
4 new risks:
5482 – Emergency CT Brain Scanning in ED (COO)
5610 – Increase in Haemodialysis (HD) numbers (COO)
5671 – POCT manufacturer contracts due to expire (COO)
5961 – Shortage of ICCU Consultants (COO)
2 risks removed:
5681 – Radiology Workforce Levels at a Critical Level (COO)
4472 – Delays in timely assessment and treatment in ED (COO)

8 red risks:
5849 - Reduced Scan Capacity in Fetal Medicine Department (CMO)
5802 - Div 2 MFFD patient numbers (COO)
5246 - Lack of Consultant cover within Cancer Services (COO)
5610 - Increase in Haemodialysis (HD) numbers (COO)
4900 - Histology Cases Breaching Turnaround Time Target (COO)
5667 – Cancer Backlog (COO)
4596 – QS104 - Gallstone Disease (COO)
5388 – Mental Capacity Assessment (CNO)
Attention is required to the following risks:
Overdue Review
4596 – QS104 - Gallstone Disease (COO)
5802 - Div 2 MFFD patient numbers (COO)
5246 - Lack of Consultant cover within Cancer Services (COO)
5610 - Increase in Haemodialysis (HD) numbers (COO)

The following risks are more than 3 years old:
Risk 1984 – 2008
Risk 4596 – 2016
Risk 4900 – 2017
Risk 5058 – 2018
Risk 5748 – 2016

Item/paragraph 1.0

Following updates, the split of the Trust Risk Register is:

Risks currently being managed (on-going)	23
Risks managed to target level	0

There are currently 23 risks contained within the Trust Register which are distributed across the Trust's (5x5) categorisation matrix as below:

Likelihood	Consequence 1 Low	2	3	4	5 High
5 – Almost Certain			1 risk		
4 – Likely			11 risks	6 risks	
3 – Possible				4 risks	1 risks

2 – Unlikely					
1 – Rare					

Utilising the Trust categorisation matrix (risk plot above) as a way of pragmatically prioritising the Trust's risks, the following are considered to be of high risk to the Trust:

	ID	Risk Title	Lead
RED RISKS	5849	Reduced Scan Capacity in Fetal Medicine Department	CMO
	5610	Increase in Haemodialysis (HD) numbers	COO
	5246	Lack of Consultant cover within Cancer Services	COO
	5667	Cancer Backlog	COO
	4900	Histology Cases Breaching Turnaround Time Target	COO
	4596	QS104 - Gallstone Disease	COO
	5388	Mental Capacity Assessment	CNO
	5802	Div 2 MFFD patient numbers	COO

The following illustrates how risks on the TRR are mapped against the strategic objectives:

Strategic Objective	TRR			
	R	A	Y	G
1) To have an effective and well integrated health and care system that operates efficiently	3	2		
2) Seek opportunities to develop our services through digital technology and innovation				
3) Attract, retain and develop our staff and improve employee engagement				
4) Deliver a safe and high quality service	5	9	1	
5) Operationally manage the recovery from Coronavirus to achieve national standards		2		
6) Maintain financial health – appropriate investment to patient services		2		

Executive Summary – Board Assurance Framework Heat Map

1. The Trust's Approach to Risk:

The Trust operates three levels of risk register in order to manage risks, these are:

- the Board Assurance Framework (BAF) (reported in detail separately),
- the Trust Risk Register (TRR – Summary Reported herein, reported in detail separately) and
- local Risk Registers (held at Division and Directorate level, reported in detail separately).

The BAF is the Trust Board's prospective strategic risk tool focused on potential risks that might prevent or disrupt the achievement of the Trust Strategic Objectives and aims. The TRR is the corporate record of high level and includes operational risks escalated from service areas, risks identified from Director Portfolios or delegated from the strategic objectives. The TRR provides the link between local risk management activity and Board level review of operational risk. This summary of the TRR includes all approved risks scoring 12 and above using the categorization matrix. All risks include a grade assessment, mitigating controls, positive/negative assurance updates and improvement actions. Risk register updates occur at Directorate and Divisional levels to inform the Trust Risk register.

2. BAF Risk Summary:

The BAF risks are regularly reviewed and updated by the lead Chief Officer and reviewed in detail at the Board Committee's, Audit Committee and Trust Board.

3. Board-Committee Summaries:

The Quality Governance Assurance Committee review the detailed content of the full Trust Risk Register alongside the heat map summary. QGAC confirm and/or challenge the summary assurance rating to be reported to the Board. The heat maps summarize by Division all risks existing in the Trust Risk Register that score 12+ with month-to-month movement, current and target grades, and an assessment of the assurance level and rating. Target grade dates are not currently captured on Datix and will feature in future reports. The Committee challenge and view is then reflected in the QGAC Assure column in the heat map associated table using the Key below.

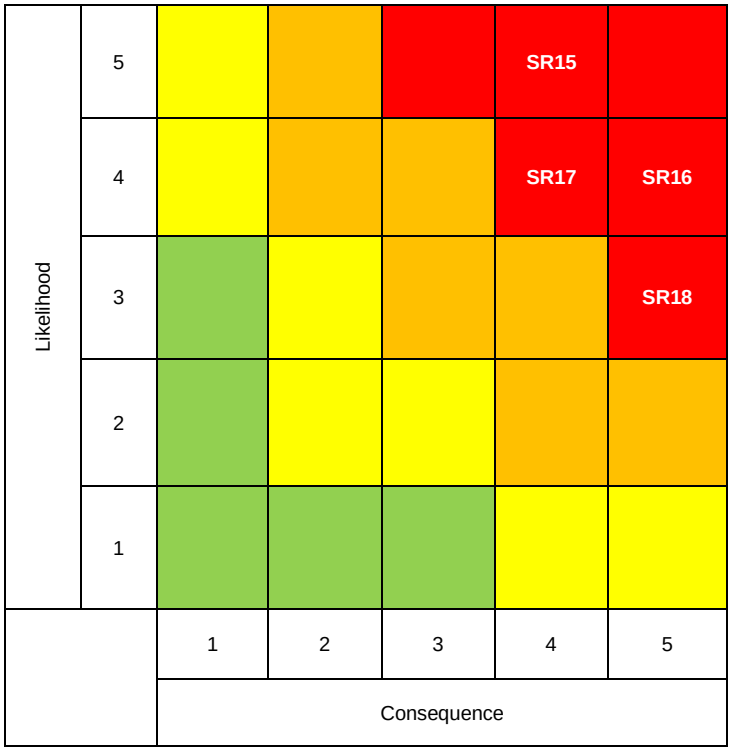
4. Action required:

That the Committee/Board review, confirm and note the heat map report

Assurance Ratings Keys:

<table>
<tr>
<td>Key to assurance ratings:
Level 1: Assurance from operational management
Level 2: Assurance from exec / board committee
Level 3: Assurance from external source
Green: ALL positive assurance
Amber: A MIX of positive & negative assurance
Red: ALL negative assurance</td>
<td rowspan="3">15-25 High Risk
8-12 Moderate Risk
4-6 Low (Minor) Risk
1-3 Very Low Risk</td>
<td>TBC/QGAC Assurance questions and ratings
- Operationally - Are the actions/measures/controls we are taking offering sufficient mitigation (against the risk)? Yes/No</td>
</tr>
<tr>
<td>Symbols Key
• New Risks since the previous report are marked *
• Risks closed since last report are marked #
• Assurance = + (positive assurance)/ - (negative assurance/gap in assurance/gap in control)
• TRR Risks impacting BAF ~</td>
<td>- Committee - Confidence in assurances that actions/are they likely to impact on the risk? Yes/No</td>
</tr>
<tr>
<td>Movement
Same as previous month
Score has increased since previous month
Score has reduced since previous month</td>
<td>TBC Assurance Rating = Yes/Yes (Green), Yes/No or No/Yes (Amber) and No/No (Red)</td>
</tr>
</table>

Board Assurance Framework (BAF) 'Heat-map' Summary as of 24 January 2023



High Risks

Movement	BAF Risk Number	Rating score	Brief Headline	Controls, Mitigations L1	L2	L3	Gaps, Neg. A.	Date last update	Target score	TBC Assure Rating	Start date
	SR18	**3x5**	Data & systems loss (Cyber attack)	tbc	tbc	tbc	tbc	tbc	2x5	tbc	Dec 22
⇨	SR17	4x4	Equality, diversity, and Inclusion	+9	+7	0	-10/-1	17/12/22	3x4	tbc	Oct 22
⇨	SR16	4x5	Services restoration	+ 10	+ 10	+ 6	-5/-10	17/12/22	4x4	No	May 22
⇧	SR15	**5x4**	Maintain financial health	+ 6	+ 6	+ 6	-3/-3	13/01/23	2x3	No	Nov 21

Medium Risks

Movement	BAF Risk Number	Rating score	Brief Headline	Controls, Mitigations L1	L2	L3	Gaps, Neg. A.	Date last update	Target score	TBC Assure Rating	Start date

Symbols Key
New Risks since the previous report are marked *
Risks closed since last report are marked #
Weighting of assurance +/-
TRR Risks impacting BAF ~

Existing BAF Risks
Dates for risk target grades are to be established for all risks.

Assurance questions for to Board Committee are:
Operationally 'Under control' means ***are the actions*** *outlined/in place and/or active and/or completed and/or happening as planned appropriately mitigating/****offering sufficient mitigation*** *on/****against the risk***, plus **Committee** 'Confidence/Assurance' means *if/when/****as the actions are completed****/in place,* ***what is the level of confidence is there that they will act on the risk*** *- i.e. move the score down*.
TBC Assurance Rating = Yes/Yes (Green), Yes/No or No/Yes (Amber) and No/No (Red)

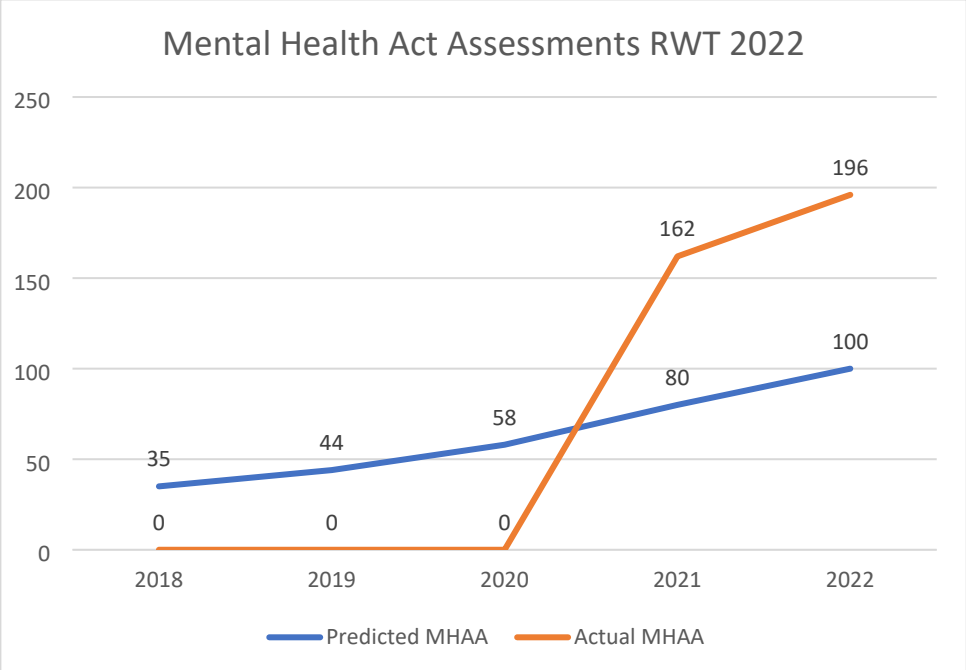
Potential new BAF Risks

Trust Board RWT	
Meeting Date:	7 February 2023
Title:	Report of the use and application of the Mental Health Act. Inclusive of a Mental Health Overview.
Purpose of the Report:	Informs the Committee of trends of application of the Mental Health Act and patient outcomes and the current developments in mental health within the organisation.
Action required:	Received and noted.
Assure	• 65 patients were sectioned under the MHA in July 2022-January 2023 • Governance update detailed in this report. • All patients have Mental Health Act compliance.
Advise	• Mental Health is a key pillar of Trust priorities for both patients and staff. • Overview of the use of the Mental Health Act. • The Mental Health Act administration team have expanded the data collected for all MHA detentions to ensure all demographic and ethnicity data is collected as per best practice. • Overview included.
Alert	• Nationally there has been an increase in mental health presentations to acute trusts. • Hospital admissions for eating disorders increased by 84% in the last five years and there have been changes to the Royal College of Psychiatrists eating disorder guidelines. The launch for this guidance highlighted a noted increased in eating disorder deaths within acute trusts and the correlation between death and delays for refeeding in an emergency presentation to acute trusts. • Locally there has been an increase in LOS for ED and an increase in out of area patients who have had an increased length of stay within ED and the hospital. Increase in violence and aggression towards staff relating to acutely unwell mental health patients. • Increase in admissions for all ages for mental health primary reason. • Increase in Mental Health Act detentions and activity within the organisation compared to 2021/2022.
Author + Contact Details:	Jodie Kirby – Lead Mental Health Nurse Email: Jodie.kirby-owens@nhs.net on behalf of Dr Brian McKaig – Chief Medical Officer Tel 01902 695948 Email brian.mckaig@nhs.net
CQC Domains	**Safe: Effective: Caring: Well-led.**
Trust Strategic Objectives	1. Create a culture of compassion, safety, and quality 2. Proactively seek opportunities to develop our services
Resource Implications:	None

Report Data Caveats	Overview of MHA Activity.
Equality and Diversity Impact	There is a risk of biased use of the MHA therefore ethnicity, age and sex of those detained is reported in this paper.
Risks:	Being updated – will be completed by 3/2/23
Risk register reference:	On Local Risk Registers

Brief/Executive Report Details	
Brief/Executive Summary Title:	Report of the application of the Mental Health Act (Mental Health Act)
Item/paragraph 1.0	The Mental Health Act (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 Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others. The Mental Health Act (MHA) enables a person to be detained or treated without their agreement. There are many sections of the MHA. Common section so the MHA used at RWT are. Section 136 – Police detention Section 2 – detention for assessment Section 3 – detention for treatment Section 5 (2) – short term detention for assessment, usually resulting in further MHA assessment. Section 17 leave - for those patients detained under the MHA who are within RWT for physical health treatment on leave. This report gives the board assurance on the use of the MHA within RWT. It will be supported by a new Trust policy on use of the Mental Health Act and is supported by a training programme. In the MHA the Trust Board is referred to as Hospital Managers. This group has specific responsibilities which have been covered in training. One such responsibility is to be assured of the safe use of the MHA. Other staff members have responsibilities to act on the Hospital Mangers behalf. These are usually on call staff and senior nurses who work out of hours.

Brief/Executive Report Details	
Patients detained under the MHA at RWT January 2022 – December 2022	There was a total of 196 Mental Health Act Assessments during January – December 2022 compared to 162 Mental Health Act Assessments during January-December 2021. Section 5:2 can be administered by hospital doctors.



The section types: Section 136, Section 2, Section 3 and Section 5(2) are those that would be expected in an acute trust including emergency care.

- Moving forward we aim to add in any Section 17 leave that is often utilised in acute trusts.

This report focuses on the patients that were detained to RWT and our responsibility to support and care for those patients.

The information provided in this report is supplied by the Mental Health Act administrators.

We can give assurance that the MHA was applied correctly to RWT inclusive of the section 132 rights. This is a positive change in practice since the last report submitted to TMC.

We can give assurance that documentation for the Mental Health Act was completed for each patient, and this has been recorded through the correct process for RWT. Meeting our requirements under the Mental Health Act and CQC regulatory status.

3.0 Mental Health Work Stream Progress	The Mental Health steering group is a bi-monthly meeting. In November there was good representation and an agreed action plan for mental health moving forward. Caroline Whyte is the Chair for this meeting.

CAMHS Patients: -

There has been continued challenges with managing CYP on the paediatric ward who are awaiting Tier 4 admission. There is a national shortage of Tier 4 beds, especially those who require specialist placements such as eating disorder. Therefore, there has been challenges for the paediatric team to support and manage patients who are on the ward for a prolonged period of time.

There has been minimal change in the challenges for paediatrics, there has been an increase in eating disorder presentations/ admissions and an increased LOS.

- A CAMHS Clinical nurse specialist was requested within the mental health business case in January 2022. It would be beneficial to the paediatric team to have a specialist resource to help support the management of CYP in crisis and training for the divisions.

MHLS: -

The MHLS has continued to deliver 24/7 service working towards CORE24.

- Consultant psychiatrist has been appointed – several months with no psychiatrist in the team within 2022(Psychiatrist is part time).
- Team manager is now based on site at RWT.
- Agency staffing utilised to backfill vacancies and leave.
- MHLS service manager has confirmed challenges with recruitment and vacancies within the team - this is ongoing.

There has continued to be incident reports submitted relating to MHLS with themes of:

- Delay in access to assessment
- Delay in access to adequate care planning and support
- Challenges with making referrals.
- Increased length of stay for patients within ED.
- Incidents relating to poor service quality such as: refusal of assessment, suboptimal support delivered from MHLS.
- MHLS continue to have retention and recruitment challenges for the service, and this has a direct impact on the level of service delivered.

The MH Governance Manager now works across both WHT and RWT. There have been challenges accessing data relating to MH patients at RWT, but this is now resolved and from Dec 2022 we are able to extract reports detailing incidents submitted relating to patients with a mental health illness.

Incident themes are:

- Delays in MHLS response times
- Delays in transport to external MH inpatient bed facilities
- Violence and aggression

	There has been consistent challenges due to MHLS continuing to work towards CORE24 standards, currently CORE24 standards are not being delivered. To escalate to the board: • MHLS do not have a current operational policy for the remit of the service • MHLS have had continued challenges recruiting to posts • No out of hours face to face psychiatrist available. <u>Mental Health related risks are currently under review by the Lead Nurse for MH with RWT governance team.</u> A joint incident review meeting with Black Country Healthcare Trust is due to commence Feb 23 and this will feed into the Bi – Monthly MH Steering group. A TOR will be presented at the next MH steering group for approval. We are currently working with our partner organisations to share incidents and learning. Quality concerns will be sent through the correct process by mental health governance manager to support the ongoing themes and challenges with MHLS service delivery. <u>Summary of future/ongoing work:</u> - MEED (eating disorder pathways and guidance) - Completion of escalation process - Restrictive practice guidance - MHA training trust wide - review patient journey / pathways across both organisations - Review of Mental Health training package across both organisations - develop collaborative action plan - continue to develop services to meet the needs of the organisations Develop CAMHS framework (strategy) to support the CYP in crisis that attend the acute trust. Continue to work with all partners to support developing services and shared learning. To optimise the resources within the service, for the mental health team to work collaboratively across both RWT & WHT to support the increasing demand.

Trust Board Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee:	Audit Committee
Date(s) of Committee Meetings since last Board	6 September 2022
Chair of Committee:	Julie Jones
Date of Report:	30 December 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	• Following receipt of the Cyber Risk Management report it was suggested that cyber security should be evaluated as a potential BAF strategic risk.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The planned update on actions arising from the Waiting List audit was deferred due to needing to reframe some of the recommendations. • A new Board Assurance Framework (BAF) template is being drafted in conjunction with Walsall. • Following feedback from the respective chairs of QGAC and P&FC, the committee discussed the risks posed to the organisation from the Cancer Recovery Plan, A&E waits and ambulance breaches, stroke metrics, staff turnover and retention, financial outturn, and the cost improvement plan. • The internal audit review of Bank and Agency gave '**partial** assurance', which is a negative opinion, due to incomplete rollout of the health roster system. • Internal audits reports of the Business Case Process, and the follow up of Ophthalmology, had been issued in draft so were not available for discussion. • The Business Case Process report was circulated to members by email in November and gave '**partial** assurance', which is a negative opinion. The governance framework surrounding the development and approval of business cases needs improving. The report was carried forward for discussion at the December meeting of the committee. • Internal audit reported that 14 actions from previous reports were overdue.
ASSURE **Positive assurances & highlights of note for the Board**	• The quarterly security report gave assurance that risks were being managed and staff concerns responded to. • The Counter Fraud Functional Standard return was submitted ahead of the deadline with an overall rating of green (positive). • Four new staff-raised counter fraud cases were discussed, giving encouraging assurance that staff feel able to speak up and report concerns. • External audit (KPMG) noted their planning for the 2023 audit had commenced. • An update on ICS and ICB governance was received and discussed. • Members noted a new committee workplan which is now aligned with Walsall.

Recommendation(s) to the Board	• Losses and special payment proposed write offs were agreed for final approval by the Trust Board.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• Potential for new cyber security BAF risk escalated.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, changes to Work Plan)**	• The committee will take forward the actions relating to the recommendations previously made by external and internal auditors.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• Please refer to agenda on ibabs.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Please refer to agenda on ibabs.
Matters presented for information or noting	• No interests were declared by members. • The committee meeting dates for 2023 were agreed.
Self-evaluation/ Terms of Reference/ Future Work Plan	• Members were asked to consider what the committee had done well, what could have been done better, and whether the business of the meeting had made a difference to patients. • Members were satisfied that they contributed positively and felt they made a difference to the patients and staff of the hospital with their contributions. There was a good discussion on how risk management can be challenged more effectively and in greater detail. They also felt that the discussion on cyber security was timely and important. • Members resolved to hold the next two meetings on MS Teams but consider face-to-face thereafter.
Items for Reference Pack	• None

Trust Board Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee:	Audit Committee
Date(s) of Committee Meetings since last Board	13 December 2022
Chair of Committee:	Julie Jones
Date of Report:	17 January 2023

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	• Internal audit reported on their follow-up review of Ophthalmology. Positive assurance was received that six recommendations from their original report have been addressed or superseded, however **three** high risk recommendations remain, leading internal audit to conclude that they cannot provide assurance that Ophthalmology has capacity to see new referrals, follows up patients in a timely manner and, therefore, prevents harm from occurring. ○ No agreement has yet been reached with the ICB to fund stable patients identified as being suitable to receive care from community Optometrists. ○ Members noted that whilst the Wrekin House development had been approved, it would not be until Year 3 of the works that there would be an impact on Ophthalmology. Until then, only limited improvements could be made to increasing clinical space. ○ Initial validation of the Ophthalmology Waiting List has been undertaken at Cannock Chase Hospital; however a Trust-wide service validation exercise still needs to be undertaken.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Following feedback from the respective chairs of QGAC and P&FC, the committee discussed the risks posed to the organisation from insufficient staffing levels, and pressures on waiting lists and the 52-week waits. Members noted the new holding area in A&E will provide a better environment for patients arriving by ambulance. • The Business Case Process internal audit report, previously circulated to members by email in November 2022, gave '**partial** assurance', which is a negative opinion. Members noted the update received regarding addressing the recommendations raised. • Members agreed changes to the Standing Financial Instructions for recommendation to the Trust Board for approval. Delegated limits are to be increased in order to reflect the scrutiny deemed appropriate based on current procurement levels and when compared to other similar trusts. It was agreed that P&FC should receive a monthly report detailing authorisations in excess of £250k.

ASSURE **Positive assurances & highlights of note for the Board**	• The committee received a briefing on the new format BAF, and noted that the internal audit review of the BAF was deferred to February 2023 to allow for the new system to be embedded. • The quarterly security report gave assurance that risks were being managed and staff concerns responded to. Assurance was given that procurement was underway for two key contract appointments/renewals. • The internal audit review of Key Financial Controls – General Ledger gave '**substantial** assurance', an excellent outcome. • Internal audit noted good progress in implementing recommendations from their reviews. • The internal audit review of the Effectiveness of the Freedom to Speak Up Function gave '**reasonable** assurance' demonstrating that the Trust has robust controls in place to promote a positive culture for staff to be able to speak up. • Eight new counter fraud cases referrals had been received since the last meeting. Additional data was requested about single tender waivers based on the Trust appearing to be an outlier in the number of waivers undertaken compared to other trusts in the auditor's client base. • External audit outlined various changes in accounting and auditing standards. Changes in International Standards on Auditing require external auditors to undertake a more enhanced risk assessment process, and to undertake more testing of the Trust's key IT controls than has been undertaken in the past. • An update on ICS and ICB governance was received and discussed. • A new report was received outlining Single Tender Actions and Suspension Breaches, giving the committee additional assurance over the management and context of actions and breaches. The visibility provided by the new report was welcomed by the committee. • Members noted the reviews of a number of key policies. • The committee noted a revised Terms of Reference for the Committee that reflected the Trust's new strategic aims.
Recommendation(s) to the Board	• Losses and special payment proposed write offs were agreed for final approval by the Trust Board. • Changes to Standing Financial Instructions were agreed for final approval by the Trust Board.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• None.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, changes to Work Plan)**	• The committee will take forward the actions relating to the recommendations previously made by external and internal auditors. • The outstanding recommendations from the Ophthalmology review will be an area of particular focus and follow-up.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• Please refer to agenda on ibabs.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Please refer to agenda on ibabs.

Matters presented for information or noting	• No interests were declared by members.
Self-evaluation/ Terms of Reference/ Future Work Plan	• Members were asked to consider what the committee had done well, what could have been done better, and whether the business of the meeting had made a difference to patients. • Members felt that the meeting had been focused, positive and with relevant discussion, involvement, and challenges from members. The quality of the agenda items had been very good, and the meeting had flowed smoothly.
Items for Reference Pack	• None

AUDIT COMMITTEE

TERMS OF REFERENCE

Trust Strategic Aims

Strategic Aim	Associated Strategic Objectives
1. Excel in the delivery of Care ***We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.***	a) Embed a culture of learning and continuous improvement b) Prioritise the treatment of cancer patients c) Safe and responsive urgent and emergency care d) Deliver the priorities within the National Elective Care Strategy e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations
2. Support our Colleagues *We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations.*	a) Be in the top quartile for vacancy levels b) Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing c) Improve overall staff engagement d) Deliver improvement against the Workforce Equality Standard
3. Improve the health of our communities *We will positively contribute to the health and wellbeing of the communities we serve.*	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1st April 2025 c) Deliver improvements at PLACE in the health of our communities
4. Effective Collaboration *We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.*	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care

Meeting Purpose/Remit

The Audit Committee provides the Board with a means to undertake and obtain independent and objective reviews of financial systems / financial information and help ensure compliance with relevant law, guidance, and codes of conduct. The Audit Committee's role has been enhanced to take a wider view over internal controls across the whole of the Trust's activities.

Responsibilities	**1. Internal Control** The Committee shall review the establishment and maintenance of an effective system of internal control. In particular, the Committee will review: - • The Annual Governance Statement, and the related Head of Internal Audit Opinion, prior to the endorsement of the Annual Accounts by the Trust Board. In order to undertake such a review, the Audit Committee will need to seek assurance from the activities of the Quality Governance Assurance Committee (QGAC), not least to ensure that, between the Audit Committee and the QGAC, full coverage is achieved. • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and the operational effectiveness of such policies and related procedures • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect • The timeliness of the implementation of agreed action plans arising from all audit reports within the purview of the Committee • The policies and procedures for security within the Trust **2. Internal Audit** The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board. This will be achieved by: - • The consideration of the provision of the Internal Audit service, the audit fee and any questions of resignation and dismissal • The review and approval of the Internal Audit strategy and annual plans, ensuring that these are consistent with the audit needs of the Trust, including the needs of the QGAC • The review of progress against the agreed annual internal audit plan • The consideration of the major findings of internal audit reviews and management's response • Ensuring that the quality of the Internal Audit service is maintained and that the service has appropriate standing within the Trust • Ensuring co-ordination between the Internal and External Auditors to optimise audit resources • The review of an Annual Report, provided by the Head of Internal Audit, summarising audit activities during the year • Note: for the purposes of the above section, references to Internal Audit are deemed to include Counter Fraud work

3. External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications of, and management response to, their work. This shall be achieved by: -

- The consideration of the appointment and performance of the External Auditor
- The discussion with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Audit Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Reviewing External Audit reports, including the agreement of the annual audit letter before its submission to the Trust Board, together with the appropriateness of management responses.
- Reviewing and agreeing any additional work beyond the review of the accounts and Annual Report/Annual Quality reports

4. Financial Reporting

The Audit Committee shall review the Annual Accounts before submission to the Board, focusing particularly on: -

- The Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted misstatements in the Annual Accounts
- Major judgmental areas
- Significant adjustments resulting from the audit
- Review and approval of the Value For Money (VFM) statement
- Undertake reviews of single tenders as and where appropriate at each meeting.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

5. Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

The Committee should review arrangements by which staff of the Trust may, in confidence, raise concerns about possible improprieties in matters of financial reporting or other matters. The Audit Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

	6. Security Report The Audit Committee shall receive regular reports regarding all aspects of security in the Trust specifically relating to physical security of people, buildings, and property. • Incidents reporting including severity actions and learning. • Role and function of security staff. • Any other security related oversight. **7. Losses and Compensations** The Committee shall approve all Losses and Compensations. The Chair will be informed prior to the meeting of any novel or high value losses and compensations as agreed with the Chief Financial Officer (CFO). **8. Other** The Committee shall review proposed changes to Standing Orders, the Scheme of Reservation and Delegation, and Standing Financial Instructions, and advise the Board accordingly. The Committee shall examine the circumstances associated with each occasion when Standing Orders are waived. Where requested by the Board, the Committee should review the content of the Annual Report/ Quality Account and Accounts and advise the Board on whether, taken as a whole, it is fair, balanced, and understandable and provides the information necessary for stakeholders to assess the Trust's performance and strategy In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this should include the Quality Governance and Assurance Governance Committee and any risk management committees that are established. The Audit Committee Chair will actively consult with and take recommendations from the Chairs of other Committees of the Board for the internal audit programme. Where an internal audit or other audit is undertaken where responsibility crosses with other Committees of the Board the report recommendations and actions will be shared with the respective and appropriate Committees. It may be agreed that those Committees then agree oversight for the Governance of the completion of the actions and resulting impact.
Authority & Accountabilities	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Committee shall transact all business in accordance with the policy of the Trust on openness and conformity with the principles and values of the Public Services.

	The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01).
Reporting Arrangements	The minutes of Audit Committee meetings shall be formally recorded and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues of significance or that require disclosure to the full Board. The minutes of the Audit Committee meetings will be made available to the Chair of QGAC and in due course to the Trust Board as an addition to the Trust Board agenda for information. The Chair of the Audit Committee shall provide to the Board an Annual Report of the activities of the Committee.
Membership	The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. The Chair of the Trust Board shall not be a member of the Audit Committee. The Chair of the Audit Committee shall be appointed by the Chair and Non-Executive Directors of the Trust. The Chairs of other Committees of the Board (if not already a member of the Audit Committee) are to be extended an open invitation to attend (excluding Remuneration Committee, Charity Committee, and Innovation Committee) where the Committee Chair is a voting Non-Executive (Associate NEDs being excluded).
Attendance	The Chief Financial Officer and appropriate representatives from internal and external audit shall normally attend meetings, and the Audit Committee can require the attendance of any officer of the Trust relevant to the discussion of a specific issue. The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft Internal Audit Plan and the Annual Accounts. All other executive directors may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Company Secretary will attend as required to ensure that the Committee business is transacted as per the terms of reference and the Trust Standing Orders.

Chair	NED Chair
Quorum	A quorum shall be two members
Administrative Report	Chief Financial Officer and Deputy Chief Executive PA, and Deputy Chief Financial Officer PA
Annual Workplan	The Audit Committee will agree an Annual Workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will then form part of the agenda alongside the standing agenda items.
Frequency of Meetings	Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if either considers that one is necessary. At least annually the members of the Committee will meet with the Trusts' Auditors without any other Committee attendees being present.
Papers Publication	All papers will be published using the Ibabs Board paper sharing system. A progress report of outstanding/pending Internal Audit actions will be presented to each meeting of the committee by Internal Audit. Actions relating to the meeting of the committee will be presented and updated at each meeting of the committee and will be administered by the CFO PA who will mark as completed and closed once confirmed by the Audit Committee All Internal Audit Report recommendations/actions whether rated low, medium or high will be allocated, tracked, updated, and reported using Ibabs administrated by the CFO PA. Each allocated Internal Audit action is the responsibility of the identified manager to update, report against and declare as "done".
Standards	NHSI Code of Governance NHSI Risk Assessment Framework NHSI Annual Planning Guidance The Health NHS Board – Principles of Good Governance Corporate Governance – Principles of Public Life (GP01) Guidance on Audit Committees – FRC (September 2012) NHS Audit Committee Handbook
Standard Agenda	Agendas will be built around the annual Committee workplan, and most of the following will appear on each agenda, while some will appear only once or twice each year: Declarations of interest, minutes of previous meeting, Action list, Security report, Counter Fraud report, Internal Audit reports, External Audit Plan and progress reports, Annual Audit letter, External Auditor's report to those charged with Governance, Losses and Compensations, Breaches of SO/SFI, Recommendation Tracker, Annual Report/Quality Account, Annual Governance Statement, Internal Audit Strategy and Annual Plan, review of SO/SFIs, self-assessment of the Committee's effectiveness, review of the Committee's terms of reference, Annual Report of Audit Committee.

Subgroups	As instigated or identified by the Committee
Date Approved	December 2022
Date Review	December 2023

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7 February 2023
Title:	Workforce Safeguards - Nursing and Allied Health Professionals (AHP)
Purpose of the Report:	To inform the committee of the outcome of the re self-assessment against the Workforce Safeguards document for nursing and AHPs
Action required:	**Receive for information and assurance**
Assure	• Of the 14 recommendations within the NHSI workforce safeguard document, the Trust is compliant with 12 with recommendations 2 and 8 being partially compliant, from an AHP perspective. • Recommendations 11 and 12 - governance processes are in place around the completion of Quality Impact Assessments (QIA)and Risk Assessments (RA) when changes are made to ward/department locations, skill mix or case mix of patients, and large scale redeployment of staff • All nursing workforce are on an electronic rostering system.
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. • Scoping work has commenced in regards NHSI guidance to have e-jobs plans for all clinical staff not working 24/7 shift system.
Clinical implications and view	Matrons, Senior Nurses, Midwifes and Health Visitors Group Role Development Steering group
Patient, carer, public impact and views	
Author + Contact Details:	Chrissla Davis Head of Nursing - Workforce email Chrissla.davis@nhs.net
CQC Domains	**Safe** **Effective** **Caring** **Responsive** **Well-led**
Trust Strategic Objectives	1. To have an effective and well-integrated health and care system that operates efficiently 2. Seek opportunities to develop our services through digital technology and innovation 3. Attract, retain and develop our staff, and improve employee engagement 4. Deliver a safe and high quality service 5. Operationally manage the recovery from Coronavirus to achieve national standards 6. Maintain financial health – appropriate investment to patient services
Resource Implications:	None
Public or Private	Public
Risks:	None
Risk register reference:	
Other formal bodies involved:	As above
References	• See reference pack

Brief/Executive Report Details	
Brief/Executive Summary Title:	Workforce Safeguards–Nursing and AHP

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.

Findings of the latest self-assessment

- The Trust has re-self-assessed against the recommendations and is compliant with recommendations 1; 3; 4; 5; 6; 7; 9;10; 11; 12; 13 and 14. It remains partly compliant with recommendation 2 and 8.
- Recommendations 11 and 12 - Governance processes have been put into place around the completion of quality impact assessments and risk assessments when changes are made to ward/department locations, skill mix or case mix of patients, and large scale redeployment of staff.

Workforce Safeguards January 2023

Workforce Safeguards - NHSI

Recommendations

Recommendation 1 - Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance

– Compliant

Recommendation 2 - Trusts must ensure the 3 components are used in their safe staffing process

– Partially Compliant

Figure 1: Principles of safe staffing

Figure 1 – Data source NHSI, 2018

Whilst the majority of nursing and midwifery reviews will be undertaken using the safer nursing care tool (SNCT) methodology, this is not appropriate for all clinical areas across RWT. The table 1 outlines where different methodologies and guidelines are available and which will be used in each of the clinical settings

Table 1

Area	Methodology
Wards – adults, paediatrics, AMU and SEU	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	Professional Judgement
Endoscopy	JAG guidance/Professional Judgement methodology
General Practice	Professional Judgement as no current validated tool available
Physiotherapists	Chartered Society of Physiotherapy Workforce Data Modelling Tool (2015) Calculating Staffing Levels in Physiotherapy Services (2000) Physiotherapy Staffing Recommendations for Neonatal Units in England (2018) National Clinical Guideline for Stroke (RCP, 2016) Standards for the Clinical Care of Children and Adults with Cystic Fibrosis in the UK (2011) Standards for Physical Activity and Exercise in the Cardiovascular Population ACPICR (2015) Service Specification: Pulmonary Rehabilitation Service DH (2012)
Occupational Therapists	College of Occupational Therapists Workforce planning in Occupational Therapy (2010)

	National Clinical Guideline for Stroke (RCP, 2016)
Speech and Language Therapists	Royal College of Speech and Language Therapists Calculating hours available to a FTE speech and language therapist (2012) A Sense of the whole Public Service Review, Health and Social care 33 (2011) Speech and Language Therapy Staffing Recommendations for Neonatal Units, Neonatal Speech and Language Therapy Stakeholders group (2018) National Clinical Guideline for Stroke (RCP, 2016)
Dieticians	BDA Safe Caseload Management (2012) BDA Safe Staffing, Safe Workload (2016) Information from www.diabetes.org.uk (2010) Guidelines for the Provision of Intensive Care Services (the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS), 2018) Dietitian Staffing on Neonatal Units, Neonatal Sub-Group Recommendations for Commissioning (2018) National Clinical Guideline for Stroke (RCP, 2016) IBD standards (2013) CREST (2006) British Renal Society (2002) Standards for the Clinical Care of Children and Adults with cystic fibrosis in the UK (2011)
Orthotists	Professional Judgement as no current validated tool available
Podiatrists	College of Podiatry Developing a Sustainable Podiatry Workforce for the UK Towards 2030 (2013)
Radiographers	Professional Judgement as no current validated tool available/in use
Orthoptists	Professional Judgement as no current validated tool available/in use

Operating Department Practitioners	Association for Perioperative Practice guidelines 'Staffing for Patients in the Perioperative Setting' 2014. Association for Anaesthetists Great Britain and Ireland. Royal College of Anaesthesia

The Trust board will be receiving from June 2022 biannual nursing skill mix reports for all nursing workforce on a rostered workplan.

There is not a single standardised safer staffing tool for Allied Health Professionals (AHP's) that is appropriate for all clinical areas across RWT. The Standard Operational Procedure (SOP) for Registered Health Care Professionals (non-nursing/medical) – Ensuring Safe Staffing Levels in Departments/Services includes the current safe staffing methodologies employed by each profession.

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, ICCU, majority of outpatients departments and day care areas, majority of community services are on e-roster. Theatres, advanced clinical practitioners, and clinical nurse specialists have been rolled out over the previous 12 months. A piece of work for student nurses being added to the health roster system has taken place and is due to be released for the January 2023 cohort. The piece of work for Clinical Nurse Fellows/ International Nurses (CNF's) to be added onto the health roster system has commenced and is due to be released for any new CNF's starting within the organisation.

- Several AHP groups/services are currently either on e-roster/are piloting e-roster/are planning to use e-roster. Physio Therapists and Occupational Therapists are still in progress. There will also be a piece of work that supports AHP student to be added to the health roster system once the nursing staff piece of work has been completed.

<u>E-job plans</u>

- There is a job planning protocol in place for Clinical Nurse Specialists (CNS) and Advanced Clinical Practitioners (ACP); some CNS's and ACP have a job plan held locally. An e-job planning module is being introduced for medical staff and the ambition is to utilise this for other clinical staff groups as yet there is no confirmed date for roll out. AHP teams are currently utilising activity manager.

- Physiotherapy, Occupational Therapy, Speech and Language Therapy and Dieticians are currently developing job plans as part of the Carter Deep Dive pilot.

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 1 – Formally ensuring NQB's 2016 guidance is embedded in safe staffing governance.

-Compliant

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. Assessed annually.

-Partially Compliant

From a nursing perspective the organisation is compliant, but this remains in progress for AHP Teams.

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

– Compliant

Recommendation 5 – As part of the yearly assessment assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against 5 themes

– Compliant

These 5 themes are monitored at Trust Board:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

Recommendation 6 - As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable

– Compliant

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

– Compliant

Workforce plan is completed annually and signed off by Executive Leaders

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

– Partial Compliant

Compliant for nursing and midwifery. AHP data is currently triangulated from numerous reports, including the Model Hospital – however this data is not reported monthly.

This data is currently triangulated from numerous reports, including a quality nursing dashboard, extracts from model hospital are used as part of the biannual nursing skill mix review which is presented to Trust Board which includes all inpatient wards.

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

Recommendations 11 and 12 - As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review

– Compliant

- QIA are completed for changes required as part of the Cost Improvement Programme and reviewed by Chief Nurse.
- QIA are completed for nursing/midwifery/AHP establishment changes and reviewed by Chief Nurse
- QIA of new roles for nursing/midwifery/AHP are reviewed by Workforce Organisational Development Committee
- QIA are completed if additional bed capacity is opened and reviewed by Chief Nurse and shared with Trust Management Committee and Trust Board (**Appendix 1**)

- QIA are completed if relocation of ward/department occurs, reviewed by Chief Nurse and shared with Trust Management Committee and Trust Board (**Appendix2**)

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**.**

and

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

Local nursing/midwifery and AHP staffing escalation guides/standard operational procedures are available. Safe Care module and associated protocols/procedures, staffing guidance and escalation is implemented in adult and paediatric inpatient wards. Daily challenge is implemented by the Nursing Workforce Team to monitor compliance.

Conclusion and Next Steps

Action Plan for recommendations 2 and 8

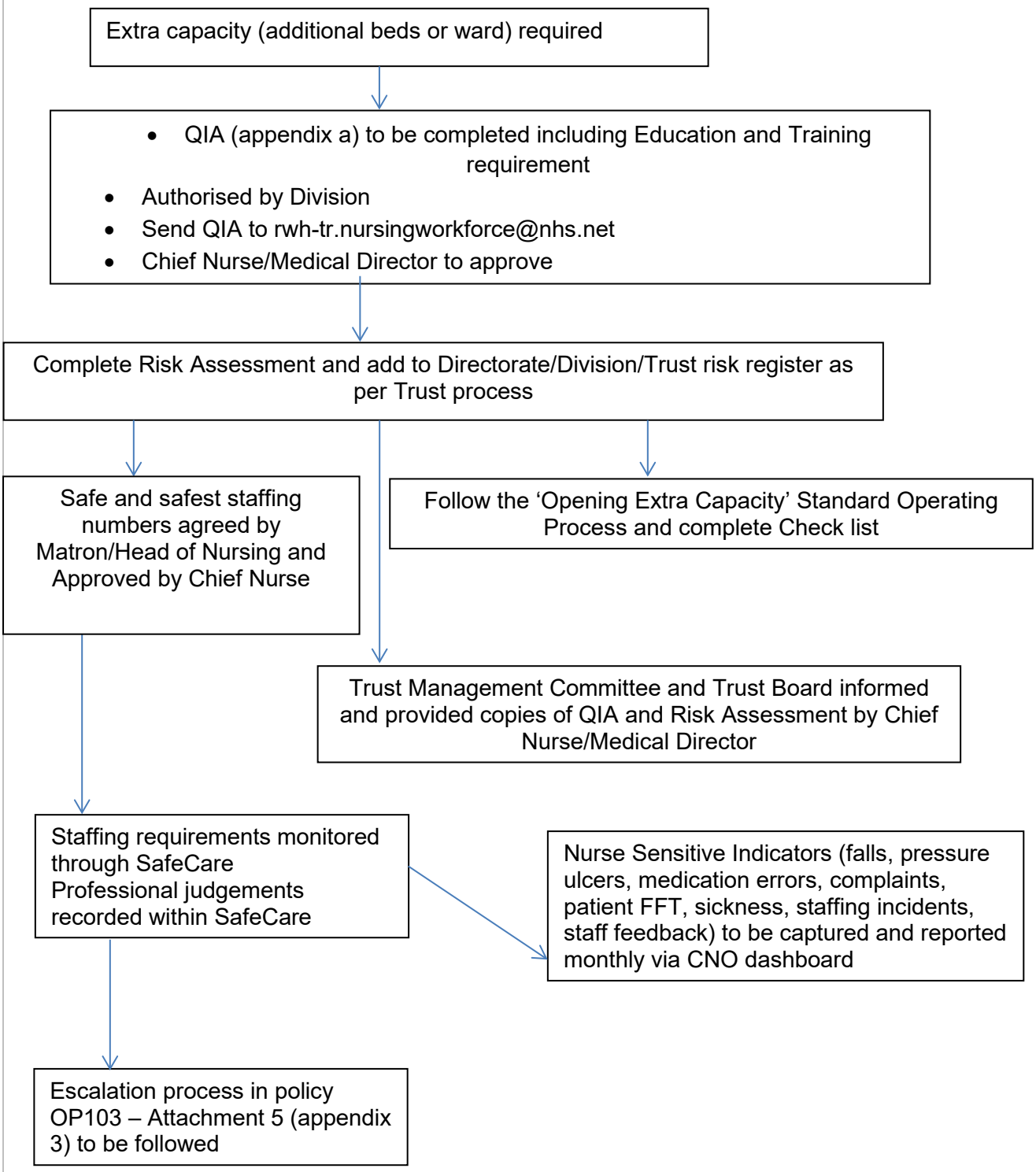
Action	Lead	Date
Recommendation 2 Include the review of AHP roles within the workforce in the current annual and bi-annual Nursing and Midwifery staffing report to the Trust Board.	Chief AHP/Head of Nursing Workforce	October 2023
Recommendation 8 Include AHP data in quality dashboard on a monthly basis	Chief AHP	May 2023

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.

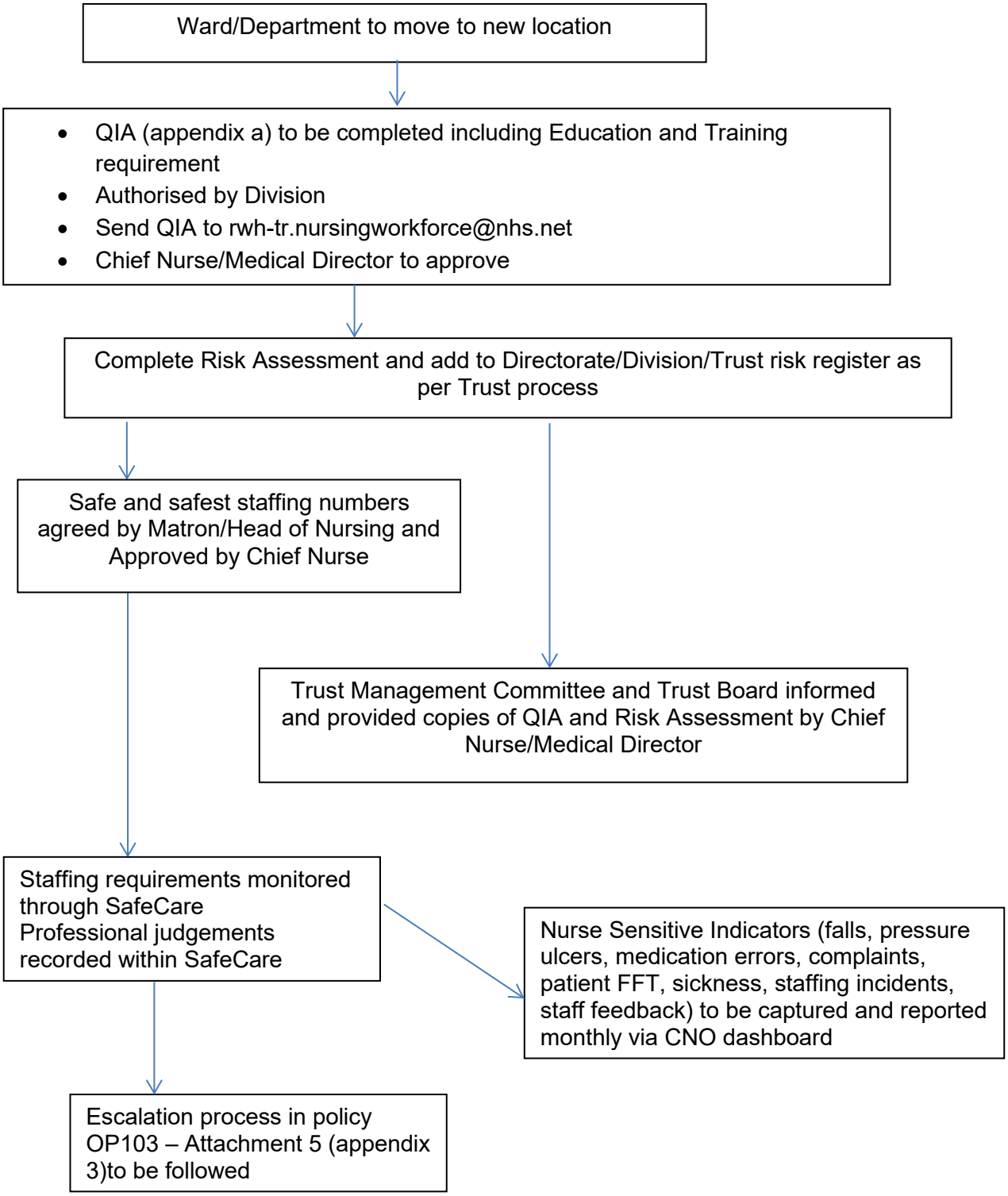
Extra Capacity Required Flow Chart



This flow chart only covers adult, children inpatient wards on Healthroster

Appendix 2

Relocation of Ward/Department Flow Chart



This flow chart only covers adult, children inpatient wards on Healthroster

Appendix 3 - OP103 Attachment 5 - SafeCare
http://intranet.xrwh.nhs.uk/pdf/policies/OP_103_Attachment5.pdf

Trust Board Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee:	**Performance & Finance Committee**
Date(s) of Committee Meetings since last Board meeting:	25th January 2023
Chair of Committee:	John Dunn
Date of Report:	27th January 2023

ALERT

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

- The committee discussed the initial planning for the **Annual Operating Plan for 2023/2024.** Whilst the Trust is forecasting to meet this financial year end target through its recovery plan and funds from the risk share arrangements, it's exit run rate and shortage of maturing CIP initiatives for Q1 and Q2 puts significant pressures on next year's plans.
- The operational plan continues to focus on reducing the long wait patients, the Trust exit position with a growing pipeline will make this a significant challenge.
- Currently the release of medically fit patients is still a critical issue in improving and stabilising emergency admissions. The Trust is working very closely with partners to resolve these issues.
- Elective care Recovery is likely to be further impacted if industrial relations issues arise with Junior doctors and with the remuneration for WLI's. This has been highlighted to PODC.

COMMITTEE APPROVAL TO GO TO TRUST BOARD CHAIR

- Blood Gas Analysers Managed Service Contract Tender Project (REAF 559) – endorsed for Board approval.
- Cardiac Balloons & Stents - Cath Labs (REAF 567) – noted, for noting by Trust Board
- Allocate Renewal (REAF 738) – endorsed for Board approval.

ASSURE

- N/A

ADVISE

Finance

- The Trust is reporting an in month(P9) surplus of £1.8m, this is £0.2m better than plan. Overall, the Trust expects to meet the break-even target at year end through its recovery plan and support via the risk share arrangements with the ICS.
- The in-month position has improved significantly due to the release of provisions and accruals no longer necessary totalling £6.9m.
- The Cost Improvement Plan is expected to outturn £7m adverse to plan.

Elective Care Recovery

- Currently the Trust is meeting its trajectory to reduce 78 week waits, however the target to fully clear all 78week waits by the end of March is very challenging.
- Overall, the Trusts waiting list continues to grow due to capacity constraints resulting in the overall profile moving more patients into the >52-week category.
- Cancer waits are not expected to return to the February 2020 position by the end of March due to the combined effects of, an increase in referrals, diagnostic delays and speciality specific constraints.

Winter Plan

- An extremely difficult time for the Trust over the holiday period. The combined pressures of delivering elective recovery whilst managing unprecedented non-elective demand put significant demand on the Trust and wider systems. This resulted in patients waiting for a bed in the ED department and long waits on the back of ambulances. Several additional initiatives were rapidly implemented that helped to improve matters and the overall situation moving into January showed real improvement. Through a very difficult period the operational team need to be congratulated on their work and dedication as the Trust exited the New Year in a stronger position.

	Procurement Report • The Committee received the Integrated Supplies and Procurement Collaboration (The Royal Wolverhampton, Walsall Healthcare, North Staffordshire NHS Trusts and the Black Country Pathology Services organisation) quarterly update report. Through this joint approach significant benefits have been delivered - consistent and professional appraisal/negotiation, cost reduction. The trust has seen significant benefits. The committee commended the approach and the benefits achieved. The Committee commended the approach and the benefits achieved and thanked the team. **Sustainability Report/Green Issues** • The Trust Sustainability work has gained national recognition and is regarded as a trailblazer particularly in greening its services as well as in onsite energy generation. This resulted in the Trust being invited twice to judge the Environmental Project of the Year category of the Health Service Journal Partnership award and recently the HSJ Digital Innovation Award. • Based on positive reviews of attendees, the Trust pragmatic approach to reducing its carbon footprint has resonated with those who attended the various national conferences and webinars that the Trust participated as speaker. Invitations to speak in national conferences and webinars continues to come in. • The quarterly Sustainability "Share and Learn Forum" that the Head of Sustainability organised has attracted over 40 NHS sustainability leads eager to learn from the Trust experience.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• SR15 – Strategic risk: If the future funding flows for the Trust are insufficient to fund the levels of service and activity undertaken then the Trust will be in an increasing underlying deficit position resulting in significant financial challenge to viability with system pressures, external inspection, and potential adverse reputational impact. The recommendation was that the score remained at 20. • SR16 – Strategic risk: If the Trust is unable to recover or exceed previous (pre-Covid-19) activity by at least 10% compared with pre-Covid-19 levels, then Trust waiting times for diagnostics and treatments will increase resulting in potential harm to patients due to delays in diagnosis or treatment for all conditions delays, in treatment may mean that conditions are harder to treat, require more invasive treatments or which result in long-term harm leading to reputational damage to the Trust. The recommendation was that the score remain the same. • SR18 – Strategic risk: If the Trust suffers a successful cyber-attack via any one of a number of access points and vulnerabilities, then there is the potential denial of access (Ransomware) and/or compromise of data (copying/data breach) resulting in a data breach, denial of access to critical systems and impact on access to patient information and clinical care systems with consequential denial of care, potential harm and/or delay in patient care with reputational loss, financial risk of fines from the Data Commissioner. The recommendation was that the initial risk remain at 15.
Matters presented for information or noting	NHSI Monthly Return Annual Work Plan Supplementary Finance Report Capital Plan Report Contracting & Business Development High Value Contract Report Sustainability Report Public Sector Decarbonisation Scheme Update Summary of Planning Guidance

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	6th December 2022
Title:	Report of the Chief Financial Officer - Month 7
Action Requested:	□ Make a decision □ Approve X Receive for assurance □ Received and noted If the item has already been approved by a body with delegated powers of approval from the Board such as a Committee of the Board, then the item would be received and noted.
For the attention of the Board	
Assure	N/A
Advise	N/A
Alert	N/A
Author + Contact Details:	Kevin Stringer, Chief Financial Officer - 01902 695954 kevin.stringer@nhs.net
Links to Trust Strategic Objectives	Maintain financial health – Appropriate investment in patient services
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.
CQC Domains	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	N/A
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A
Public or Private:	Public
Other formal bodies involved:	Finance and Performance Committee
References	N/A
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	Report of the Chief Financial Officer - Month 7
Item/paragraph 1	This paper reports the in-month, year-to-date and the draft year end position for the Trust as at Month 7. The paper also reports on delivery against financial targets.

The Royal Wolverhampton NHS Trust

Reference Pack

Report of the Chief Financial Officer

Finance Report
October 2022 - Month 7

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Dashboard

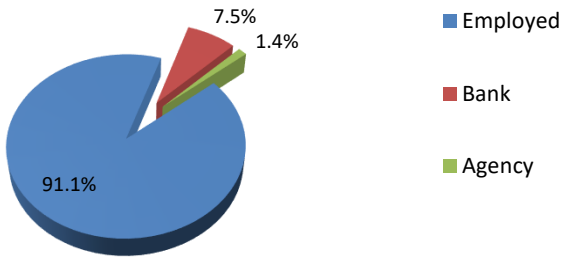
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Block payment	56.79	389.97
2. Other income	18.61	95.39
3. Top-up payment	0.61	2.75
Total	**76.02**	**488.10**
Expenditure	**76.31**	**500.89**
Surplus/ (deficit)	**(0.29)**	**(12.79)**
Planned surplus/(deficit)	**1.75**	**(6.00)**
Variance to plan	**(2.04)**	**(6.79)**

Workforce

(see page 8)



Other includes recharges to from other organisations

Patient Income

Greyed out sections will not currently be used for 22/23 reporting due to the nature of block funding.

Underlying Position

Cost Improvement Programme (CIP)

(see page 9)

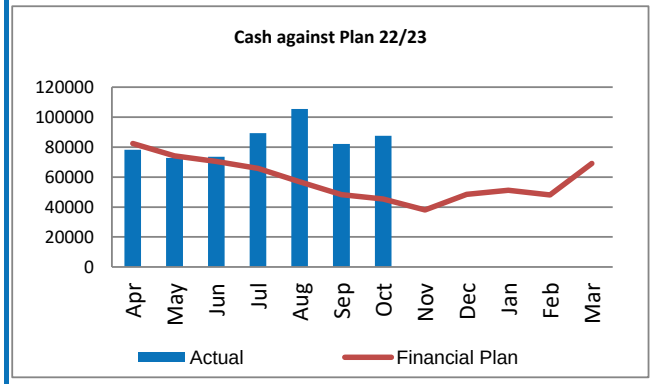
YTD CIP achievement is £8.58m against a target of £8.49m, with £3.71m of the YTD total arising from the rebasing exercise that does not reduce current run rates.

The Trust is forecasting CIP achievement of £14.81m, with £6.20m of this being achieved recurrently.

Cash in the Bank

(see page 7)

Plan £45.4m
Actual £87.5m



Covid-19 Expenditure

In month 7 there was a total of £846k expenditure relating to Covid-19.

Of this amount £779k is reimbursed for testing and vaccinations.

Reserves

(see page 9)

£6.6m of reserves are released into the position at month 7 of an annual value of £12.8m.

Actual Outturn

(see page 5)

£0.3m deficit in month
(£2.0m adverse to plan)

and £12.8m deficit year to date
(£6.8.m adverse to plan)

Overview of Financial Performance

The Trust is reporting an in month adjusted deficit of £293k, £2.0m adverse to plan. The year to date deficit of £12.8m is £6.8m adverse to plan.

£3.6m of the year to date deficit relates to budget reduction CIP that was planned to be delivered by this point in the year, whereas much of the CIP performance has been around cost avoidance efficiencies.
There is also an overspend of £7.1m on pay (year to date), which is temporarily offset by £6m of unspent reserves, and a £1.7m overspend on drugs due to activity and the application of block contract arrangements to costs previously passed through to CCGs.

Significant run rate improvements and CIP delivery are needed later in the year to achieve the planned break-even position.

System Updates

The latest ICB position was unavailable at the time of reporting, at M06 the YTD deficit was £42m, with most organisations running deficits, and this being £34.6m adverse to plan. The ICB along with its members are still forecasting break-even for the year but the system recognises the significant inherent risks in delivering the break-even position by the end of 22/23 and we are working collectively to review these risks in order to manage and mitigate these as comprehensively as possible. This process has included a Q1 stocktake review with NHSE regional team and individual escalation meetings with the ICB team.

Current guidance is that ICBs should not forecast loss of funds for ERF underperformance and on that basis it is assumed that ERF will not be clawed back where planned activity is below plan. However, final guidance on this is yet to be issued. NHSE's review of the ICS position continues with a focus on the underlying ICS deficit moving into 2023/24.

Capital

The Trust have spent £32.1m of capital YTD to 31st October 22. Of this £32.1m, £12.0m relates to capital spend which the ICS is measured against, with the Trust anticipating meeting it's agreed Full Year ICS CRL of £19.9m. The balance of capital YTD (£20.1m) relates to capital spend on grant funded items with £5.5m relating to PSDS Phase 2 and £12.5m relating to PSDS Phase 3; £0.3m on a new lease for BCPS which is capitalised under IFRS 16 and £1.8m of PDC monies.

The Trust anticipate meeting their current planned gross capital expenditure of £100.6m, which consists of £19.9m ICS CRL (internally generated funds); PDC £30.1m, Grant funding of £39.5m, IFRIC 12 related capital spend of £5.1m and IFRS 16 new leases £6.1m.

Income and Expenditure Run Rates

		21/22						22/23							YTD	Move-
	£m	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Avg	ment
	Patient Income															
1	Plan	52.76	53.72	54.42	54.46	54.57	87.42	52.92	53.09	55.94	54.24	54.79	61.89	57.85	*55.48*	*2.37*
2	Actual	52.95	53.24	53.95	53.70	55.21	88.60	52.60	53.12	55.67	56.40	54.82	60.56	56.79	*55.53*	*1.26*
3	Variance	0.18	(0.48)	(0.47)	(0.75)	0.64	1.18	(0.32)	0.02	(0.27)	2.17	0.03	(1.33)	(1.06)	*0.05*	*(1.11)*
	Non Patient Income															
4	Plan	11.95	12.95	15.44	13.70	14.41	12.38	11.60	17.19	15.53	11.30	11.67	17.01	13.26	*14.05*	*(0.79)*
5	Actual	11.16	11.85	12.77	11.86	11.60	22.72	10.72	17.70	15.61	11.60	11.80	11.49	19.22	*13.15*	*6.07*
6	Variance	(0.79)	(1.11)	(2.67)	(1.84)	(2.81)	10.34	(0.89)	0.51	0.08	0.30	0.13	(5.52)	5.97	*(0.90)*	*6.87*
	Pay Expenditure															
7	Plan	39.17	39.33	39.56	39.54	39.68	59.97	39.52	39.50	42.73	41.29	41.49	46.92	42.71	*41.91*	*(0.80)*
8	Actual	39.05	39.45	39.53	39.77	40.30	69.33	41.08	41.96	41.42	42.23	42.75	48.28	43.60	*42.95*	*(0.65)*
9	Variance	0.11	(0.12)	0.03	(0.23)	(0.62)	(9.36)	(1.56)	(2.46)	1.31	(0.94)	(1.27)	(1.37)	(0.89)	*(1.05)*	*(0.15)*
	Non Pay Expenditure															
10	Plan	16.12	16.90	19.56	18.06	18.36	17.89	17.14	16.02	17.80	16.48	16.35	16.60	17.14	*16.73*	*(0.41)*
11	Actual	16.54	16.63	17.77	17.23	16.68	25.99	16.55	16.25	16.52	15.94	16.24	16.32	17.23	*16.30*	*(0.92)*
12	Variance	(0.41)	0.27	1.79	0.83	1.68	(8.10)	0.59	(0.23)	1.28	0.54	0.12	0.28	(0.09)	*0.43*	*0.52*
	Drugs Expenditure															
13	Plan	5.37	5.31	5.65	5.49	5.40	5.92	5.65	5.31	5.74	5.51	5.58	6.10	5.55	*5.65*	*0.10*
14	Actual	5.38	5.64	5.83	5.76	5.23	6.03	5.78	5.59	5.63	5.66	6.03	6.58	5.91	*5.88*	*(0.03)*
15	Variance	(0.00)	(0.33)	(0.18)	(0.28)	0.16	(0.10)	(0.12)	(0.28)	0.11	(0.15)	(0.45)	(0.48)	(0.36)	*(0.23)*	*0.13*
	CIP over/ (under) achievement															
16	Variance	(0.23)	(0.17)	0.03	(0.17)	(0.13)	0.63	(0.42)	(0.13)	0.08	(0.79)	(0.76)	(0.41)	(1.19)	*(0.41)*	*0.79*
	BCPS Savings over/ (under) achievement															
16	Variance							0.08	0.08	0.08	0.08	0.08	0.08	(0.01)	*0.08*	*0.09*
	Reserves supporting position															
17	Actual	1.23	2.00	1.96	2.24	2.43	12.26	2.81	2.49	(1.70)	(0.71)	0.68	1.58	1.47	*0.86*	*(0.61)*
	Other Non Operating Expenditure															
18	Plan	(3.11)	(3.11)	(3.11)	(3.18)	(3.18)	(3.19)	(2.98)	(4.37)	(3.27)	(3.61)	(3.61)	(3.27)	(3.78)	*(3.52)*	*(0.26)*
19	Actual	(3.08)	(3.09)	(3.10)	(3.10)	(3.06)	0.46	(3.17)	(3.72)	(3.79)	(3.58)	(3.54)	(3.53)	(3.75)	*(3.56)*	*(0.20)*
20	**Variance**	0.03	0.02	**0.02**	**0.08**	**0.12**	**3.64**	**(0.19)**	**0.65**	**(0.53)**	**0.03**	**0.08**	**(0.26)**	**0.03**	*(0.04)*	*(0.06)*
	Total															
	Plan	(0.06)	0.19	**(0.00)**	**(0.18)**	**0.06**	**(0.06)**	**(3.24)**	**2.64**	**3.46**	**0.06**	**(0.58)**	**4.76**	**1.65**		
	Actual	0.06	0.27	**0.49**	**(0.30)**	**1.54**	**10.43**	**(3.25)**	**3.30**	**3.91**	**0.60**	**(1.93)**	**(2.66)**	**5.52**		
	Variance	0.12	0.09	**0.49**	**(0.12)**	**1.48**	**10.49**	**(0.01)**	**0.65**	**0.45**	**0.54**	**(1.35)**	**(7.42)**	**3.87**		

Commentary on variances and trends:

Patient Income was below plan by £1m at month 7 due to a planned income target of £0.6m that has not been achieved for ERF. No ERF adjustment has been made so far this year, and activity underperformed against the plan, so the Trust would not have benefited from the ERF adjustment if it was in action. Year to date there has also been an underperformance on public health activity, lower than planned performance on devices which will be offset by Non Pay cost, and some provision for contract challenges this year.

Non Patient Income - has increased in month by £7.74m. £1.1m of this relates to Health Education Income due to a rebased LDA schedule from October. There is also grant income for capital expenditure of £5.9m as well as an increase in covid testing income (offsets non pay) £427k. The budget variance is largely being driven by the grant income as this was budgeted to have been received in month 6 but was actually received in month 7.

Pay - Overspent in month by £894k and broadly continues the recent trend, the decrease of £4.6m compared to last month being due to the pay award arrears paid in month 6.

The overspend was again mainly in the clinical divisions, due to temporary staffing being used to cover vacancies and absences, Surgery £365k, Medicine £813k, there were offsetting underspends due to vacancies in BCPS £165k and Trustwide where accruals no longer needed were released, £287k.

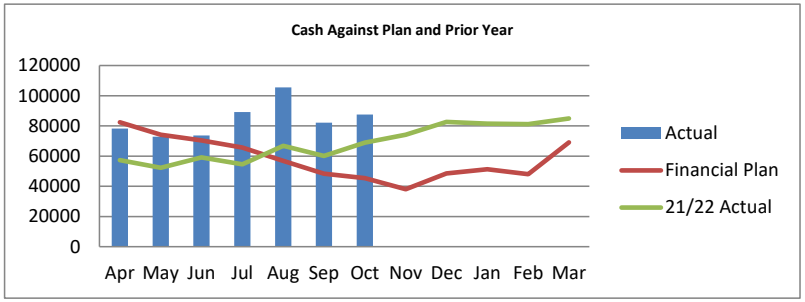
Non Pay - Overspent by £86k in month and the actual expenditure rising by £900k compared to last month.

The rise is due to costs within BCPS relating to Covid testing due to backdated point of care charges £427k, (offset by income), as well as an increase in blood science testing activity costing £108k. There was also an increase in spend within Division 3 relating to Radiology offsite reporting £236k, sexual health testing kits £107k, and Covid CMDU and vaccination costs £154k.

In terms of the overspend there was a £529k overspend in Division 3, linked to the reasons above, along with £242k in Division 2 due to Renal, Stepdown and Insulin pump activity. These were partially off set by activity related underspends in Division 1 £78k, BCPS £301k along with Estates and Facilities £163k where the levels of maintenance were lower than budget. Accruals no longer required were also released, £145k.

Drugs - Expenditure has reduced in month by £672k, this reduction is split between Division 2 £408k and Division 3 £233k. The reduction in both areas is due to lower spend on high cost drugs. The in month overspend £360k is due to: Increased eye injection activity £69k, Expired drugs £70k, Cardiology due to patient mix and acuity £31k and continued higher activity in Gastroenterology £94k, General Surgery £17k, Renal £21k and Neonatal £49k.

Cash Position



The cash balance as at 31st October 2022 is £87.5m, a £5.3m increase on the previous month and an increase of £42.1m on financial plan. Plan variances are due to pass through commissioner income (£16.2m) including pay award, timing of LVA Income (£1.7m), timing of HEE income (£11.2m), timing of capital spend (£28.8m), additional BCPS income (£7.3m) & higher than planned VAT income (£5.9m). Conversely there is an increase in pay costs (£16.3m) and increased non pay spend (£13.2m).

Better Payment Practice Code

The Better Payment Practice Code sets out a target for payment of 95%, in value and volume, to be paid within 30 days of receipt. The Trust's performance against this target is:

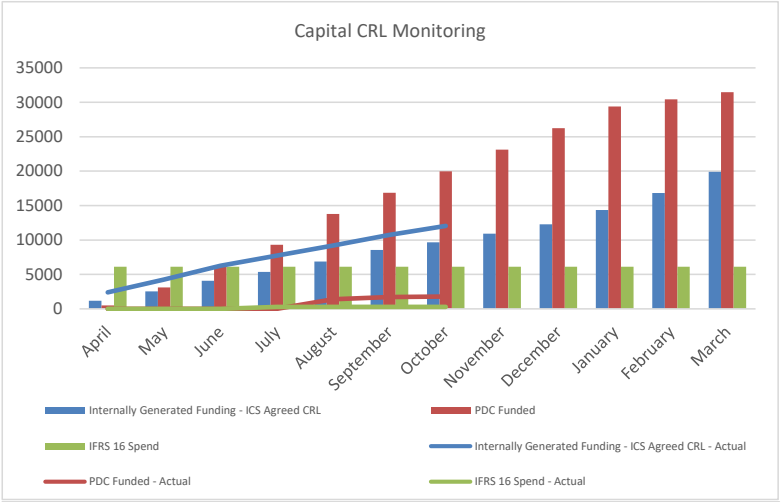
	M7 22/23	Cumulative	M6 22/23	Cumulative
Value	89%	92%	91%	93%
Volume	87%	89%	86%	89%

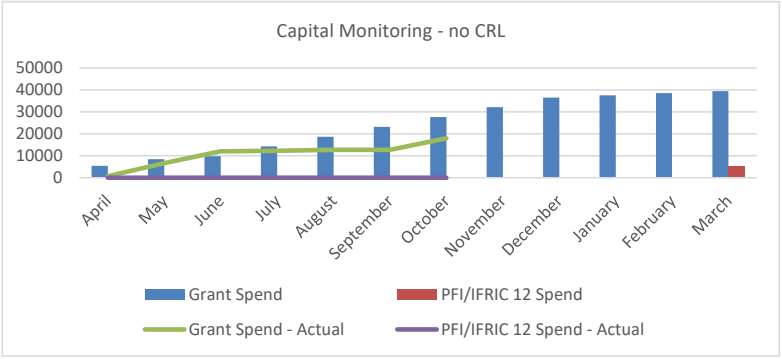
Debtor Days

Calculated Debtor Days for the year are:-

	M7 Actual	M6 Actual
Total	4.15	3.57
Being:-		
NHS	3.99	2.82
Non NHS	4.79	6.86

Capital





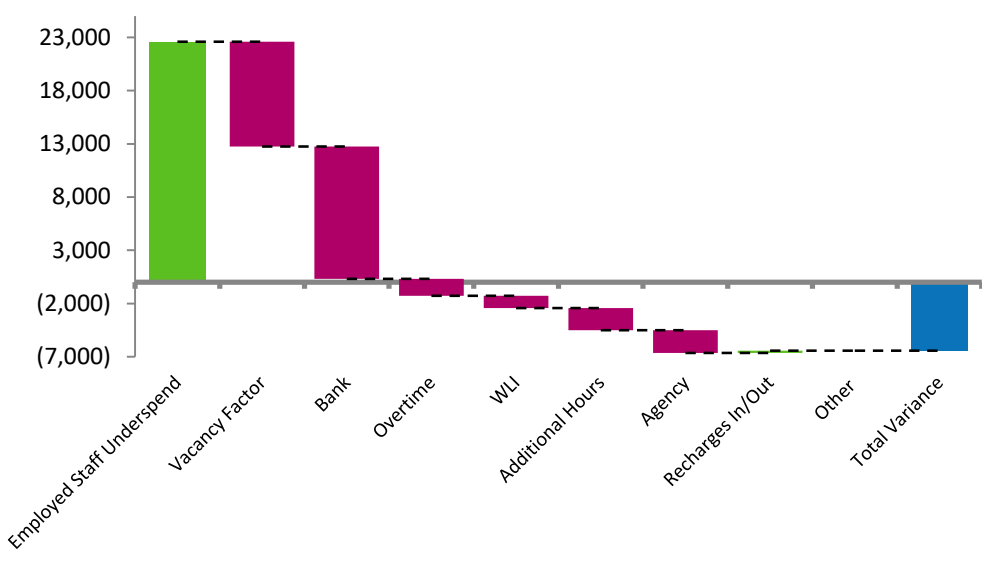
The Trust have spent £32.1m of capital YTD to 31st October 22.

Capital CRL Monitoring - Of this £32.1m, £12.0m relates to capital spend which the ICS is measured against. This is currently ahead of Plan due to timing of orders, with the Trust anticipating meeting its agreed Full Year ICS CRL of £19.9m. There has been £1.8m spend YTD on PDC due to new PDC for Western Power supply to Cannock Chase hospital and £0.4m for Black Country North Elective Hub, the rest of the PDC forecast has not been approved with these projects having yet to commence. There is £0.3m spend YTD on IFRS 16 which is below forecast due to leases (predominantly BCPS) still being required to be commercially agreed.
Capital Monitoring - no CRL - The balance of the capital YTD, £18.0m, relates to capital spend on grant funded items with £5.5m relating to PSDS Phase 2 and £12.5m relating to PSDS Phase 3.

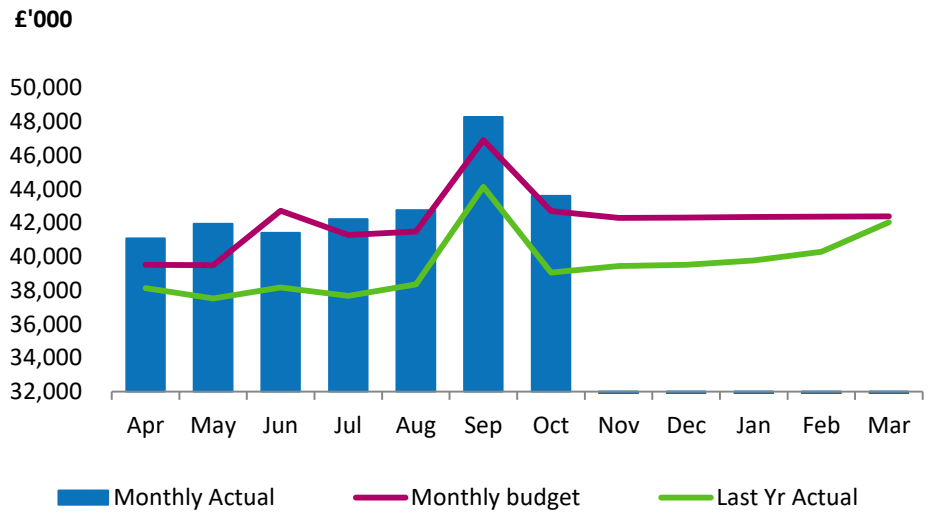
The Trust anticipate meeting their current planned gross capital expenditure of £100.7m, which consists of £19.9m ICS CRL (internally generated funds); PDC £30.1m, Grant funding of £39.5m, IFRIC 12 related capital spend of £5.1m and IFRS 16 new leases £6.1m (still to be agreed nationally).

Pay Expenditure

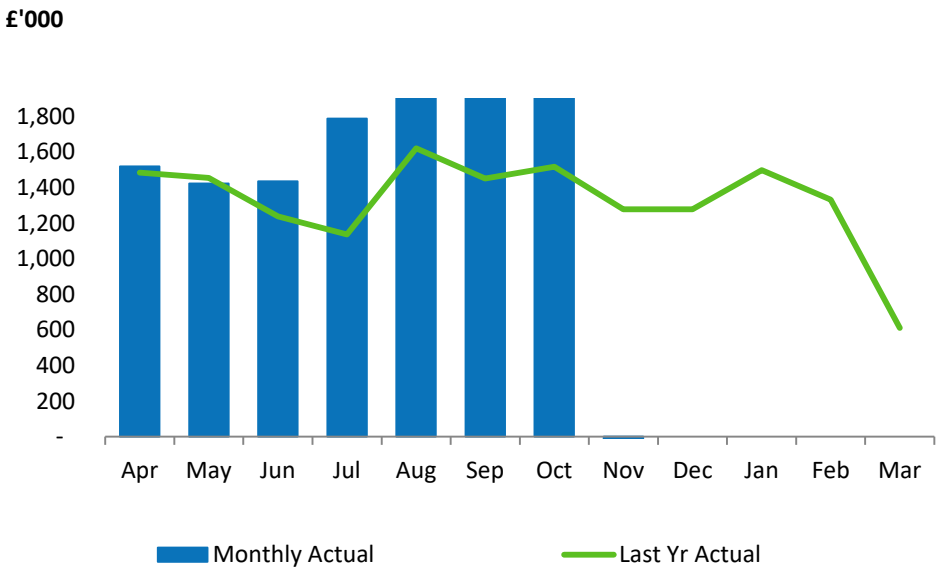
Year to Date Variance to plan



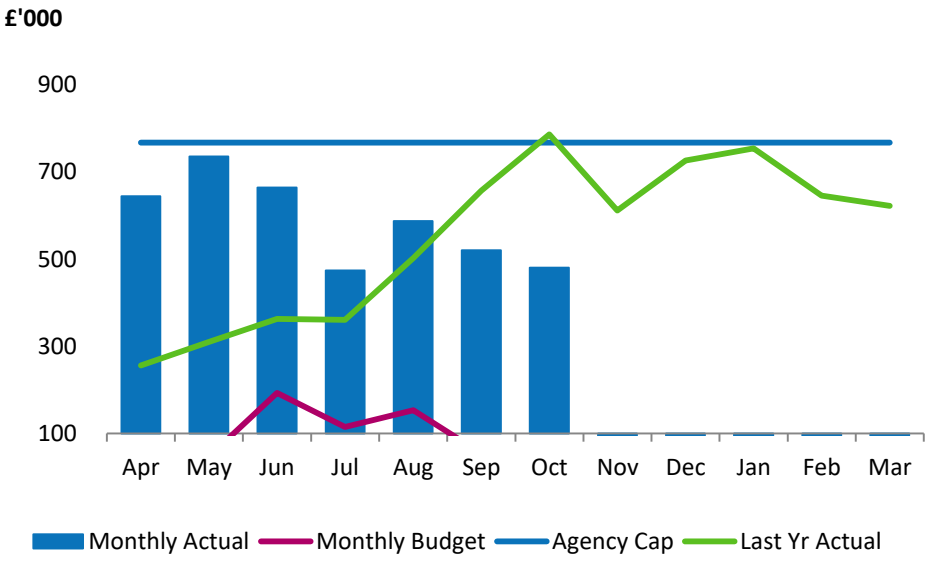
Total Pay Expenditure Trend



Bank Expenditure Trend



Agency Expenditure Trend



Agency Cap for 22/23 not yet confirmed, therefore using 21/22 currently

Cost Improvement

Division	Full Year Target	Year to Date: Non Recurrent Achieved	Year to Date: Recurrent Achieved	Year to Date: Total Achieved	Full Year Forecast: Non Recurrent	Full Year Forecast: Recurrent	Full Year Forecast: Total Forecast	Full Year Forecast: Unmet CIP
Division 1	7,090,685	1,290,074	403,527	1,693,601	1,934,869	916,781	2,851,650	(4,239,035)
Division 2	4,451,811	613,145	669,000	1,282,145	838,738	1,193,163	2,031,901	(2,419,910)
Division 3	3,450,606	907,488	18,069	925,557	986,234	577,334	1,563,569	(1,887,037)
Division 4	195,706	333	71	404	666	12,441	13,107	(182,598)
Estates and Facilities	1,914,988	331,089	29,301	360,390	644,077	148,722	792,798	(1,122,189)
Corporate	1,853,809	1,120,590	94,363	1,214,953	1,163,295	199,883	1,363,178	(490,631)
Trustwide	129,395	(0)	3,101,479	3,101,478	0	3,155,395	6,192,395	6,063,000
	19,087,000	**4,262,719**	**4,315,809**	**8,578,528**	**5,567,880**	**6,203,719**	**14,808,599**	**(4,278,401)**
Cash avoidance/ no budget reduction		*£ 2,077*	*£ 1,631*	*£ 3,708*	*£ 3,850*	*£ 3,822*	*£ 7,672*	

Against an in month target of £2.12m, the Trust has achieved £1.69m. YTD £8.58m achieved against a target of £8.49m. Within this, there has been a rebasing of CIP achievement to ensure reporting is consistent across the ICB although this does not impact the Trust's bottom line.

Recurrent savings are forecast at £6.2m, of which £3.8m are from the revised reporting, with total savings currently forecast at £14.80m.

There are approved PIDs of £8.183m, £2.12m recurrent and £6.06m non-recurrent with, £48.5k of schemes in progress.

Reserves

Start point			34,789,751
Additional Income allocated to reserves			20,950,052
Full Year Effect of reserves 'drawn down' upto current month			(42,893,483)
Reserves phased into position			(6,635,889)
Reserves available for future months			**6,210,431**
Earmarked Reserves	Division 1	(684,428)	
	Division 2	(2,669,072)	
	Division 3	(4,588,816)	
	Division 4	0	
	Estates and Facilities	(37,107)	
	Corporate & Other	(2,012,064)	
	Less: Expected Slippage	1,837,500	
			(8,153,986)
	Available Balance		**(1,943,555)**
Balance made up of	Drugs	264,191	
	Inflation	511,166	
	Trustwide Education/LDA	704,282	
	Contingency	(126,082)	
Less:	Expected Balance Sheet Release	(3,297,112)	
			(1,943,555)

The Royal Wolverhampton NHS Trust Charity

Charitable Funds for Period Ending 30 September 2022

2022/23 Q2 Information

The table below shows a draft summary for information purposes, relating to the value and movement in The Royal Wolverhampton NHS Trust Charity Funds for the period 1st June 2022 to 30th September 2022. The more significant income over £3k and expenditure items over £2k during the year, have been detailed below along with a comparative summary table for the previous 12 months. An adjustment for year end has been included within the comparative summary at Q4 21/22 to show an accurate reflection of the closing balance at 31 March 2022. This adjustment includes a £191k creditor accrual recorded during the audit of the accounts and year end creditor/debtor adjustments totalling £4k. Q1 22/23 has been adjusted for the year end creditor/debtors that have been released during the period.

Opening balance 1 June 2022 £'000	Donations £'000	Investment Income £'000	Expenditure £'000	Realised Gains/(Losses) as at 30 September 2022 £'000	Closing balance 30 September 2022 £'000
3,094	483	21	(105)	(0)	3,493

INCOME

- In Memory - £10k (Renal Unit)
- NHSCT Stage 2 Grant Funding - £59k (NHSCT Fund)
- WARRANT Grant Funding - £3.5k (Care of the Elderly)
- Gift Aid from various large donations - £25k (Cardiac) and £6k (Deanesly)
- Baby Blues - £10k (Neo Natal)
- Legacy - £442k (Paediatrics)

EXPENDITURE

- Staff Cakes re Queen's Jubilee - £11.6k (New Cross General Purpose)
- Patients cakes re Queen's Jubilee - £6.2k (New Cross General Purpose)
- Aromatherapist x 2 - £15k (Deanesly)
- Holistic Therapist x 2 - £11k (NHSCT Fund)
- Laptops x 2 – to support families – £2k (Neo Natal Unit)
- Food vouchers for families – £2k (Neo Natal Unit)
- Bladder Scanner - £7k (Deanesly)
- Sensory Room 50% Deposit - £13k (Paediatrics)
- Wall art - £2k (Wolverhampton Lung Foundation)
- **Apportioned Costs**
- Trust Administration and Fundraising Recharge - £87k

PREVIOUS 12 MONTHS AT A GLANCE

Summary	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1
Opening Balance Bfwd	2,985	3,000	3,323	3,032
Income	131	413	181	134
Expenditure	(116)	(90)	(253)	(76)
Gains/Losses	0	0	(24)	0
Year end adj			-195	4
Closing Balance Cfwd	3,000	3,323	3,032	3,094

Appendix A - Income and Expenditure Account

Last Year to Date £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000		Annual Budget £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
				Income				
361,527	57,850	56,792	(1,058)	Patient Activity Income	676,152	390,727	389,967	(760)
507	123	77	(46)	Other Patient Care Income	1,478	862	632	(230)
6,540	584	610	26	Top Up Income	2,772	2,772	2,746	(26)
28,053	5,189	5,214	24	Education, Training & Research Income	50,962	29,747	29,977	230
0	0	5,885	5,885	Non Patient Care Other Income	39,831	15,120	18,610	3,490
34	82	58	(25)	Private Patient Income	987	576	160	(416)
45,056	7,277	7,380	104	Income on Directorate Budgets	82,496	48,473	46,011	(2,463)
441,717	**71,105**	**76,015**	**4,910**	**Total Income**	**854,679**	**488,278**	**488,104**	**(175)**
				Expenditure				
273,077	42,709	43,603	(894)	Directorate Expenditure Budgets - Pay	505,897	294,150	301,327	(7,177)
110,066	17,140	17,226	(86)	Directorate Expenditure Budgets - Non Pay	200,372	117,536	115,037	2,499
37,234	5,550	5,909	(359)	Directorate Expenditure Budgets - Drugs	66,751	39,445	41,172	(1,727)
0	1,381	0	1,381	Activity Changes/Service Dev./Cost Pressures/Inflation Reserves	12,398	6,061	0	6,061
0	89	0	89	Contingency Reserves	449	575	0	575
(0)	(1,190)	0	(1,190)	Cost Improvement Savings	(13,517)	(3,621)	0	(3,621)
0	(5)	0	(5)	BCPS Savings	(537)	495	0	495
420,377	**65,673**	**66,738**	**(1,065)**	**Total Expenditure**	**771,812**	**454,641**	**457,536**	**(2,895)**
21,340	**5,432**	**9,277**	**3,845**	**EBITDA Surplus/(Deficit)**	**82,867**	**33,637**	**30,567**	**(3,070)**
13,457	2,561	2,657	(96)	Depreciation	29,609	16,720	16,933	(213)
1,286	201	42	159	Interest Receivable / (Payable)	2,066	1,059	781	278
6,759	1,016	1,054	(38)	Other Charges	12,194	7,113	7,372	(259)
21,502	**3,778**	**3,753**	**26**	**Other non operating items**	**43,869**	**24,892**	**25,086**	**(194)**
(162)	**1,654**	**5,525**	**3,871**	**Net Surplus/(Deficit) before Adjustments**	**38,998**	**8,745**	**5,481**	**(3,264)**
267	92	(5,817)	(5,909)	Adjustments as per NHSI reported position	(38,998)	(14,745)	(18,269)	(3,523)
105	**1,745**	**(293)**	**(2,038)**	**Adjusted Financial Performance as NHSI**	**(0)**	**(6,000)**	**(12,788)**	**(6,787)**
(7)	*0*	*0*	*0*	*Adjustments as per ICS reported position*	*0*	*0*	*(7)*	*(7)*
97	***1,745***	***(293)***	***(2,038)***	***Adjusted Financial Performance as ICS***	***(0)***	***(6,000)***	***(12,795)***	***(6,794)***

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2022/23 Balance Sheet as at 31st October 2022

	October 2022 Plan	October 2022 Actual	September 2022 Actual	Movement in Month	March 2022 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	474,380	444,812	437,273	7,539	416,282
Intangible Assets	5,798	5,806	5,983	(176)	6,462
Other Investments/Financial Assets	161	161	161	0	161
Trade and Other Receivables Non Current	1,794	1,795	1,795	0	1,795
PFI Deferred Non Current Asset	4,877	4,877	4,877	0	4,877
TOTAL NON CURRENT ASSETS	**487,010**	**457,451**	**450,089**	**7,362**	**429,576**
CURRENT ASSETS					
Inventories	8,253	8,120	8,083	38	8,253
Trade and Other Receivables	33,228	39,036	36,609	2,427	33,801
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	45,427	87,502	82,199	5,303	84,918
TOTAL CURRENT ASSETS	**86,908**	**134,658**	**126,890**	**7,767**	**126,973**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**573,918**	**592,109**	**576,979**	**15,130**	**556,548**
CURRENT LIABLILITES					
Trade & Other Payables	(98,375)	(117,720)	(117,832)	111	(106,225)
Liabilities arising from PFIs / Finance Leases	(6,596)	(8,277)	(5,517)	(2,760)	(2,101)
Provisions for Liabilities and Charges	(7,428)	(5,609)	(6,145)	535	(7,427)
Other Financial Liabilities	(8,204)	(17,689)	(11,430)	(6,259)	(8,204)
TOTAL CURRENT LIABILITIES	**(120,603)**	**(149,295)**	**(140,923)**	**(8,372)**	**(123,957)**
NET CURRENT ASSETS / (LIABILITIES)	**(33,695)**	**(14,638)**	**(14,033)**	**(604)**	**3,016**
TOTAL ASSETS LESS CURRENT LIABILITIES	**453,315**	**442,813**	**436,055**	**6,758**	**432,592**
NON CURRENT LIABILITIES					
Trade & Other Payables	(86)	(67)	(71)	4	(86)
Other Liabilities	(15,669)	(8,514)	(8,997)	483	(5,475)
Provision for Liabilities and Charges	(2,308)	(2,308)	(2,308)	0	(2,308)
TOTAL NON CURRENT LIABILITIES	**(18,063)**	**(10,890)**	**(11,377)**	**487**	**(7,869)**
TOTAL ASSETS EMPLOYED	**435,252**	**431,924**	**424,679**	**7,245**	**424,723**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	288,653	288,373	286,653	1,720	286,653
Retained Earnings	51,541	48,493	42,968	5,525	43,012
Revaluation Reserve	96,137	96,137	96,137	0	96,137
Donated Asset Reserve	0	0	0	0	0
Financial assets at FV through OCI reserve	(1,269)	(1,269)	(1,269)	0	0
Other Reserves	190	190	190	0	(1,079)
TOTAL TAXPAYERS EQUITY	**435,252**	**431,924**	**424,679**	**7,245**	**424,723**

Appendix C Cash Flow Statement

2022/23 Cash Flow as at 31st October 2022

	Oct-22 Plan £'000	Oct-22 Actual £'000	Oct-22 Variance £'000	Oct-22 In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit)	**17,506**	**13,635**	(3,871)	6,621
Depreciation	17,007	16,933	(74)	2,657
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(14,578)	(18,610)	(4,032)	(5,885)
Interest Paid	(1,612)	(1,536)	76	(222)
Dividends Paid	(6,324)	(6,126)	198	0
Release of PFI /Deferred Credit	0	0	0	0
(Hncrease)/Decrease in Inventories	0	133	133	(37)
(Hncrease)/Decrease in Trade/Receivables	0	(5,434)	(5,434)	(3,140)
Increase/(Decrease) in Trade/Payables	58	18,087	18,029	(1,331)
Increase/(Decrease) in Trade/Payables Ann Leave Acc	0	(527)		(176)
Increase/(Decrease) in Other liabilities	0	9,485	9,485	6,259
Increase/(Decrease) in Provisions	0	(1,818)	(1,818)	(535)
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**12,057**	**24,222**	**12,165**	**4,211**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	14	755	741	180
Payment for Property, Plant and Equipment	(64,621)	(39,494)	25,127	(6,153)
Payment for Intangible Assets	0	0	0	33
Receipt of cash donations to purchase capital assets	15,109	18,610	3,501	5,885
Proceeds from sales of Tangible Assets	0	7	7	0
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(49,498)**	**(20,122)**	**29,376**	**(56)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(37,441)**	**4,099**	**41,540**	**4,155**
FINANCING				
New Public Dividend Capital Received	2,000	1,720	(280)	1,720
Capital Element of Finance Lease and PFI	(4,050)	(3,236)	814	(572)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(2,050)**	**(1,516)**	**534**	**1,148**
INCREASE/(DECREASE) IN CASH	**(39,491)**	**2,583**	**42,074**	**5,303**
CASH BALANCES				
Opening Balance at 1st April 2022	84,918	84,918	0	
Opening Balance at 1st October 2022				82,199
Closing Balance at 31 October 2022	45,427	87,502	42,075	87,502

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	No meeting
Title:	Report of the Chief Financial Officer - Month 8
Action Requested:	□ Make a decision □ Approve X Receive for assurance □ Received and noted If the item has already been approved by a body with delegated powers of approval from the Board such as a Committee of the Board, then the item would be received and noted.
For the attention of the Board	
Assure	N/A
Advise	N/A
Alert	N/A
Author + Contact Details:	Kevin Stringer, Chief Financial Officer - 01902 695954 kevin.stringer@nhs.net
Links to Trust Strategic Objectives	Maintain financial health – Appropriate investment in patient services
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.
CQC Domains	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	N/A
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A
Public or Private:	Public
Other formal bodies involved:	Finance and Performance Committee
References	N/A
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	Report of the Chief Financial Officer - Month 8
Item/paragraph 1	This paper reports the in-month, year-to-date and the draft year end position for the Trust as at Month 8. The paper also reports on delivery against financial targets.

The Royal Wolverhampton NHS Trust

Reference Pack

Report of the Chief Financial Officer

Finance Report
November 2022 - Month 8

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Dashboard

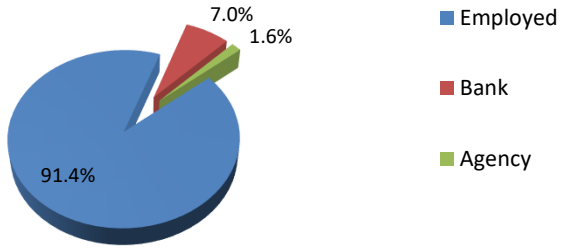
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Block payment	60.38	450.35
2. Other income	13.48	108.87
3. Top-up payment	0.26	3.01
Total	**74.13**	**562.24**
Expenditure	**70.68**	**571.57**
Surplus/ (deficit)	**3.46**	**(9.33)**
Planned surplus/(deficit)	**0.71**	**(5.29)**
Variance to plan	**2.74**	**(4.05)**

Workforce

(see page 8)



Patient Income

Greyed out sections will not currently be used for 22/23 reporting due to the nature of block funding.

Underlying Position

Cost Improvement Programme (CIP)

(see page 9)

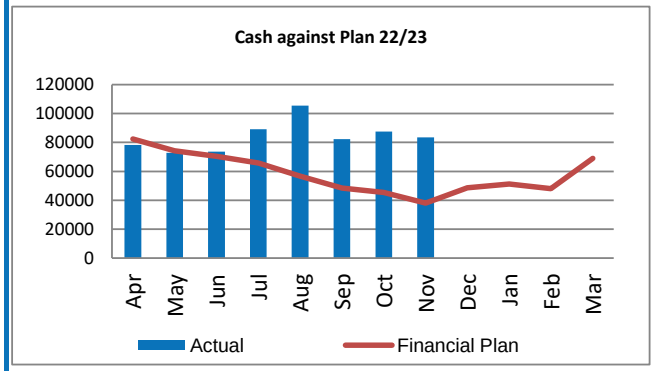
YTD CIP achievement is £9.48m against a target of £10.61m, with £4.34m of the YTD total arising from the rebasing exercise that does not reduce current run rates.

The Trust is forecasting CIP achievement of £14.90m, with £6.36m of this being achieved recurrently.

Cash in the Bank

(see page 7)

Plan £38.0m
Actual £83.4m



Covid-19 Expenditure

In month 8 there was a total of £487k expenditure relating to Covid-19.

Of this amount £411k is reimbursed for testing.

Reserves

(see page 9)

£8.24m of reserves are released into the position at month 8 of an annual value of £14m.

Actual Outturn

(see page 5)

£3.4m surplus in month
(£2.7m favourable to plan)

and £9.3m deficit year to date
(£4m adverse to plan)

Overview of Financial Performance

The Trust is reporting an in month adjusted surplus of £3.5m, this is £2.7m favourable to plan. The year to date deficit of £9.3m is £4m adverse to plan.

£5.5m of the year to date deficit relates to budget reduction CIP that was planned to be delivered by this point in the year, whereas much of the CIP achievement reported relates to cost avoidance schemes that do not impact on the run rates.

There is an overspend on pay of £6.8m on pay, year to date, and a £2m overspend on drugs due to activity and the application of block contract arrangements to costs previously passed through to CCGs, The overspends are offset by £8.2m of unspent reserves.

The in-month position has improved due to the release of provisions and accruals no longer required, these total £2.5m.
Significant run rate improvements and CIP delivery will be required in the remainder of the year in order to achieve the planned break-even position.

System Updates

The ICB has forecast a £58.5m deficit without any mitigating actions at the year end, however through recovery planning a number of actions and mitigations have been identified to achieve system break-even and once this is achieved the ICB risk share arrangement will mean that funds will be redistributed to ensure all organisations report break-even. This means that the ICB and its members will not be enacting the recently proposed NHS protocols.

Current guidance is that ICBs should not forecast loss of funds for ERF underperformance and on that basis it is assumed that ERF will not be clawed back where planned activity is below plan. However, final guidance on this is yet to be issued. NHSE's review of the ICS position continues with a focus on the underlying ICS deficit moving into 2023/24.

Capital

The Trust have spent £37.0m of capital YTD to 30th November 22. Of this £37.0m, £14.5m relates to capital spend which the ICS is measured against, with the Trust anticipating meeting it's agreed Full Year ICS CRL of £19.9m. The balance of capital YTD £22.5m relates to capital spend on grant funded items of £19.2m, made up of £5.5m relating to PSDS Phase 2, £12.7m relating to PSDS Phase 3 and £1.0m relating to ERDF Grant; £0.3m on a new lease for BCPS which is capitalised under IFRS 16; and £2.9m of PDC monies.

The Trust anticipate meeting the current planned gross capital expenditure of £102.2m, which consists of £19.9m ICS CRL (internally generated funds), PDC £31.6m, Grant funding of £39.5m, IFRIC 12 related capital spend of £5.1m, and IFRS 16 new leases £6.1m.

Income and Expenditure Run Rates

		21/22					22/23								YTD	Move-
	£m	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Avg	ment
	Patient Income															
1	Plan	53.72	54.42	54.46	54.57	87.42	52.92	53.09	55.94	54.24	54.79	61.89	57.85	57.06	*55.82*	*1.25*
2	Actual	53.24	53.95	53.70	55.21	88.60	52.60	53.12	55.67	56.40	54.82	60.56	56.79	60.38	*55.71*	*4.68*
3	Variance	(0.48)	(0.47)	(0.75)	0.64	1.18	(0.32)	0.02	(0.27)	2.17	0.03	(1.33)	(1.06)	3.32	*(0.11)*	*3.43*
	Non Patient Income															
4	Plan	12.95	15.44	13.70	14.41	12.38	11.60	17.19	15.53	11.30	11.67	17.01	13.26	12.41	*13.94*	*(1.52)*
5	Actual	11.85	12.77	11.86	11.60	22.72	10.72	17.70	15.61	11.60	11.80	11.49	19.22	13.75	*14.02*	*(0.27)*
6	Variance	(1.11)	(2.67)	(1.84)	(2.81)	10.34	(0.89)	0.51	0.08	0.30	0.13	(5.52)	5.97	1.34	*0.08*	*1.25*
	Pay Expenditure															
7	Plan	39.33	39.56	39.54	39.68	59.97	39.52	39.50	42.73	41.29	41.49	46.92	42.71	42.52	*42.02*	*(0.50)*
8	Actual	39.45	39.53	39.77	40.30	69.33	41.08	41.96	41.42	42.23	42.75	48.28	43.60	42.16	*43.05*	*0.89*
9	Variance	(0.12)	0.03	(0.23)	(0.62)	(9.36)	(1.56)	(2.46)	1.31	(0.94)	(1.27)	(1.37)	(0.89)	0.37	*(1.03)*	*(1.39)*
	Non Pay Expenditure															
10	Plan	16.90	19.56	18.06	18.36	17.89	17.14	16.02	17.80	16.48	16.35	16.60	17.14	17.10	*16.79*	*(0.30)*
11	Actual	16.63	17.77	17.23	16.68	25.99	16.55	16.25	16.52	15.94	16.24	16.32	17.23	17.78	*16.43*	*(1.35)*
12	Variance	0.27	1.79	0.83	1.68	(8.10)	0.59	(0.23)	1.28	0.54	0.12	0.28	(0.09)	(0.68)	*0.36*	*1.04*
	Drugs Expenditure															
13	Plan	5.31	5.65	5.49	5.40	5.92	5.65	5.31	5.74	5.51	5.58	6.10	5.55	5.65	*5.64*	*(0.01)*
14	Actual	5.64	5.83	5.76	5.23	6.03	5.78	5.59	5.63	5.66	6.03	6.58	5.91	5.95	*5.88*	*(0.07)*
15	Variance	(0.33)	(0.18)	(0.28)	0.16	(0.10)	(0.12)	(0.28)	0.11	(0.15)	(0.45)	(0.48)	(0.36)	(0.30)	*(0.25)*	*0.05*
	CIP over/ (under) achievement															
16	Variance	(0.17)	0.03	(0.17)	(0.13)	0.63	(0.42)	(0.13)	0.08	(0.79)	(0.76)	(0.41)	(1.19)	(1.83)	*(0.52)*	*1.31*
	BCPS Savings over/ (under) achievement															
16	Variance						0.08	0.08	0.08	0.08	0.08	0.08	(0.01)	0.03	*0.07*	*0.04*
	Reserves supporting position															
17	Actual	2.00	1.96	2.24	2.43	12.26	2.81	2.49	(1.70)	(0.71)	0.68	1.58	1.47	1.61	*0.95*	*(0.66)*
	Other Non Operating Expenditure															
18	Plan	(3.11)	(3.11)	(3.18)	(3.18)	(3.19)	(2.98)	(4.37)	(3.27)	(3.61)	(3.61)	(3.27)	(3.78)	(3.78)	*(3.56)*	*(0.22)*
19	Actual	(3.09)	(3.10)	(3.10)	(3.06)	0.46	(3.17)	(3.72)	(3.79)	(3.58)	(3.54)	(3.53)	(3.75)	(3.57)	*(3.58)*	*0.01*
20	**Variance**	0.02	**0.02**	**0.08**	**0.12**	**3.64**	**(0.19)**	**0.65**	**(0.53)**	**0.03**	**0.08**	**(0.26)**	**0.03**	**0.21**	*(0.03)*	*(0.24)*
	Total															
	Plan	0.19	**(0.00)**	**(0.18)**	**0.06**	**(0.06)**	**(3.24)**	**2.64**	**3.46**	**0.06**	**(0.58)**	**4.76**	**1.65**	**0.62**		
	Actual	0.27	**0.49**	**(0.30)**	**1.54**	**10.43**	**(3.25)**	**3.30**	**3.91**	**0.60**	**(1.93)**	**(2.66)**	**5.52**	**4.68**		
	Variance	0.09	**0.49**	**(0.12)**	**1.48**	**10.49**	**(0.01)**	**0.65**	**0.45**	**0.54**	**(1.35)**	**(7.42)**	**3.87**	**4.06**		

Commentary on variances and trends:

Patient Income was above plan for month 8 due to an additional £5.8m agreed between the Trust and the Black Country ICB as part of the risk sharing arrangements to support delivery of break even at all ICS organisations. £3.8m of this funding is included in the year to date position. No ERF adjustment has been made so far this year, and planned activity levels have not been achieved, and therefore the Trust would not have benefited from the ERF adjustment if it was in action. Year to date there has also been an underperformance on Public Health activity, but devices income was above plan, however this income is offset by non-pay costs.

Non Patient Income - in month there is a favourable variance of £1.34m against budget. This is due mainly to grant income that has been received to offset against capital expenditure however the variance is only due to phasing of the budget rather than a continued over-achievement. The amount of grant income in month was £1.27m compared to £5.9m in month 7.

Pay - within this line there has been a release of annual leave accrual valued at £1.1m, allowing for this there was still an overall slight reduction in pay compared to previous month.

The overspend continues in the same areas as earlier periods due to temporary staffing being used to cover absences and vacancies. Within the medical division the overspend is £767k, surgical division £278k and community £295k. The overspends are offset by the release of the accrual mentioned above.

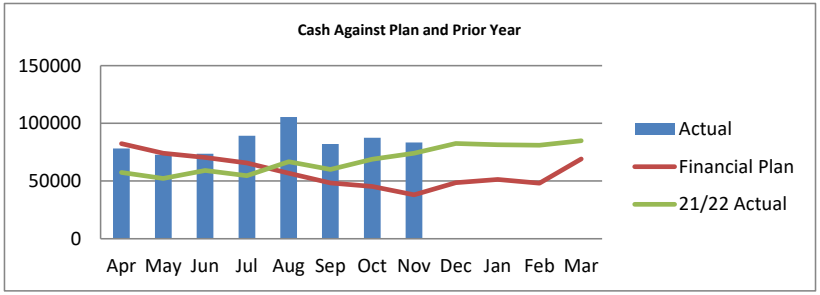
Non Pay - Overspent by £684k in month with expenditure rising by £550k compared to last month.

The overspend is predominantly within the three clinical divisions. Surgery (£346k) is due to Cardiology overspending by £444k caused by activity levels, Orthopaedics similarly activity related issues causing over spending of £143k offset by underspending areas (mainly pathology). Medicine are overspent by £238k mainly caused by increased blood and consumable use in ED (£70k), Insulin pumps (previously pass through) (£89k), renal welfare rights, which are no longer charity funded (£64k). In Division 3, Children's increased use in Insulin pumps is £156k, and a budget realignment with income £115k are the main drivers of their total non pay overspend of £240k.

The increase in expenditure in month of £554k is attributable to the activity increases in Cardiology and Orthopaedics mentioned above. There is also an increase in Estates and Facilities due to energy consumption but this is offset by a reduction in Division 3 due to one off increases they experienced in month 7.

Drugs - the trend continues with the level of expenditure and overspend being similar to last month. The in month overspend is due to Ophthalmology injection activity £82k, patient acuity in Women's and Neonatal £59k, and £27k in both Critical care and orthopaedics. There is also continued higher activity in Gastro £249k.

Cash Position



The cash balance as at 30th November 2022 is £83.4m, a £4.1m decrease on the previous month and an increase of £45.4m on financial plan. Plan variances are due to pass through commissioner income (£19.8m) including pay award, timing of LVA Income (£1.7m), timing of HEE income (£11.2m), timing of capital spend (£32.6m), additional BCPS income (£8.3m) & higher than planned VAT income (£6.3m). Conversely there is an increase in pay costs (£19.7m) and increased non pay spend (£16.1m).

Better Payment Practice Code

The Better Payment Practice Code sets out a target for payment of 95%, in value and volume, to be paid within 30 days of receipt. The Trust's performance against this target is:

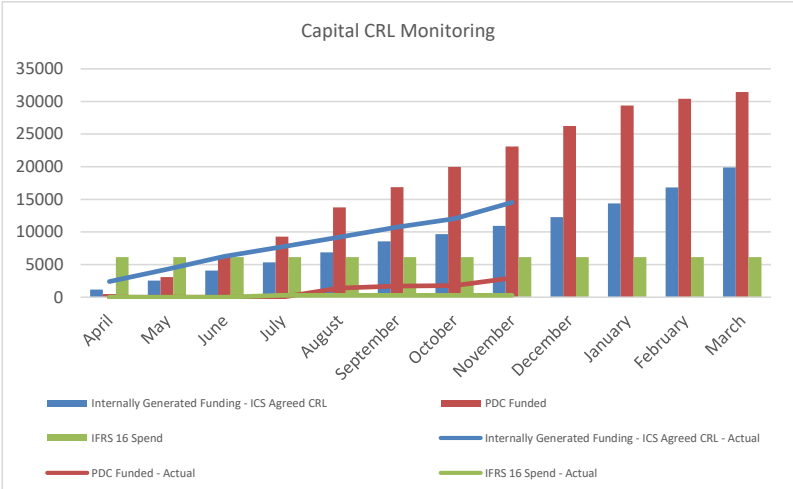
	M8 22/23	Cumulative	M7 22/23	Cumulative
Value	90%	92%	89%	92%
Volume	87%	89%	87%	89%

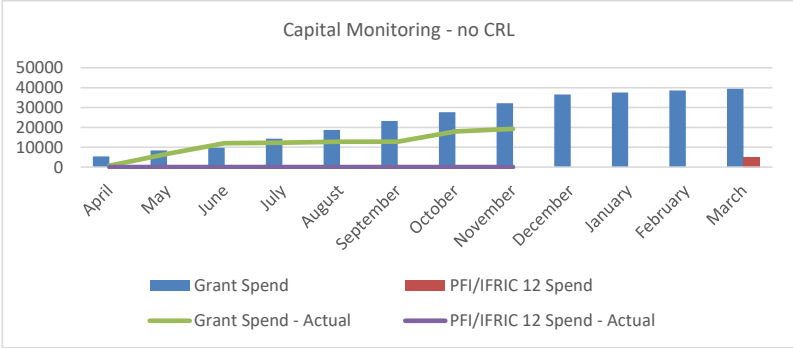
Debtor Days

Calculated Debtor Days for the year are:-

	M8 Actual	M7 Actual
Total	3.70	4.15
Being:-		
NHS	3.17	3.99
Non NHS	5.93	4.79

Capital





The Trust have spent £37.0m of capital YTD to 30th November 22.

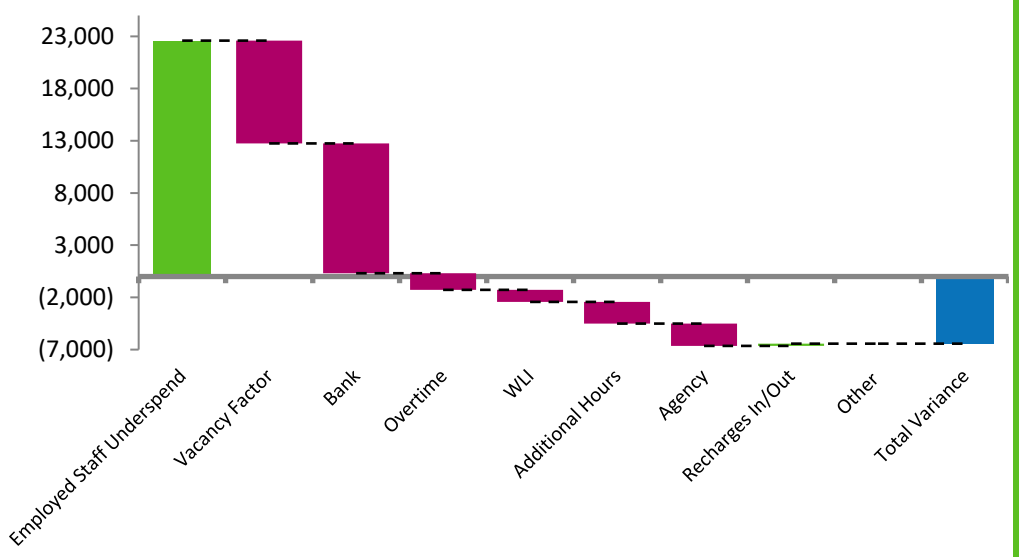
Capital CRL Monitoring - Of this £37.0m, £14.5m relates to capital spend which the ICS is measured against. This is currently ahead of Plan due to timing of orders, with the Trust anticipating meeting its agreed Full Year ICS CRL of £19.9m. There has been £2.9m spend YTD on PDC due to new PDC for Western Power supply to Cannock Chase hospital £2.4m and £0.5m for Black Country North Elective Hub, the rest of the PDC forecast has not been approved with these projects having yet to commence. There is £0.3m spend YTD on IFRS 16 which is below forecast due to leases (predominantly BCPS) still being required to be commercially agreed.

Capital Monitoring - no CRL - The balance of the capital YTD, £19.2m, relates to capital spend on grant funded items with £5.5m relating to PSDS Phase 2, £12.7m relating to PSDS Phase 3 and £1.0m relating to ERDF Grant.

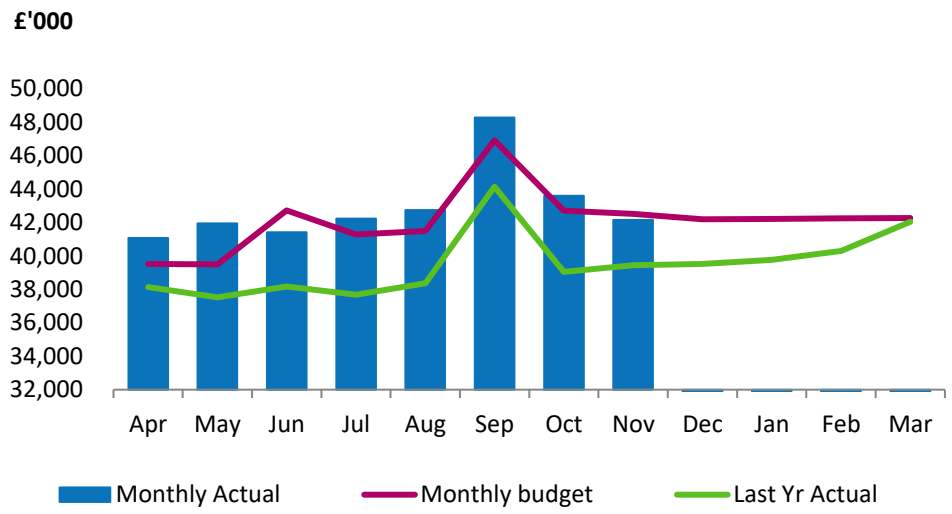
The Trust anticipate meeting their current planned gross capital expenditure of £102.2m, which consists of £19.9m ICS CRL (internally generated funds); PDC £31.6m, Grant funding of £39.5m, IFRIC 12 related capital spend of £5.1m and IFRS 16 new leases £6.1m (still to be agreed nationally).

Pay Expenditure

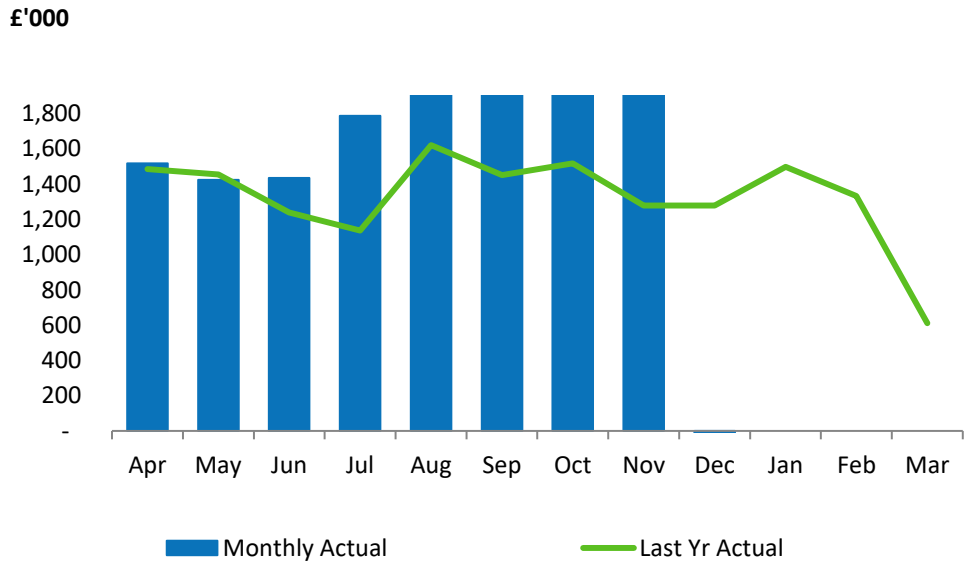
Year to Date Variance to plan



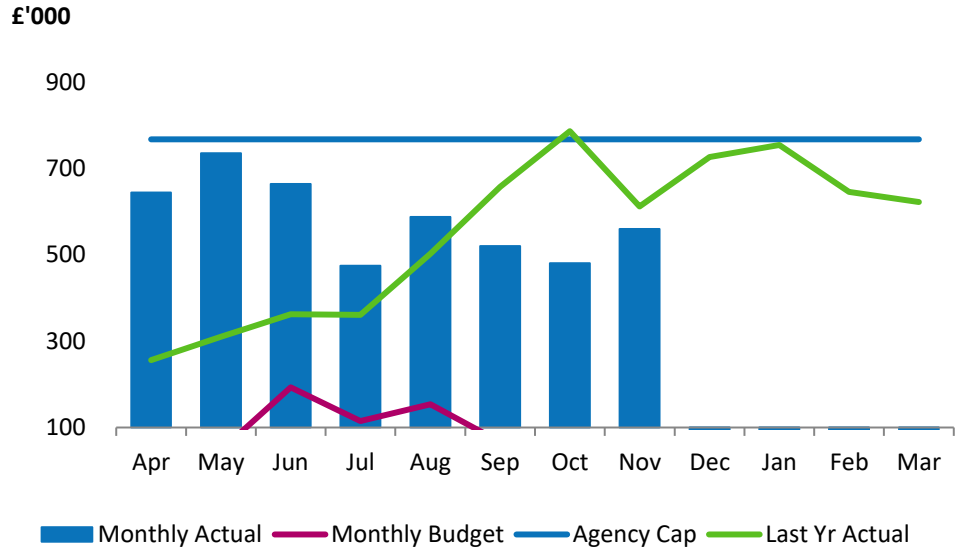
Total Pay Expenditure Trend



Bank Expenditure Trend



Agency Expenditure Trend



Agency Cap for 22/23 not yet confirmed, therefore using 21/22 currently

Cost Improvement

Board Report Table

Division	Full Year Target	Year to Date Non Recurrent Achieved	Year to Date Recurrent Achieved	Year to Date Total Achieved	Full Year Forecast Non Recurrent	Full Year Forecast Recurrent	Full Year Forecast Total Forecast	Unmet CIP
Division 1	7,090,685	1,377,596	480,504	1,858,101	1,701,917	1,006,840	2,708,757	(4,381,928)
Division 2	4,451,811	677,145	725,635	1,402,780	864,228	1,005,629	1,869,856	(2,581,955)
Division 3	3,450,606	907,488	137,834	1,045,322	1,145,749	413,476	1,559,224	(1,891,382)
Division 4	195,706	333	71	404	683	159	842	(194,864)
Estates and Facilities	1,914,988	331,173	33,432	364,604	585,790	76,906	662,696	(1,252,291)
Corporate	1,853,809	1,120,625	107,794	1,228,419	1,316,827	258,611	1,575,438	(278,371)
Trustwide	129,395	26,861	3,553,203	3,580,064	26,861	3,596,337	6,527,252	6,397,856
	19,087,000	**4,441,221**	**5,038,473**	**9,479,695**	**5,642,055**	**6,357,958**	**14,904,066**	**(4,182,934)**
Cash avoidance/ no budget reduction		*£ 2,370*	*£ 1,965*	*£ 4,335*	*£ 3,850*	*£ 3,822*	*£ 7,672*	

Against an in month target of £2.12m, the Trust has achieved £0.90m. YTD £9.48m achieved against a target of £10.61m. £4.34m of this has been achieved through the rebasing exercise.

Recurrent savings are forecast at £6.36m, of which £3.82m are from the revised reporting, with total savings currently forecast at £14.90m, against the full year target of £19.09m.

There are approved PIDs of £8.18m, £2.12m recurrent and £6.06m non-recurrent with £854k of schemes in progress.

Reserves

Start point				34,789,751
Additional Income allocated to reserves				21,423,234
Full Year Effect of reserves 'drawn down' upto current month				(42,203,930)
Reserves phased into position				(8,242,100)
Reserves available for future months				**5,766,956**
Earmarked Reserves		Division 1	(783,693)	
		Division 2	(2,205,657)	
		Division 3	(4,531,900)	
		Division 4	(17,000)	
		Estates and Facilities	(29,686)	
		Corporate & Other	(1,609,651)	
	Less:	Expected Slippage	1,531,250	
				(7,646,337)
		Available Balance		**(1,879,381)**
Balance made up of		Drugs	211,350	
		Inflation	637,778	
		Trustwide Education/LDA	377,434	
		Contingency	(260,965)	
Less:		Expected Balance Sheet Release	(2,844,979)	
				(1,879,381)

Appendix A - Income and Expenditure Account

Last Year to Date £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000		Annual Budget £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
				Income				
414,763	57,064	60,385	3,321	Patient Activity Income	676,673	447,791	450,352	2,561
611	123	123	0	Other Patient Care Income	1,478	985	755	(230)
7,447	265	265	0	Top Up Income	3,037	3,037	3,011	(26)
32,168	4,975	5,050	75	Education, Training & Research Income	51,802	34,722	35,027	305
0	0	1,274	1,274	Non Patient Care Other Income	39,831	15,120	19,884	4,764
41	82	99	17	Private Patient Income	987	658	260	(399)
51,772	6,967	6,936	(30)	Income on Directorate Budgets	83,415	55,440	52,947	(2,493)
506,801	**69,476**	**74,133**	**4,657**	**Total Income**	**857,223**	**557,754**	**562,236**	**4,482**
				Expenditure				
312,524	42,524	42,156	368	Directorate Expenditure Budgets - Pay	505,590	336,674	343,483	(6,809)
126,698	17,095	17,779	(684)	Directorate Expenditure Budgets - Non Pay	201,345	134,631	132,816	1,815
42,873	5,648	5,950	(302)	Directorate Expenditure Budgets - Drugs	67,101	45,094	47,123	(2,029)
0	1,471	0	1,471	Activity Changes/Service Dev./Cost Pressures/Inflation Reserves	13,560	7,532	0	7,532
0	135	0	135	Contingency Reserves	449	710	0	710
0	(1,829)	0	(1,829)	Cost Improvement Savings	(13,367)	(5,450)	0	(5,450)
0	30	0	30	BCPS Savings	(322)	525	0	525
482,094	**65,074**	**65,885**	**(811)**	**Total Expenditure**	**774,356**	**519,715**	**523,422**	**(3,706)**
24,707	**4,401**	**8,247**	**3,846**	**EBITDA Surplus/(Deficit)**	**82,867**	**38,039**	**38,815**	**776**
15,402	2,561	2,522	39	Depreciation	29,609	19,281	19,455	(174)
1,468	201	8	193	Interest Receivable / (Payable)	2,066	1,261	789	472
7,726	1,016	1,039	(23)	Other Charges	12,194	8,129	8,411	(282)
24,596	**3,778**	**3,569**	**209**	**Other non operating items**	**43,869**	**28,671**	**28,655**	**15**
111	**623**	**4,679**	**4,056**	**Net Surplus/(Deficit) before Adjustments**	**38,998**	**9,368**	**10,159**	**792**
304	92	(1,222)	(1,314)	Adjustments as per NHSI reported position	(38,998)	(14,654)	(19,491)	(4,837)
415	**715**	**3,457**	**2,742**	**Adjusted Financial Performance as NHSI**	**(0)**	**(5,286)**	**(9,331)**	**(4,045)**
(7)	*0*	*(15)*	*(15)*	*Adjustments as per ICS reported position*	*0*	*0*	*(22)*	*(22)*
408	***715***	***3,442***	***2,727***	***Adjusted Financial Performance as ICS***	***(0)***	***(5,286)***	***(9,353)***	***(4,067)***

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2022/23 Balance Sheet as at 30th November 2022

	November 2022 Plan	November 2022 Actual	October 2022 Actual	Movement in Month	March 2022 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	480,693	447,734	444,812	2,922	416,282
Intangible Assets	5,659	5,692	5,806	(114)	6,462
Other Investments/Financial Assets	161	161	161	0	161
Trade and Other Receivables Non Current	1,794	1,795	1,795	0	1,795
PFI Deferred Non Current Asset	4,877	4,877	4,877	0	4,877
TOTAL NON CURRENT ASSETS	**493,184**	**460,259**	**457,451**	**2,808**	**429,576**
CURRENT ASSETS					
Inventories	8,253	8,055	8,120	(65)	8,253
Trade and Other Receivables	33,170	45,068	39,036	6,033	33,801
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	38,047	83,402	87,502	(4,099)	84,918
TOTAL CURRENT ASSETS	**79,470**	**136,526**	**134,658**	**1,868**	**126,973**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**572,654**	**596,785**	**592,109**	**4,676**	**556,548**
CURRENT LIABLILITES					
Trade & Other Payables	(97,171)	(120,192)	(117,720)	(2,471)	(106,225)
Liabilities arising from PFIs / Finance Leases	(6,596)	(8,695)	(8,277)	(418)	(2,101)
Provisions for Liabilities and Charges	(7,428)	(5,004)	(5,609)	605	(7,427)
Other Financial Liabilities	(8,204)	(16,629)	(17,689)	1,060	(8,204)
TOTAL CURRENT LIABILITIES	**(119,399)**	**(150,519)**	**(149,295)**	**(1,224)**	**(123,957)**
NET CURRENT ASSETS / (LIABILITIES)	**(39,929)**	**(13,993)**	**(14,638)**	**644**	**3,016**
TOTAL ASSETS LESS CURRENT LIABILITIES	**453,255**	**446,265**	**442,813**	**3,452**	**432,592**
NON CURRENT LIABILITIES					
Trade & Other Payables	(86)	(64)	(67)	4	(86)
Other Liabilities	(15,085)	(7,224)	(8,514)	1,291	(5,475)
Provision for Liabilities and Charges	(2,308)	(2,308)	(2,308)	0	(2,308)
TOTAL NON CURRENT LIABILITIES	**(17,479)**	**(9,595)**	**(10,890)**	**1,294**	**(7,869)**
TOTAL ASSETS EMPLOYED	**435,776**	**436,670**	**431,924**	**4,747**	**424,723**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	288,653	288,441	288,373	68	286,653
Retained Earnings	52,065	53,171	48,493	4,679	43,012
Revaluation Reserve	96,137	96,137	96,137	0	96,137
Donated Asset Reserve	0	0	0	0	0
Financial assets at FV through OCI reserve	(1,269)	(1,269)	(1,269)	0	0
Other Reserves	190	190	190	0	(1,079)
TOTAL TAXPAYERS EQUITY	**435,776**	**436,670**	**431,924**	**4,747**	**424,723**

2022/23 Cash Flow as at 30th November 2022

	Nov-22 Plan £'000	Nov-22 Actual £'000	Nov-22 Variance £'000	Nov-22 In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit)	**19,316**	**19,360**	44	5,725
Depreciation	19,637	19,454	(183)	2,521
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(14,578)	(19,884)	(5,306)	(1,274)
Interest Paid	(1,844)	(1,769)	75	(233)
Dividends Paid	(6,324)	(6,126)	198	0
Release of PFI /Deferred Credit	0	0	0	0
(Hncrease)/Decrease in Inventories	0	198	198	65
(Hncrease)/Decrease in Trade/Receivables	0	(11,466)	(11,466)	(6,032)
Increase/(Decrease) in Trade/Payables	(3,510)	19,426	22,936	1,339
Increase/(Decrease) in Trade/Payables Ann Leave Acc	0	(1,862)		(1,336)
Increase/(Decrease) in Other liabilities	0	8,425	8,425	(1,060)
Increase/(Decrease) in Provisions	0	(2,423)	(2,423)	(605)
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**12,697**	**23,332**	**10,635**	**(889)**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	16	980	964	225
Payment for Property, Plant and Equipment	(72,120)	(42,996)	29,125	(3,502)
Payment for Intangible Assets	0	0	0	0
Receipt of cash donations to purchase capital assets	15,109	19,884	4,775	1,274
Proceeds from sales of Tangible Assets	0	22	22	15
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(56,995)**	**(22,110)**	**34,885**	**(1,987)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(44,298)**	**1,223**	**45,521**	**(2,877)**
FINANCING				
New Public Dividend Capital Received	2,056	1,788	(268)	68
Capital Element of Finance Lease and PFI	(4,629)	(4,527)	102	(1,291)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(2,573)**	**(2,739)**	**(166)**	**(1,223)**
INCREASE/(DECREASE) IN CASH	**(46,871)**	**(1,516)**	**45,355**	**(4,099)**
CASH BALANCES				
Opening Balance at 1st April 2022	84,918	84,918	0	
Opening Balance at 1st November 2022				87,502
Closing Balance at 30 November 2022	38,047	83,402	45,355	83,402

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Report of the Chief Financial Officer - Month 9
Action Requested:	□ Make a decision □ Approve X Receive for assurance □ Received and noted If the item has already been approved by a body with delegated powers of approval from the Board such as a Committee of the Board, then the item would be received and noted.
For the attention of the Board	
Assure	N/A
Advise	N/A
Alert	N/A
Author + Contact Details:	Kevin Stringer, Chief Financial Officer - 01902 695954 kevin.stringer@nhs.net
Links to Trust Strategic Objectives	Maintain financial health – Appropriate investment in patient services
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.
CQC Domains	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	N/A
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A
Public or Private:	Public
Other formal bodies involved:	Finance and Performance Committee
References	N/A
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	Report of the Chief Financial Officer - Month 9
Item/paragraph 1	This paper reports the in-month, year-to-date and the draft year end position for the Trust as at Month 9. The paper also reports on delivery against financial targets.

The Royal Wolverhampton NHS Trust

Reference Pack

Report of the Chief Financial Officer

Finance Report
December 2022 - Month 9

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Dashboard

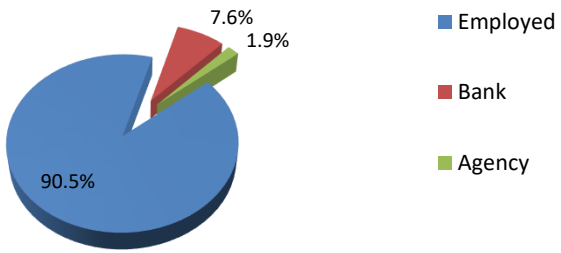
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Block payment	54.88	505.23
2. Other income	16.63	125.51
3. Top-up payment	0.35	3.37
Total	**71.87**	**634.11**
Expenditure	**70.03**	**641.60**
Surplus/ (deficit)	**1.84**	**(7.49)**
Planned surplus/(deficit)	**1.67**	**(3.62)**
Variance to plan	**0.17**	**(3.87)**

Workforce

(see page 8)



Patient Income

Greyed out sections will not currently be used for 22/23 reporting due to the nature of block funding.

Underlying Position

Cost Improvement Programme (CIP)

(see page 9)

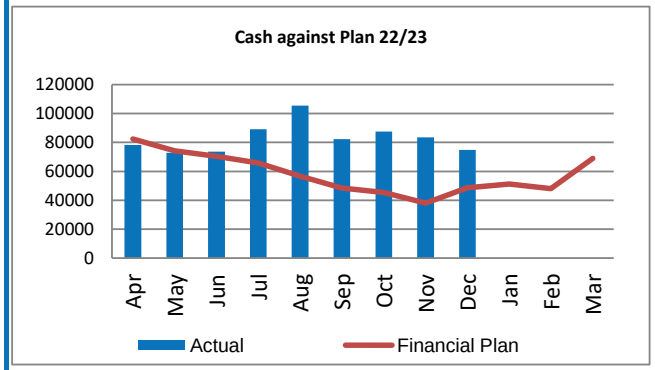
YTD CIP achievement is £10.33m against a target of £12.73m, with £4.90m of the YTD total arising from the rebasing exercise that does not reduce current run rates.

The Trust is forecasting CIP achievement of £15.74m, with £8.17m of this being achieved recurrently.

Cash in the Bank

(see page 7)

Plan £48.5m
Actual £74.8m



Covid-19 Expenditure

In month 9 there was a total of £565k expenditure relating to Covid-19.

Of this amount £504k is reimbursed for testing.

Reserves

(see page 9)

£7.75m of reserves are released into the position at month 9 of an annual value of £12.44m.

Actual Outturn

(see page 5)

£1.8m surplus in month
(£171k favourable to plan)

and £7.5mm deficit year to date
(£3.9m adverse to plan)

Overview of Financial Performance

The Trust is reporting an in month adjusted surplus of £1.8m, this is £0.2m favourable to plan. The year to date deficit of £7.5m is £3.9m adverse to plan. The Trust has enacted its recovery plan and is forecasting break-even but is reliant on system perfromance and support through the risk share arrangements.

£7.3m of the year to date deficit relates to budget reduction CIP that was planned to be delivered by this point in the year, whereas much of the CIP achievement reported relates to cost avoidance schemes that do not impact on the run rates.

There is an overspend on pay of £4.1m year to date, and a £2.4m overspend on drugs due to activity and the application of block contract arrangements to costs previously passed through to CCGs. The overspends are offset by £7.7m of unspent reserves.

The in-month position has improved due to the release of provisions and accruals no longer required, these total £6.9m.
Significant run rate improvements and CIP delivery will be required in the remainder of the year in order to achieve the planned break-even position.

System Updates

The ICB is reporting a reduced £34.7m year-to-date deficit and are forecasting to break-even after enactment of recovery plans. Organisational and ICB break-even is inter-dependant as the ICB risk share arrangement will mean that funds will be redistributed to ensure all organisations report break-even. This means that the ICB and its members will not be enacting the recently proposed NHS protocols.

Current guidance is that ICBs should not forecast loss of funds for ERF underperformance and on that basis it is assumed that ERF will not be clawed back where planned activity is below plan. However, final guidance on this is yet to be issued. NHSE's review of the ICS position continues with a focus on the underlying ICS deficit moving into 2023/24.

Capital

The Trust have spent £44.9m of capital YTD to 31st December 22. Of this £44.9m, £14.8m relates to capital spend which the ICS is measured against, with the Trust anticipating meeting it's agreed Full Year ICS CRL of £19.9m. The balance of capital YTD £29.5m relates to capital spend on grant funded items of £23.2m, made up of £5.5m relating to PSDS Phase 2, £16.7m relating to PSDS Phase 3 and £1.0m relating to ERDF Grant; £0.3m on a new lease for BCPS which is capitalised under IFRS 16; £6.0m of PDC monies and £0.7m of donated assets.

The Trust anticipate meeting the current planned gross capital expenditure of £88.9m, which consists of £19.9m ICS CRL (internally generated funds), PDC £17.5m, Grant funding of £39.5m, IFRIC 12 related capital spend of £5.1m, IFRS 16 new leases £6.1m, and £0.7m of donated assets. The planned gross capital expenditure has moved from prior month forecast of £102.2m due to removal of PDC of £19.4m for CDC, which will not be built in 22/23. This has been partial offset by additional PDC monies £5.4m and £0.7m for donated assets.

Income and Expenditure Run Rates

		21/22				22/23									YTD	Move-
	£m	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Avg	ment
	Patient Income															
1	Plan	54.42	54.46	54.57	87.42	52.92	53.09	55.94	54.24	54.79	61.89	57.85	57.06	57.44	*55.97*	*1.46*
2	Actual	53.95	53.70	55.21	88.60	52.60	53.12	55.67	56.40	54.82	60.56	56.79	60.38	54.88	*56.29*	*(1.41)*
3	Variance	(0.47)	(0.75)	0.64	1.18	(0.32)	0.02	(0.27)	2.17	0.03	(1.33)	(1.06)	3.32	(2.56)	*0.32*	*(2.88)*
	Non Patient Income															
4	Plan	15.44	13.70	14.41	12.38	11.60	17.19	15.53	11.30	11.67	17.01	13.26	12.41	21.15	*13.75*	*7.41*
5	Actual	12.77	11.86	11.60	22.72	10.72	17.70	15.61	11.60	11.80	11.49	19.22	13.75	16.99	*13.99*	*3.00*
6	Variance	(2.67)	(1.84)	(2.81)	10.34	(0.89)	0.51	0.08	0.30	0.13	(5.52)	5.97	1.34	(4.16)	*0.24*	*(4.41)*
	Pay Expenditure															
7	Plan	39.56	39.54	39.68	59.97	39.52	39.50	42.73	41.29	41.49	46.92	42.71	42.54	43.20	*42.09*	*(1.11)*
8	Actual	39.53	39.77	40.30	69.33	41.08	41.96	41.42	42.23	42.75	48.28	43.60	42.16	40.52	*42.94*	*2.42*
9	Variance	0.03	(0.23)	(0.62)	(9.36)	(1.56)	(2.46)	1.31	(0.94)	(1.27)	(1.37)	(0.89)	0.38	2.68	*(0.85)*	*(3.53)*
	Non Pay Expenditure															
10	Plan	19.56	18.06	18.36	17.89	17.14	16.02	17.80	16.48	16.35	16.60	17.14	17.10	18.15	*16.83*	*(1.32)*
11	Actual	17.77	17.23	16.68	25.99	16.55	16.25	16.52	15.94	16.24	16.32	17.23	17.78	15.75	*16.60*	*0.86*
12	Variance	1.79	0.83	1.68	(8.10)	0.59	(0.23)	1.28	0.54	0.12	0.28	(0.09)	(0.68)	2.40	*0.23*	*(2.17)*
	Drugs Expenditure															
13	Plan	5.65	5.49	5.40	5.92	5.65	5.31	5.74	5.51	5.58	6.10	5.55	5.65	5.98	*5.64*	*(0.34)*
14	Actual	5.83	5.76	5.23	6.03	5.78	5.59	5.63	5.66	6.03	6.58	5.91	5.95	6.32	*5.89*	*(0.43)*
15	Variance	(0.18)	(0.28)	0.16	(0.10)	(0.12)	(0.28)	0.11	(0.15)	(0.45)	(0.48)	(0.36)	(0.30)	(0.34)	*(0.25)*	*0.09*
	CIP over/ (under) achievement															
16	Variance	0.03	(0.17)	(0.13)	0.63	(0.42)	(0.13)	0.08	(0.79)	(0.76)	(0.41)	(1.19)	(1.83)	(1.86)	*(0.68)*	*1.17*
	BCPS Savings over/ (under) achievement															
16	Variance					0.08	0.08	0.08	0.08	0.08	0.08	(0.01)	0.03	0.00	*0.07*	*0.06*
	Reserves supporting position															
17	Actual	1.96	2.24	2.43	12.26	2.81	2.49	(1.70)	(0.71)	0.68	1.58	1.47	1.59	(0.48)	*1.03*	*1.51*
	Other Non Operating Expenditure															
18	Plan	(3.11)	(3.18)	(3.18)	(3.19)	(2.98)	(4.37)	(3.27)	(3.61)	(3.61)	(3.27)	(3.78)	(3.78)	(3.78)	*(3.58)*	*(0.19)*
19	Actual	(3.10)	(3.10)	(3.06)	0.46	(3.17)	(3.72)	(3.79)	(3.58)	(3.54)	(3.53)	(3.75)	(3.57)	(3.54)	*(3.58)*	*0.04*
20	**Variance**	**0.02**	**0.08**	**0.12**	**3.64**	**(0.19)**	**0.65**	**(0.53)**	**0.03**	**0.08**	**(0.26)**	**0.03**	**0.21**	**0.24**	*0.00*	*(0.24)*
	Total															
	Plan	**(0.00)**	**(0.18)**	**0.06**	**(0.06)**	**(3.24)**	**2.64**	**3.46**	**0.06**	**(0.58)**	**4.76**	**1.65**	**0.62**	**9.81**		
	Actual	**0.49**	**(0.30)**	**1.54**	**10.43**	**(3.25)**	**3.30**	**3.91**	**0.60**	**(1.93)**	**(2.66)**	**5.52**	**4.68**	**5.74**		
	Variance	**0.49**	**(0.12)**	**1.48**	**10.49**	**(0.01)**	**0.65**	**0.45**	**0.54**	**(1.35)**	**(7.42)**	**3.87**	**4.06**	**(4.07)**		

Commentary on variances and trends:

Patient Income - was below plan in month 9 due to a YTD technical reduction to the Black Country ICB risk share agreement and the ICB element of the BCPS adjustment on Non Pay (£2m). There is still no assumed ERF clawback from underperformance to target but this also means we have been unable to achieve additioanl ERF stretch. Year to date there has also been an underperformance on Public Health activity.

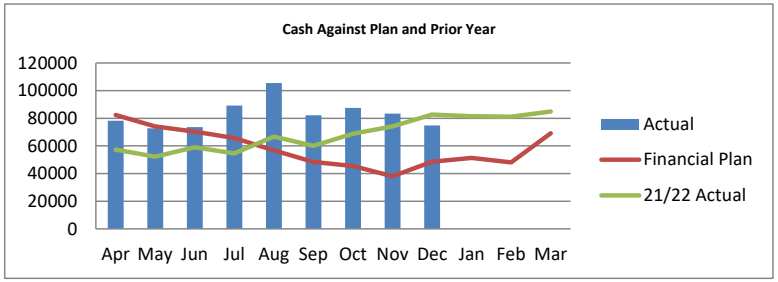
Non Patient Income - there is an underperformance of £4.1m in month. The increase in income recieved in month is made up of £0.5m from additional lead recruiter income, which is offset by costs of delivering this programme on behalf of the Black Country, and £2.5m of Grant income. However due to timing differences grant icnome recieved in the period was less than origannly planned which accounts for the underperformance against budget.

Pay - was £2.7m below plan in month this is largely due to the release of previous accrual no longer required totalling £3m (compared to £1.6m last month). After accounting for these pay is £0.9m overspent. This is across Division 1 £332k, Division 2, £907k and Division 3 £125k, these are all due to temporary staffing costs covering vacancies, sickness and leave. There are vacancies in other areas that are offsetting some of this BCPS £205k, Corporate £150k and Estates and Facilities £115k.

Non Pay - The in month underspend is a result of releasing accruals within BCPS that are no longer required by the hosted service worth £2.6m, this also accounts for the majority of the movement in month. Division 2 was overspent by £285k this was due to activity related costs in Renal £95k, Insulin pumps £49k, ED £40k as well as smaller overspends in other Directorates. In Estates and Facilities there was also an overspend of £120k, £72k relating to utilities, decontamination £21k and increased medical gas usage £25k

Drugs - The in month overspend continues to follow the trend of the last two months, the largest overspending areas are Women's and Neonatal due to seasonal respiratory drug usage £82k, Gastro, £158k and Diabetes £29k due to patient activity, Primary care £42k seasonal flu vaccinations, other directorates have smaller overspends, offset partly by underspends in Rheumatology and Neurology.

Cash Position



The cash balance as at 31st December 2022 is £74.8m, an £8.6m decrease on the previous month and an increase of £26.3m on financial plan. Plan variances are due to pass through commissioner income (£22.2m) including pay award, timing of LVA Income (£1.7m), timing of HEE income (£11.2m), timing of capital spend (£35.1m), additional BCPS income (£8.5m) & higher than planned VAT income (£7.8m). Conversely there is an increase in pay costs (£22.4m), timing of Grant & PDC income (£14.6m) and increased non pay spend (£25.7m).

Better Payment Practice Code

The Better Payment Practice Code sets out a target for payment of 95%, in value and volume, to be paid within 30 days of receipt. The Trust's performance against this target is:

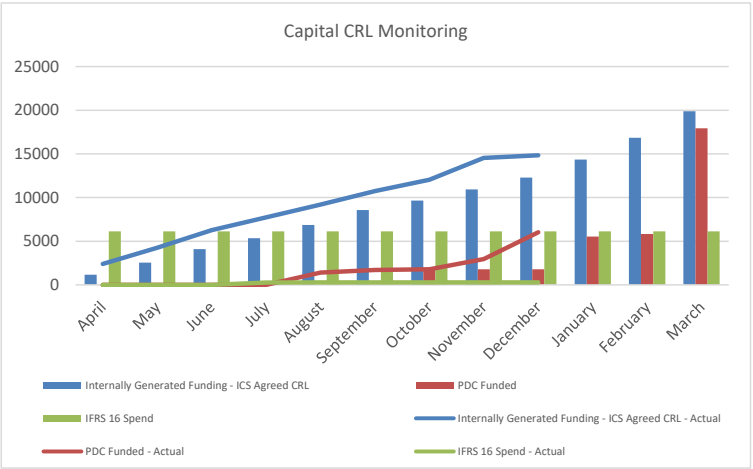
	M9 22/23	Cumulative	M8 22/23	Cumulative
Value	95%	92%	90%	92%
Volume	91%	89%	87%	89%

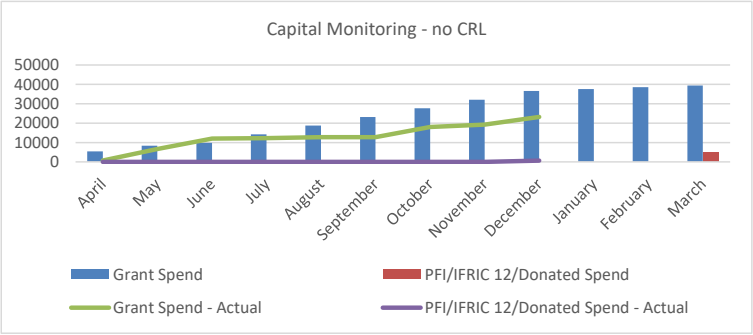
Debtor Days

Calculated Debtor Days for the year are:-

	M9 Actual	M8 Actual
Total	4.78	3.70
Being:-		
NHS	4.60	3.17
Non NHS	5.53	5.93

Capital





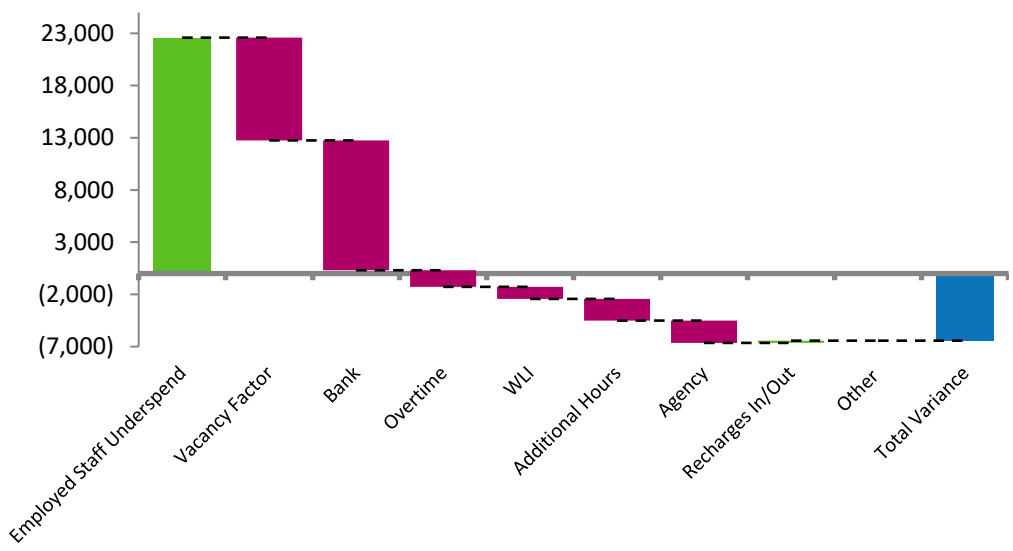
The Trust have spent £44.9m of capital YTD to 31st December 22.

Capital CRL Monitoring - Of this £44.9m, £14.8m relates to capital spend which the ICS is measured against. This is currently ahead of Plan due to timing of orders, with the Trust anticipating meeting its agreed Full Year ICS CRL of £19.9m. There has been £6.0m spend YTD on PDC for Western Power supply to Cannock Chase hospital £1.4m, £3.9m for Cannock Community Diagnostic Hub and £0.7m for Black Country North Elective Hub.. There is £0.3m spend YTD on IFRS 16 which is below forecast due to leases (predominantly BCPS) still being required to be commercially agreed.
Capital Monitoring - non CRL - The balance of the capital YTD, £23.2m, relates to capital spend on grant funded items with £5.5m relating to PSDS Phase 2, £16.7m relating to PSDS Phase 3 and £1.0m relating to ERDF Grant. In addition there has been £0.7m of donated assets from RWT Charity.

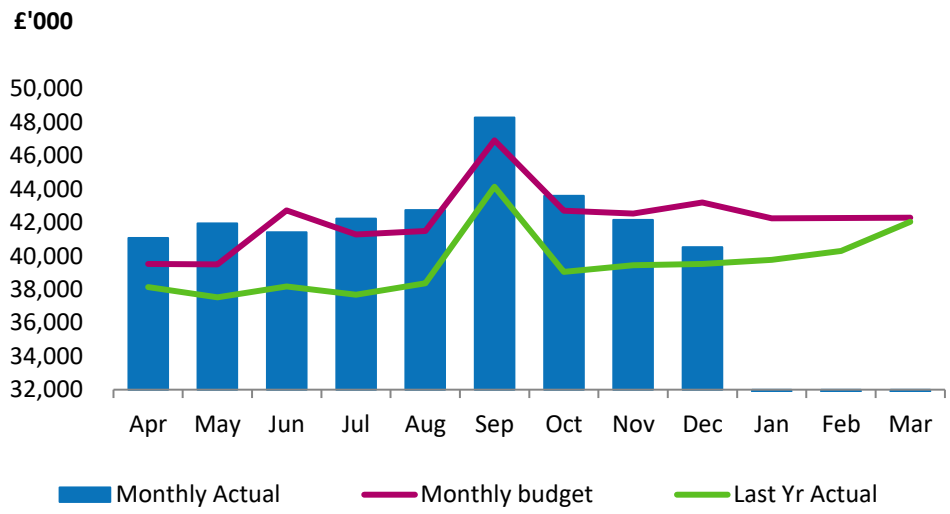
The Trust anticipate meeting their current planned gross capital expenditure of £88.9m, which consists of £19.9m ICS CRL (internally generated funds); PDC £17.5m, Grant funding of £39.5m, IFRIC 12 related capital spend of £5.1m, IFRS 16 new leases £6.1m (still to be agreed nationally) and £0.7m donated assets. The planned gross capital expenditure has moved from prior month forecast of £102.2m due to removal of PDC of £19.4m for CDC, which will not be built in 22/23. This has been partial offset by additional PDC monies £5.4m and £0.7m for donated assets.

Pay Expenditure

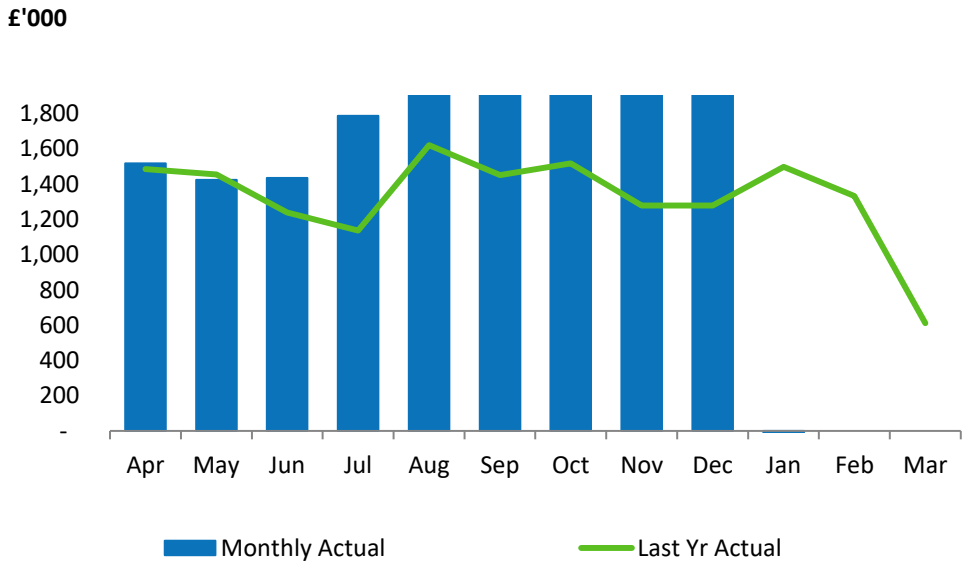
Year to Date Variance to plan



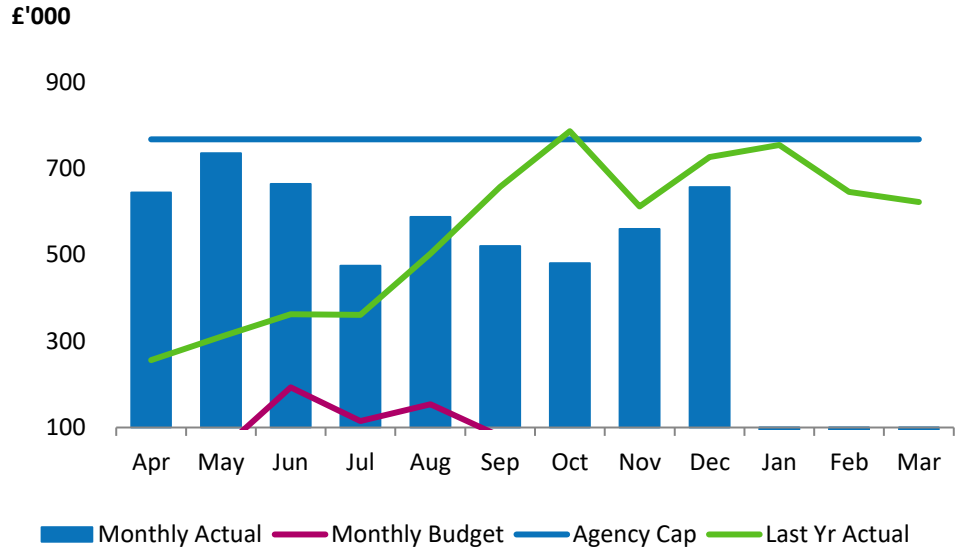
Total Pay Expenditure Trend



Bank Expenditure Trend



Agency Expenditure Trend



Agency Cap for 22/23 not yet confirmed, therefore using 21/22 currently

Cost Improvement

Division	Full Year Target	Year to Date			Full Year Forecast			
		Non Recurrent Achieved	Recurrent Achieved	Total Achieved	Non Recurrent	Recurrent	Total Forecast	Unmet CIP
Division 1	7,090,685	1,465,119	557,481	2,022,600	1,993,314	788,412	2,781,726	(4,308,960)
Division 2	4,451,811	708,145	782,602	1,490,747	847,381	966,940	1,814,321	(2,637,490)
Division 3	3,450,606	907,488	199,099	1,106,588	1,131,923	427,485	1,559,407	(1,891,199)
Division 4	195,706	333	71	404	333	71	404	(195,302)
Estates and Facilities	1,914,988	331,256	37,562	368,819	332,702	94,542	427,244	(1,487,744)
Corporate	1,853,809	1,154,678	121,226	1,275,904	1,163,245	181,026	1,344,271	(509,537)
Trustwide	129,395	26,861	4,035,239	4,062,100	814,861	7,000,392	7,815,253	7,685,857
	19,087,000	**4,593,881**	**5,733,280**	**10,327,161**	**6,283,759**	**9,458,867**	**15,742,626**	**(3,344,374)**
Cash avoidance/ no budget reduction		*£ 26*	*£ 4,877*	*£ 4,903*	*£ 334*	*£ 7,838*	*£ 8,172*	

Against an in month target of £2.12m, the Trust has achieved £0.83m. YTD £10.33m achieved against a target of £12.73m. £4.90m of this has been achieved through the rebasing exercise.

Recurrent savings are forecast at £9.46m, of which £7.84m are from the revised reporting, with total savings currently forecast at £15.74m.

There are approved PIDs of £8.825m, £2.27m recurrent and £6.06m non-recurrent with, £752k of schemes in progress.

Reserves

Start point				34,789,751
Additional Income allocated to reserves				21,751,087
Full Year Effect of reserves 'drawn down' upto current month				(44,099,739)
Reserves phased into position				(7,751,098)
Reserves available for future months				**4,690,002**
Earmarked Reserves		Division 1	(580,621)	
		Division 2	(1,600,614)	
		Division 3	(3,366,777)	
		Division 4	(17,000)	
		Estates and Facilities	(57,264)	
		Corporate & Other	(1,197,490)	
	Less:	Expected Slippage	918,750	
				(5,901,017)
		Available Balance		**(1,211,015)**
Balance made up of		Drugs	158,525	
		Inflation	551,477	
		Trustwide Education/LDA	282,034	
		Contingency	(183,870)	
Less:		Expected Balance Sheet Release	(2,019,181)	
				(1,211,015)

Appendix A - Income and Expenditure Account

Last Year to Date £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000		Annual Budget £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
				Income				
468,715	57,438	54,881	(2,557)	Patient Activity Income	677,024	505,229	505,233	4
713	123	119	(4)	Other Patient Care Income	1,478	1,108	875	(234)
8,829	354	354	0	Top Up Income	3,391	3,391	3,365	(26)
36,617	4,687	4,521	(166)	Education, Training & Research Income	52,278	39,409	39,548	139
0	8,237	3,953	(4,284)	Non Patient Care Other Income	39,831	23,357	23,837	480
51	82	46	(36)	Private Patient Income	987	741	306	(435)
58,597	7,670	7,995	325	Income on Directorate Budgets	83,967	63,110	60,942	(2,168)
573,521	**78,592**	**71,869**	**(6,722)**	**Total Income**	**858,956**	**636,345**	**634,106**	**(2,240)**
				Expenditure				
352,051	43,200	40,518	2,683	Directorate Expenditure Budgets - Pay	506,687	379,887	384,000	(4,113)
144,470	18,147	15,746	2,401	Directorate Expenditure Budgets - Non Pay	202,887	152,778	148,562	4,216
48,708	5,981	6,324	(343)	Directorate Expenditure Budgets - Drugs	67,531	51,075	53,446	(2,372)
0	(331)	0	(331)	Activity Changes/Service Dev./Cost Pressures/Inflation Reserves	12,062	7,188	0	7,188
0	(147)	0	(147)	Contingency Reserves	379	563	0	563
0	(1,855)	0	(1,855)	Cost Improvement Savings	(13,243)	(7,306)	0	(7,306)
0	4	0	4	BCPS Savings	(215)	528	0	528
545,229	**64,999**	**62,587**	**2,412**	**Total Expenditure**	**776,089**	**584,714**	**586,009**	**(1,295)**
28,292	**13,593**	**9,282**	**(4,311)**	**EBITDA Surplus/(Deficit)**	**82,867**	**51,631**	**48,097**	**(3,534)**
17,351	2,561	2,488	73	Depreciation	29,609	21,841	21,942	(101)
1,650	201	(1)	202	Interest Receivable / (Payable)	2,066	1,462	788	674
8,693	1,016	1,054	(38)	Other Charges	12,194	9,145	9,465	(320)
27,693	**3,778**	**3,541**	**237**	**Other non operating items**	**43,869**	**32,449**	**32,196**	**253**
599	**9,815**	**5,741**	**(4,073)**	**Net Surplus/(Deficit) before Adjustments**	**38,998**	**19,182**	**15,901**	**(3,282)**
341	(8,145)	(3,901)	4,244	Adjustments as per NHSI reported position	(38,998)	(22,799)	(23,392)	(593)
940	**1,669**	**1,840**	**171**	**Adjusted Financial Performance as NHSI**	**(0)**	**(3,617)**	**(7,491)**	**(3,874)**
(7)	*0*	*0*	*0*	*Adjustments as per ICS reported position*	*0*	*0*	*(22)*	*(22)*
933	***1,669***	***1,840***	***171***	***Adjusted Financial Performance as ICS***	***(0)***	***(3,617)***	***(7,513)***	***(3,896)***

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2022/23 Balance Sheet as at 31st December 2022

	December 2022 Plan	December 2022 Actual	November 2022 Actual	Movement in Month	March 2022 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	487,094	452,622	447,734	4,889	416,282
Intangible Assets	5,520	5,659	5,692	(34)	6,462
Other Investments/Financial Assets	161	161	161	0	161
Trade and Other Receivables Non Current	1,794	1,795	1,795	0	1,795
PFI Deferred Non Current Asset	4,877	4,877	4,877	0	4,877
TOTAL NON CURRENT ASSETS	**499,446**	**465,113**	**460,259**	**4,855**	**429,576**
CURRENT ASSETS					
Inventories	8,253	8,432	8,055	376	8,253
Trade and Other Receivables	33,111	46,427	45,068	1,359	33,801
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	48,547	74,834	83,402	(8,568)	84,918
TOTAL CURRENT ASSETS	**89,911**	**129,693**	**136,526**	**(6,833)**	**126,973**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**589,357**	**594,807**	**596,785**	**(1,978)**	**556,548**
CURRENT LIABLILITES					
Trade & Other Payables	(95,359)	(114,664)	(120,192)	5,527	(106,225)
Liabilities arising from PFIs / Finance Leases	(6,596)	(8,695)	(8,695)	0	(2,101)
Provisions for Liabilities and Charges	(7,428)	(4,416)	(5,004)	588	(7,427)
Other Financial Liabilities	(8,204)	(14,955)	(16,629)	1,674	(8,204)
TOTAL CURRENT LIABILITIES	**(117,587)**	**(142,730)**	**(150,519)**	**7,789**	**(123,957)**
NET CURRENT ASSETS / (LIABILITIES)	**(27,676)**	**(13,037)**	**(13,993)**	**956**	**3,016**
TOTAL ASSETS LESS CURRENT LIABILITIES	**471,770**	**452,076**	**446,265**	**5,811**	**432,592**
NON CURRENT LIABILITIES					
Trade & Other Payables	(86)	(60)	(64)	4	(86)
Other Liabilities	(14,500)	(7,297)	(7,224)	(73)	(5,475)
Provision for Liabilities and Charges	(2,308)	(2,308)	(2,308)	0	(2,308)
TOTAL NON CURRENT LIABILITIES	**(16,894)**	**(9,665)**	**(9,595)**	**(69)**	**(7,869)**
TOTAL ASSETS EMPLOYED	**454,876**	**442,412**	**436,670**	**5,741**	**424,723**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	298,028	288,441	288,441	0	286,653
Retained Earnings	61,790	58,913	53,171	5,741	43,012
Revaluation Reserve	96,137	96,137	96,137	0	96,137
Donated Asset Reserve	0	0	0	0	0
Financial assets at FV through OCI reserve	(1,269)	(1,269)	(1,269)	0	0
Other Reserves	190	190	190	0	(1,079)
TOTAL TAXPAYERS EQUITY	**454,876**	**442,412**	**436,670**	**5,741**	**424,723**

2022/23 Cash Flow as at 31st December 2022

	Dec-22	Dec-22	Dec-22	Dec-22
	Plan £'000	Actual £'000	Variance £'000	In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit)	**30,325**	**26,154**	(4,171)	6,794
Depreciation	22,267	21,940	(327)	2,487
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(22,815)	(655)	22,160	19,229
Interest Paid	(2,076)	(1,993)	83	(224)
Dividends Paid	(6,324)	(6,126)	198	0
Release of PFI /Deferred Credit	0	0	0	0
(Hncrease)/Decrease in Inventories	0	(178)	(178)	(376)
(Hncrease)/Decrease in Trade/Receivables	0	(12,824)	(12,824)	(1,359)
Increase/(Decrease) in Trade/Payables	(7,687)	11,861	19,548	(7,564)
Increase/(Decrease) in Trade/Payables Ann Leave Acc	0	(3,198)		(1,336)
Increase/(Decrease) in Other liabilities	0	6,751	6,751	(1,674)
Increase/(Decrease) in Provisions	0	(3,011)	(3,011)	(588)
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**13,690**	**38,722**	**25,032**	**15,389**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	18	1,205	1,187	225
Payment for Property, Plant and Equipment	(79,704)	(48,059)	31,645	(5,064)
Payment for Intangible Assets	0	(52)	(52)	(52)
Receipt of cash donations to purchase capital assets	23,346	655	(22,691)	(19,229)
Proceeds from sales of Tangible Assets	0	110	110	88
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(56,340)**	**(46,141)**	**10,199**	**(24,031)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(42,650)**	**(7,420)**	**35,230**	**(8,642)**
FINANCING				
New Public Dividend Capital Received	11,487	1,788	(9,699)	0
Capital Element of Finance Lease and PFI	(5,208)	(4,453)	755	74
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**6,279**	**(2,665)**	**(8,944)**	**74**
INCREASE/(DECREASE) IN CASH	**(36,371)**	**(10,084)**	**26,287**	**(8,568)**
CASH BALANCES				
Opening Balance at 1st April 2022	84,918	84,918	0	
Opening Balance at 1st December 2022				83,402
Closing Balance at 31 December 2022	48,547	74,834	26,287	74,834

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	February 2023
Title:	GI02, Financial Management Policy Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation
Action Requested:	Approve
For the attention of the Board	
Assure	• Regular review and updating undertaken of SO's and SFI's.
Advise	• Cross checked and updated to ensure compliance with Code of Governance for NHS Trusts (2023). • Minor amendments and updates made. • Confirmation of revised financial limits as per Performance and Finance Committee instruction.
Alert	• No new or changed risks identified as a result of this review.
Author + Contact Details:	Mark Greene - Tel 01902 481598 Email mailto: mark.greene2@nhs.net Keith Wilshere - Tel 01902 307999 x84294 Email mailto: keith.wilshere1@nhs.net
Links to Trust Strategic Objectives	1. Excel in the delivery of Care – We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement. 2. Support our Colleagues – We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations. 3. Improve the health of our Communities – We will positively contribute to the health and wellbeing of the communities we serve. 4. Effective Collaboration – We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.
Resource Implications:	None.
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.
Risks: BAF/ TRR	SR15
Risk: Appetite	No new or changed risks identified.
Public or Private:	Public
Other formal bodies involved:	
References	Code of governance for NHS provider trusts - https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/

NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	GI02, Financial Management Policy Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation
Item/paragraph 1.0	Proposed changes are as follows (most notable first): Review and updates to whole policy including alignment with Code of Governance (April 2023) and revision to Financial Authority Limits (January 2023) and revised structures including Group roles. This report refers to the two versions provided for reference. The first tracks all of the changes made and the second is a clean new version.

The Royal Wolverhampton NHS Trust

Policy Number

GI02

Title of Policy

Financial Management Policy

Contents

1.0 Policy Statement (Purpose / Objectives of the policy)

The attached appendices provide managers with the financial framework they are required to adhere to as part of sound management practice in accordance with NHS guidelines and legislation.

The purpose of the policy is to provide all managers with guidance on their responsibilities in relation to Tendering/Ordering/Contracting. To provide managers with a framework and guidance to aid budget management.

To ensure all managers are equipped with the information they require to ensure sound financial management at all levels within the organisation and to ensure sound financial control is delivered in accordance with NHS requirements.

All aspects of this document regarding potential Conflicts of Interest should refer first to the Conflicts of Interest Policy (OP109). In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

Not applicable.

3.0 Accountabilities

These are responsibilities of the Trusts Audit Committee who are accountable for ensuring that elements of this policy are included within the Trusts internal audit programme.

4.0 Policy Detail

Appendix 1 – Standing Orders

Appendix 2 – Standing Financial Instructions

Appendix 3 – Scheme of Reservation and Delegation

Appendix 4 – Budget Management Principles and Guidance

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	N/A

6.0 Equality Impact Assessment

This policy has been assessed as ~~not having~~not having an adverse impact~~.~~ of any one particular group of stakeholders

7.0 Maintenance

The policy will be reviewed by Chief Financial Officer annually to ensure any new guidance and any changes included as required and there must be a formal review by the Board at least 3 yearly.

8.0 Communication and Training

This policy will be posted on the Trust Intranet and all staff will receive notification of changes through local directorate/department governance meetings and through inclusion of the key areas of change within Trust Talk.

9.0 Audit Process

This is led by the Trusts Audit Committee who are accountable for ensuring that elements of this policy are included within the Trusts internal audit programme.

Operation of the standing orders is monitored by the Company Secretary at each Board Meeting and by the relevant Chair at each Board Committee.

The Standing Financial Instructions are constantly monitored by the Finance Team and is subject to a variety of regular audits and checks throughout the financial year.

10.0 References - Legal, professional or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

Part A - Document Control

Policy number and Policy version: GI02 V7.06.2	**Policy Title:** **Financial Management**	**Status:** Final		**Author:** **Deputy Chief Financial Officer** **Chief Officer Sponsor:** **Chief Financial Officer**
Version / Amendment History	Version	Date	Author	Reason
	V1	June 2011	Financial Controller	Implementation of Financial Management Policy
	V2	June 2013	Financial Controller	Minimal changes
	V3	July 2014	Financial Controller	Minimal changes
	V4	April 2019	Head of Financial Control and Assurance	Review of policy including Appendices with updates to all appendices to ensure relevant
	V5	May 2019	Head of Financial Control and Assurance Company Secretary	Inclusion of suggested amendments following initial presentation to Trust Board in April 2019.
	V5.1	Nov. 2020	Head of Financial Control and Assurance	Extension approved.
	V5.2	Nov. 2020	Head of Financial Control and Assurance	Extension approved.
	V5.3	June 2021	Head of Financial Control and Assurance	Updates to Appendix 1, Standing Orders and Appendix 3, Scheme of Reservation and Delegation – Approved via Trust Board June 2021

	5.4	Sept. 2021	Deputy Chief Financial Officer	Extension approved.
	6.0	January 2022	Deputy Chief Financial Officer	Full review of policy and Appendices.
	6.1	April 2022	Deputy Chief Financial Officer	Minor update to Appendix 4 (hyperlink page 23)
	6.2	January 2023	Deputy Chief Financial Officer	Extension approved.
	7.0	February 2023	Deputy Chief Financial Officer	Review and updates to whole policy including alignment with Code of Governance (April 2023) and revision to Financial Authority Limits (January 2023) and revised structures including Group roles.

Intended Recipients: All Trust staff	
Consultation Group / Role Titles and Date: Company Secretary; Finance and Performance Committee, Audit Committee, Chief Financial Officer, Deputy Chief Financial Officer.	
Name and date of Trust level group where reviewed	Audit Committee – February 2023~~December 2021~~ Trust Policy Group – March 2023~~January 2022~~ ~~Trust Policy Group – April 2022 – V6.1 – Virtual Approval~~ ~~Chief Officer Sponsor approved extension to Policy – January 2023 – Version 6.2~~
Name and date of final approval committee	Trust Board – February 2023~~2~~
Date of Policy issue	February~~January~~ 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	February 2024~~3~~ (Annual review)
Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees and dissemination via Intranet.	
Publishing Requirements: Can this document be published on the Trust's public page: **No** If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.	
To be read in conjunction with: GI02, Appendix 1 - Standing Orders	

GI02, Appendix 3 - Scheme of Delegation OP109, Conflicts of Interest Policy GP02, Anti-Fraud and Anti-Bribery Policy	
Initial Equality Impact Assessment (all policies): Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator8904	
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board
Document summary/key issues covered. The attached appendices provide managers with the financial framework they are required to adhere to as part of sound management practice in accordance with NHS guidelines and legislation.	
Key words for intranet searching purposes	Financial Management Standing Orders Standing Financial Instructions Budget Management
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**Yes (delete as appropriate)** If Yes include the following sentence and relevant information in the Intended Recipients section above – In the event that this is policy is made available to the public the following information should be redacted:

Part B **Ratification Assurance Statement**

Name of document: GI02, Financial Management Policy

Name of author: Mark Greene Job Title: Deputy Chief Financial Officer

I, Mark Greene the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.

- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.

- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01).

- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.

- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.

- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.

- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author:

Date: November 2021

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

~~IMPLEMENTATION PLAN~~

~~The Standing Orders and Standing Financial Instructions are in constant use and reference throughout the Organisation. Therefore, there is no specific implementation plan other than that the Trust must adhere to its Standing Orders and Standing Financial Instructions as part of enacting its establishment order.~~

The Royal Wolverhampton NHS Trust

Standing orders – 2022 review and revision

Standing Orders	**Type: Standing orders** **Status: Public**

Developed in response to:	Governance Requirement, Code of Governance for NHS Provider Trusts (2023)
Contributes to CQC Standard number:	17

Consulted With	**Post/Committee/Group**	**Date**
Audit Committee		December 2022
Audit Committee		December 2021

Version Number	V4
Issuing Directorate	CEO Office
Ratified by:	Board of Directors
Ratified on:	1 February 2023 (Trust Board)
Implementation Date	February 2023
Next Review Date	January 2024
Author/Contact for Information	Keith Wilshere / JamesGreen & Michelle Collins
Policy to be followed by (target staff)	All Trust staff
Distribution Method	TrustNet, Website
Related Trust Policies (to be read in conjunction with)	Standing Financial Instructions Scheme of Reservation & Delegation Scheme of Responsibility, Authority & Decision

Document Review History

Revision history – v1.0		
2010	Reviewed at Trust Board 12/04/2010	
2013	Reviewed at Trust Board 24/06/2013	
2015	Reviewed at Trust Board 26/01/2015	
Revision history – v1.1		
2019	Reviewed at Trust Board 04/03/2019	Revisions as listed below.
Revision history – v2.0		
2021	Reviewed at Trust Board June 2021	Minor update/revision.
Revision history – v3.0		
2021	Reviewed at Trust Board February 2022	Review and minor updates as part of full review to overall policy
Revision history – v4.0		
2022	Reviewed at Trust Board February 2023	Review and updates to whole policy including alignment with Code of Governance (April 2023) and revision to Financial Authority Limits (January 2023) and revised structures including Group roles.

Contents **Page**

1. Foreword to Standing Orders

1.1 NHS Trusts are required by law to make **Standing Orders (SOs**), which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

1.2 These Standing Orders and associated documents are extremely important. 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.

1.3 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:

(1) Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
(2) Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
(3) Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.
(4) Additional documents, which form part of these "extended" Standing Orders are:
(5) Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
(6) Schedule of Decisions Reserved to the Board of the Trust
(7) Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

1.4 These extended Standing Orders set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values. As well as protecting the Trust's interests, they will also protect staff from any possible accusation of having acted less than properly.

1.5 All executive and Non-Executive Directors and senior staff are expected 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.

1.6 This revision (v4) includes reference to and compliance with the NHS Code of Governance for NHS Provider Trusts (PR2076, October 2022, effective from April 2023). The revised Code of Governance includes expectations in line with the UK Corporate Governance Code (2018), the NHS Long-term Plan, the Health and Care Act 2022 and the requirements to participate constructively as part of the wider integrated care system (ICS) and the Integrated Care Board (ICB) as well as other system and provider organisations at place (OneWolverhampton) and as part of a system wide provider collaborative.

SECTION A

2. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

2.1 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 Chief Executive Officer].

2.2 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 the Health & Social Care Act, 2012) UK Corporate Governance Code (2018), Health and Social Care Act (2022) or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and in addition:

(1) **"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 Chief Executive Officer.

(2) **"Trust"** means the Royal Wolverhampton NHS Trust.
(2a) **"Group"** means the partnership arrangements between the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.
(2b) **"Joint Committee"** means the Joint Committee (previously Committees in Common) formed of the Boards of the two organisations in the Group (see above).

(3) **"Board"** means the Chair, executive and non-executive members of the Trust collectively as a body.

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

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

(6) **"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 Dpeuty-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

(7) **"Chief Executive Officer"** means the chief officer of the Trust.

(8) **"Committee"** means a committee of the Board or Group (a sub-committee) created and appointed by the Trust.

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

(10) **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

(11) **"Chief Financial Officer"** means the Chief Financial Officer of the Trust.

(12) **"Funds held on trust"** shall mean those funds which the Trust holds on 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.

(13) **"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.

(14) **“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.

(15) **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations [SI 1990 / 2024] and subsequent amendments.

(16) **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders.

(17) **"Non-executive member"** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1[3] of the Membership, Procedure and Administration Arrangements Regulations. Non-executive members appointed by NHS England are regarded as voting Non-executives. Non-executive members appointed by the Trust are regarded as Associate Non-executives.

(18) **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

(19) **"Executive member**" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1[3] [i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member].

(20) **"SFIs"** means Standing Financial Instructions.

(21) **"SOs"** means Standing Orders.

(22) **"Deputy-Chair"** means the non-executive member appointed by the Board to take on the Chair’s duties if the Chair is absent for any reason.

SECTION B STANDING ORDERS

3. Introduction

3.1 Statutory Framework

The Royal Wolverhampton NHS Trust [the Trust] is a statutory body which came into existence on 1 April 1994 under The NHS Trust [Establishment] Order 1993 No 2574, [the Establishment Order]. This was amended under a statutory instrument 2012 No. 1837, NATIONAL HEALTH SERVICE, ENGLAND, The
Royal
Wolverhampton National Health Service Trust (Establishment) Amendment Order 2012 Amendment to Article 1 item 3.

3.2 Name of the Trust

The trust is to be called The Royal Wolverhampton National Health Service Trust instead of The Royal Wolverhampton Hospital National Health Service Trust.
Accordingly in article 1(2) of the Establishment Order in the definition of "the Trust", and in article 2 of the Establishment Order (establishment of the Trust), omit "Hospital".

(1) The principal place of business of the Trust is New Cross Hospital, Wolverhampton.
(2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 [NHS Act 1977], the National Health Service and Community Care Act 1990 [NHS & CC Act 1990] as amended by the Health Authorities Act 1995 and the Health Act 1999.
(3) The functions of the Trust are conferred by this legislation.
(4) 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.
(5) The Code of Governance for NHS Provider Trusts (2022, implementation from April 2023) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions [SFIs] setting out the responsibilities of individuals, and a Scheme of Delgation (SoD) summarising the delegated responsibilities.
(6) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

3.3 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.
(2) The Code of Governance for NHS Provider Trusts (2023) requires that, inter alia, Boards draw up a schedule of decisions reserved to the 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 Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness (Nolan Principles) in the NHS sets out the requirements for public access to information on the NHS.

3.4 Delegation of Powers

The Trust has powers to delegate and make arrangements 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 the Trust has powers to "make arrangements for the exercise, on behalf of the Trust, of any of its 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 may direct". Delegated Powers are covered in a separate document [Reservation of Powers to the Board and Delegation of Powers].

3.5 Integrated Governance

Trust Boards continue to develop integrated governance to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

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

4.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chair of the Trust [Appointed by the NHS England (NHSE);
(2) Up to 6 non-executive members [appointed by the NHS England];
(3) Up to 5 executive members [but not exceeding the number of non-executive members] including:
- the Chief Executive Officer (Group Chief Executive Officer);
- the Chief Finance Officer (Group Chief Finance Officer);
- a medical or dental practitioner (Chief Medical Officer);
- a registered nurse or midwife (Group Chief Nursing Officer).
- a chief officer nominated by the Chief Executive Officer

(4) Voting Executive Director Members are:
- Group Chief Finance Officer (and Deputy CEO),
- Chief Medical Officer,
- Group Chief Nursing Officer,
- Chief Operating Officer,
- Group Chief Executive Officer.

(5) Non-voting Executive Director Members are:
- Group Chief People Officer,
- Group Chief Strategy Officer,
- Deputy Chief Executive Officer (if none of the 5 above in [4])

(6) Non-voting Associate Non-executive Director Members
At the discretion of the Chair and Trust Board, the Trust may appoint additional Associate Non-executive Directors through the same process and to the same

standards as a voting NED's and for specified term periods. Associates are not members of the Remuneration Committee.

(7) Non-voting Group Chief Officer, Chief Officer, Group Director and Director Members (in attendance at Trust Board).
At the discretion of the Chief Executive Officer, the Trust may appoint additional non-voting Directors who will attend the Trust Board as defined by the Chief Executive Officer and in agreement with the Chair. These attendees are not included in relation to Quoracy.

(8) Non-voting Director Members (not in attendance at Trust Board).
At the discretion of the Chief Executive Officer, the Trust may appoint additional non-voting Directors who will not attend the Trust Board.

(9) Interim Appointments Voting Officer Responsibilities.
In the case of the Chief Executive Officer appointing an interim voting Chief Officer they are to be considered for all purposes in the Standing Orders as having the same responsibilities and role as a permanent appointee. .
Shared Appointments / Job Shares:

(10) Where the voting Chief Officer role is shared, any vote cast must reflect the consensus view of those sharing the post. In the case of a divergence of view between those sharing the post no vote will be cast and/or the record will be that the Chief Officer concerned abstained.

(11) Taking into account the above flexibilities, the overall balance of the Board between Executive and Non-executive attendees should be maintained as far as possible e.g. a balance of Officers and Non-executives with the Chair as ensuring that Non-Executive Directors are the majority of Board attendees.

(12) The Chief Executive Officer in agreement with the Chair may identify and appoint special advisors to the Board to provide expert opinion and insight to support the Board in making informed decisions. For the purposes of the Standing Orders special advisors are expected to be recruited to the same standards as an Associate Non-Executive with the same governance responsibilities. Their renumeration will be as per an Associate Non-Executive unless recommended and agreed otherwise by the Chief Executive Officer and approved by the Remuneration Committee. Such appointees will be known or be referred to as Special Advisor to the Board.

4.2 Appointment of Chair and Members of the Trust

Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chair is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chair and members is set out in the Membership, Procedure and Administration Arrangements Regulations.

4.3 Terms of Office of the Chair and Members

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 Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

4.4 Appointment and Powers of Deputy-Chair

(1) Subject to Standing Order 4.4 [2] below, the Chair and members of the Trust may appoint one of their number, who is not also an executive member, to be Deputy-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him /her.

(2) Any member so appointed may at any time resign from the office of Vice-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 4.4 [1].

(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 duties; 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.

4.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2[4][a] of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 4.5.2 as one person.

(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;

[b] if both are present at a meeting they should cast one vote if they agree;

[c] in the case of 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

[e] 5.1.1 Quorum.

4.6 Role of Members

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

4.7 Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation. These are referred to as (Group) Chief Officers (voting), (Group) Chief Officers (non-voting) and (Group) Directors (where defined by the Chief Executive Officer and agreed by the Chair).

(1) Chief Executive Officer

The Chief Executive Officer shall be responsible for the overall performance of the executive functions of the Trust. They are the **Accountable/Accounting 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.

(2) Chief Financial Officer

The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive Officer for ensuring the discharge of obligations under

relevant Financial Directions.

(3) Non-Executive Members

The non-executive members shall not be 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.

(4) Chair

[a] The Chair shall be responsible for the operation of the Board and shall 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.

[b] The Chair shall liaise with the NHS Appointments Commission over the appointment of 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.

[c] The Chair shall work in close harmony with the Chief Executive Officer 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.

[d] The provisions for the division of responsibilities and the role of the Chair, senior independent director, Non-Executive Directors, Board appointments and Conflicts of Interests is set out in further detail in the Code of Governance for NHS Provider Trusts (2023).

4.8 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(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 No. 5.17.3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State. The Code of Governance for NHS Provider Trusts recommends an externally facilitated developmental review using the CQC Well-Led Framework every 3-5 years, according to circumstance. Any review must be identified in the annual report and any potential conflicts with those carrying out the report or any Board members declared as per Conflicts of Interest Policy.

4.9 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.

4.10 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.

The lead roles for Non-Executive Directors and Executive Directors are set out in the lead roles descriptions held by the (Group) Company Secretary.

Retained Lead Roles:
Maternity Board Safety Champion (NED)
Wellbeing Guardian (NED)
Freedom to Speak Up Guardian (NED)
Doctors Disciplinary Lead (NED)
Security Management Lead (NED)

Lead Sponsor Roles:
Senior Independent Director (SID) (NED)
Deputy to the Trust Board Chair (NED)
Remuneration Committee Chair (NED)
Joint Committee Deputy Chair (NED)

Other Lead Roles Identified and Agreed by the Trust:
Green Plan Lead (NED)
Mental Health Lead (NED)

5. Meetings of the Trust

5.1 Calling meetings

(1) Ordinary public meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.
(2) The Chair of the Trust may call a meeting of the Board at any time.
(3) One third or more members of the Board may requisition a meeting in writing. 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.

5.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member via the authorised electronic Board Papers system (iBabs Board Papers), so as to be available to members at least three working days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.
(2) In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.
(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 5.6.
(4) A member desiring a matter to be included on an agenda shall make his / her request in writing to the Chair at least sufficient advance (no less than 4 working 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

4 working days before a meeting may be included on the agenda at the discretion of the Chair.

(5) Before each public meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three working days before the meeting, [required by the Public Bodies [Admission to Meetings] Act 1960 Section 1 [4] [a]] and published on the Trust website or equivalent

5.3 Agenda and Supporting Papers

The Agenda will be available to members at least 3 working days before the meeting together with supporting papers, whenever possible, shall accompany the agenda but will certainly be available no later than 3 working days before the meeting, save in emergency.

5.4 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.

5.5 Notice of Motion

(1) Subject to the provisions of Standing Orders 5.2 to 5.8 inclusive a member of the Board wishing to move a motion shall send a written notice to the Chief Executive Officer who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least l0 working days before the meeting. The Chief Executive Officer 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.

5.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 5.6 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.

5.7 Motions: Procedure at and during a meeting

(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.

(2) Contents of motions

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

- the receipt of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;

- that the Board adjourns;
- that the question be now put.

(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 shall not have the effect of negating the motion before the Board.
- If there are a number of 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.

(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 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.

(5) Withdrawing a motion

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

(6) Motions once under debate

When a motion is under debate, no motion may be moved other than: an amendment to the motion;

- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member / director be not further heard;
- a motion under Section I [2] or Section I [8] of the Public Bodies [Admissions to Meetings] Act l960 resolving to exclude the public, including the press [see Standing Order 5.17].

(7) 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.

(8) 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.

5.8 Motion to Rescind a Resolution

(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. 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 Officer for recommendation.

(2) When any such motion has been dealt with by the Trust Board it shall not be competent for any director / 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 Officer.

5.9 Chair of meeting

(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 [if the Board has appointed one], if present, shall preside.

(2) If the Chair and Vice-Chair are absent, such member [who is not also an executive member of the Trust] as the members present shall choose shall preside.

5.10 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy, and regularity [including procedure on handling motions] and on interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

5.11 Quorum

(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 member of the Trust and one member who is not] is present.

(2) An officer in attendance for an executive member, but without formal acting up status may not count towards the quorum.

(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.9.1 to 9.4 inclusive] 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.

5.12 Voting

(1) Save as provided in Standing Orders 5.l3 - Suspension of Standing Orders and 5.l4 - 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 voting on the question. In the case of an equal vote, the person presiding [i.e.: the Chair of the meeting] shall have a second, and casting vote.

(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.

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

(4) If a member so requests, his / her vote shall be recorded by name.

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

(6) A manager who has been formally appointed to act up for an executive member during a period of incapacity or temporarily to fill a vacancy shall be entitled to exercise the voting rights of the executive member.

(7) A manager attending the Trust Board meeting to represent an executive member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive member. An officer's status when attending a meeting shall be recorded in the minutes.

(8) For the voting rules relating to joint members see Standing Order 4.5.1 and 4.5.2.

5.13 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum [SO 5.11], 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 member of the Trust and one member who is not] 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.

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

(4) The Audit Committee shall review every decision to suspend Standing Orders.

5.14 Variation and amendment of Standing Orders

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

- upon a notice of motion under Standing Order 5.5;
- upon a recommendation of the Chair or Chief Executive Officer included on the agenda for the meeting;
- 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 members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

5.15 Record of Attendance

The names of the Chair and Directors / members present at the meeting shall be recorded.

5.16 Minutes

(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.

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

5.17 Admission of public and the press

The public and press representatives may attend the meeting of the Board held in public. It is important to note the difference between a Board meeting held in public and a public meeting. In this case attendees not members of the Board are expected to observe only and if they have any questions or contributions relating to the business to be transacted that they provide these in advance to the Group Company Secretary as per the requirements published with the Board papers.

The Code of Governance for NHS Provider Trusts provides additional principles, guidance, and details in respect of the leadership of the Board and the role of the Chair and these Standing Orders should be read in conjunction.

(1) Admission and exclusion on grounds of confidentiality of business to be transacted

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

(2) General disturbances

The Chair [or Vice-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 Board to complete its business without the presence of the public'. Section 1[8] Public Bodies [Admissions to Meetings] Act l960.

(3) Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in [i] and [ii] 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.

(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.

Where a meeting is conducted in public and a recording is made this will only be referred to for the production of the minutes. It may be placed in the public domain subject to the approval of the Board.

Otherwise, recordings are only permitted for reference in the creation of the draft minutes. Once the minutes are approved the recording must be deleted.

(5) **Virtual Meetings**

Where circumstances do not allow for attendees in person, participation and observation to the public section will be made available on application to the Company Secretary. Virtual attendance to the confidential section will be by application to the Company Secretary and agreement of the Chair.

Virtual meetings will be maintained whilst restrictions prevent face-to-face meetings in person until such time as the restrictions are lifted. Virtual attendance will continue to be made available thereafter by application.

5.18 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 Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

6. Appointment of Committees and Sub-Committees

6.1 Appointment of Committees

(1) Subject to such directions as may be given by the Secretary of State for Health, the Board may appoint committees of the Trust.

(2) The Trust shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees.

6.2 Joint Committees

(1) Joint committees may be appointed by the Trust by joining together with one or more health service bodies consisting, 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.

(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 or the Trust or other health bodies in question, appoint sub-committees/groups 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 the Trust or health bodies in question or the committee of the Trust or health bodies in question.

(3) The Board can under this Standing Order and in line with the directions of the Secretary of State, delegate specific hours and responsibility to the joint committee on behalf of the Sovereign Organisation. Such delegation is not in perpetuity and can be ended or withdrawn by the Board at any time.

(4) The Code of Governance for NHS Provider Trusts (2023) sets out further principles and expectations regarding partnerships, collaborations, joint committees and cooperation with other NHS Organisations including the Integrated Care System(s) and Place Based Partnerships.

6.3 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 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 committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. There is no requirement to hold meetings of committees established by the Trust in public.

6.4 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. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly and specifically authorized by the Board.

6.6 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. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and / or expenses in accordance where appropriate with national guidance.

6.7 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, 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.

6.8 Committees established by the Trust Board

The committees, sub-committees, and joint committees established by the

Board are:

(1) Audit Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Code of Governance, and the Higgs report, an Audit Committee will be established and constituted to provide the Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

(2) Remuneration (and Terms of Service) Committee

In line with the requirements of the NHS Code of Governance, and the Higgs report, a Remuneration Committee will be established and constituted.

The purpose of the Committee will be to advise the Board about appropriate remuneration and terms of service for the Chief Executive Officer and other Executive Directors.

In line with the Code of Governance for NHS Provider Trusts (2023) based on the Financial Reporting Council (FRC) UK Corporate Governance Code (2018) (Provision 32) and the FRC Board Effectiveness Guidance Provisions (2018) the Committee should have a minimum membership of 3 voting NED's, the Chair should not Chair the Committee, and the Committee Chair should have at least 12 months prior experience as a member of the Remuneration Committee.

The Committee may ask the Senior Independent Director (SID) or the Chair of Audit Committee to not be part of the Remuneration Committee so as to be available in their independent role should the need arise.

The Annual Report should describe the work of the Committee including descriptions of:

- The process for appointments
- Its approach to succession planning
- How both of the above support diversity
- How the Board has been evaluated including any external input and resulting outcomes and action taken including any that will influence the Board composition
- How it enacts the Trust policy on diversity and inclusion including all characteristics
- A breakdown of the ethnic diversity of the Board and senior managers as per the NHS Workforce Race Equality Standard (WRES) alongside the ethnic diversity of the Trust workforce and local communities served
- The gender balance of senior management and their direct reports

(1) Charity Committee

In line with its role as a corporate trustee for charitable funds held in trust, the Board will establish a Charity Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

(2) Other Committees

The Board may also establish such other committees as required to discharge the Trust's responsibilities. These are:

- Quality Governance Assurance Committee of the Board
- Finance and Performance Committee of the Board
- People and Organisational Development Committee of the Board
- Joint Committee

Trust Management Committee is the senior operational decision-making committee reporting via the executive group to the Board.

2. Arrangements for the Exercise of Trust Functions by Delegation

2.1 Delegation of Functions to Committees, Officers or other bodies

(1) Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 7.1, 7.3 and 7.5, or by an officer of the Trust, or by another body as defined in Standing Order 7.4 or 7.5 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

(2) Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trust [Membership, Procedure and Administration Arrangements] Regulations 2000 the functions of the Trust may also be carried out in the following ways:

- by another Trust;
- jointly with any one or more of the following: NHS trusts or ICS;
- by arrangement with the appropriate Trust or ICS, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(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. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

2.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders [see Standing Order 7.2] may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair [or in his / her absence the Vice- Chair]. The exercise of such powers by the Chief Executive Officer and Chair shall be reported to the next formal meeting of the Board in public session for formal ratification.

2.3 Delegation to Committees

(1) The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint- committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board.

(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.

(3) In line with the Code of Governance for NHS Provider Trusts (2023) the terms of reference for Committees shall be approved at Public Board Meeting and thereby made available to the public.

2.4 Delegation to Officers

(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 shall be exercised on behalf of the Trust by the Chief Executive Officer. The Chief Executive Officer shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

(2) The Chief Executive Officer shall prepare a Scheme of Delegation identifying his / her proposals which shall be considered and approved by the Board. The Chief Executive Officer may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

(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 Chief Financial Officer shall be accountable to the Chief Executive Officer for operational matters.

2.5 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.

2.6 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 Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive Officer as soon as possible.

3. Overlap with other Trust Strategy and Policy Statements / Procedures, Regulations and the Standing Financial Instructions

3.1 Strategy and Policy statements: general principles

(1) The Board will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by the Trust. Any decision to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

- In line with the Trust Policy for the creation of Policy (OP01), the Trust Board sets out the Strategic Direction of and for the Trust. All component Strategic Documents must be in accordance with and aligned to the Trust Strategic Objectives.
- The Trust Board is the approving body for all Trust Strategy documents.
- The approval of Trust-wide Policy documents is delegated to the Trust Management Committee.

3.2 Standing Financial Instructions

Standing Financial Instructions adopted by the Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

3.3 Specific guidance

Notwithstanding the application of SO 8.2 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:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.
- The NHS Code of Governance for NHS Provider Trusts (2023)

4. Duties and Obligations of Board Members / Directors and Senior Managers under these Standing Orders

4.1 Declaration of Interests

Requirements for Declaring Interests and applicability to Board Members

(1) The NHS Code of Governance for NHS Provider Trusts (2023) requires Board members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment. The Code of Governance provides further detail in section B – Conflicts of Interest and appointments on those matters considered to potentially impair a non-executive directors independence and that should therefore be considered as part of the recruitment process, must be declared on the public register, and must be reconsidered and reviewed at appraisal.

(2) Interests which are relevant and material

Interests that should be regarded as "relevant and material" are:

- Directorships, including non-executive directorships held in private companies or PLCs [with the exception of those of dormant companies];
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; Majority or controlling share-holdings in organisations likely or possibly seeking to do business with the NHS;
- A position of authority in a charity or voluntary organisation in the field of health and social care;
- Any connection with a voluntary or other organisation contracting for NHS services;
- Research funding / grants that may be received by an individual or his / her department;
- Interests in pooled funds that are under separate management.
- An employee of the organisation within the last two years;
- Has had or been part of a material business relationship with the Trust directly or indirectly;
- Has received remuneration other than their directors fee, of participates in any performance related pay scheme or is a member of the Trust's pension scheme;
- Has close family ties with any of the Trust's advisors, directors or senior

employees;

- Holds cross directorships or has significant links with other directors for involvement with other companies or bodies – in any such cases written permission must be sought and gained from the Chair (non-executive directors) or the CEO (executive directors and senior staff) before taking up any of these potentially conflicting roles.
- Has served on the Trust Board for more than six years from the date of their first appointment – Please note Chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval;
- The Code of Governance specifies Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment and subject to the proviso above or anything in access of six years. This can in special cases be extended beyond nine years for a limited time only where agreed with NHS England.
- For these purposes a Non-Executive Director becoming Chair will reset the start of their term.
- Is an appointed representative of the Trust's university medical or dental school;

Where any of these or other relevant circumstances apply, and the Board of Directors none the less considers a Non-Executive Director to be independent, it has to be able to explain clearly why. (Please see relevant section of Code of Governance).

(3) Any member of the 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 him / her [as defined in Standing Order 9.1 below and elsewhere] has any pecuniary interest, direct or indirect, the Board member shall declare his / her interest by giving notice in writing of such fact to the Trust as soon as practicable.

(4) Advice on Interests
If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair or the Chief Executive Officer of the Trust and with the advice of the Group Company Secretary

(5) Financial Reporting Standard No 8 [issued by the Accounting Standards Board] 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.

(6) Recording of Interests in Board minutes
At the time Board members' interests are declared, they should be recorded in the Board minutes.

(7) Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

(8) 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.

(9) Conflicts of interest which arise during the course of a meeting
During the course of a Board meeting, if a conflict of interest is established,

the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. [See overlap with SO 3.3.2]

(10) Any potential or actual Conflicts of Interest must be dealt with in line with the Trust Conflicts of Interest Policy OP109 and the Trust Anti-Fraud and Anti-Bribery Policy GP02.

4.2 Register of Interests

The Group Company Secretary on behalf of the Chief Executive Officer 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 9.3] which have been declared by both executive and non-executive Board members.

(1) 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.

(2) The Register will be available to the public and the Chief Executive Officer will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

4.3 Pecuniary Interest

(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:

(2) "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];

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

(4) "Pecuniary interest"

(5) 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:-

- 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
- they are a partner, 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.

(6) Exception to Pecuniary interests
A person shall not be regarded as having a pecuniary interest in any contract if:-

- neither they or 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
- any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him / her in relation to considering or voting on that contract, or
- 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 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 9.1.

(7) Exclusion in proceedings of the Trust Board

- Subject to the following provisions of this Standing Order, if the Chair or a member of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the 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.
- The Secretary of State 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 him / her in the interests of the National Health Service that the disability should be removed. [See SO
- on the 'Waiver' which has been approved by the Secretary of State for Health].
- The Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest is under consideration.
- Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 [pay and allowances] shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- 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.

(8) Waiver of Standing Orders made by the Secretary of State for Health

(9) Power of the Secretary of State to make waivers

- Under regulation 11[2] of the NHS [Membership and Procedure Regulations SI 1999 / 2024 ["the Regulations"], there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 [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 they have a pecuniary interest] is removed. A waiver has been agreed in line with sub-sections [2] to [4] below.
- Definition of 'Chair' for the purpose of interpreting this waiver
- For the purposes of paragraph 9.3.3[3] [below], the "relevant chair" is -

i. at a meeting of the Trust, the Chair of that Trust;
ii. at a meeting of a Committee -
iii. in a case where the member in question is the Chair of that Committee, the Chair of the Trust;
iv. in the case of any other member, the Chair of that Committee.

(10) 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 -
   1. services under the National Health Service Act 1977; or
   2. services in connection with a pilot scheme under the National Health Service Act 1997; for the benefit of persons for whom the Trust is responsible.

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

i. 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;

ii. 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:–
   1. are members of the same profession as the member in question,
   2. are providing or performing, or assisting in the provision or performance of, such of those services as they provide or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

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

i. The removal is subject to the following conditions:

ii. the member must disclose his / her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

iii. the relevant Chair must consult the Chief Executive Officer before making a declaration in relation to the member in question pursuant to paragraph 11.3.3 [2] [b] above, except where that member is the Chief Executive Officer;

iv. in the case of a meeting of the Trust:
   1. the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
   2. may not vote on any question with respect to it.

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

4.4 Standards of Business Conduct

(1) Trust Policy and National Guidance
All Trust staff and members must comply with the national guidance contained in HSG[93]5 on 'Standards of Business Conduct for NHS Staff'

and with any Trust policy derived therefrom and the subsequent requirements of the Code of Conduct in the NHS published by the Department of Health and Social Care in July 2004 and The Code of Governance (2023)y and the Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England issued by the Professional Standards Authority in November 2013, and the subsequent additional guidance published alongside the Code of Governance for NHS Provider Trusts (2023)as summarised in Trust Policy GP01 Corporate Governance – Principles of Public Life.

(2) Interest of Officers in Contracts

i. 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 him / her [as defined in SO 9.4.2.1] has any pecuniary interest, direct or indirect, the officer shall declare his / her interest by giving notice in writing of such fact to the Chief Executive Officer as soon as practicable.

ii. An officer should also declare to the Chief Executive Officer any other employment or business or other relationship of his / her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

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

iv. Senior Officers subject to very senior manager (VSM) after 2022 contracted terms and conditions must seek and gain in writing the CEO's permission before taking up a new declarable interest (as defined in these standing orders and Trust policy OP109).

(3) Canvassing of and Recommendations by Members in Relation to Appointments

i. 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.

i. 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 or character for submission to the Trust.

(4) Relatives of Members or Officers

i. 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.

i. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him / her liable to instant dismissal.

ii. The Chair and every member and officer of the Trust shall disclose to the Board any relationship between himself / herself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive Officer to report to the Board any such disclosure made.

iv. 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.

v. 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' [SO 9.3.7] shall apply.

4.5 Custody of Seal, Sealing of Documents and Signature of Documents

4.6 Custody of Seal

The common seal of the Trust shall be kept in a secure place by the Chief Executive Officer or a manager nominated by him / her – currently the Trust Chief Financial Officer.

4.7 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Chair and an executive member and shall be attested by them.

4.8 Register of Sealing

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

4.9 Signature of documents

(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 Officer or any Executive Director.

(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. sale / purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed].

4.10 Issuing Standing Orders to Directors and Officers

The Chief Executive Officer shall ensure that a copy of the Standing Orders is provided to each Director of the Trust and to appropriate officers. All new appointees should be notified of, and understand, their responsibilities under both Standing Orders and Standing Financial Instructions.

5. Partnership Agreements

The Trust has established a process for the approval of Partnership Agreements (see OP09, Corporate Policy and Framework for the Governance of Partnership Agreements) The Board shall be considered the approving body for any proposed partnership agreements. Any agreements approved will be placed on the Partnership Agreements Register by the Company Secretary. The Trust Board will ensure that the register is reviewed at least annually.

References:

Code of governance for NHS provider trusts - https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/

Appendix 1:

For Standing Orders.
Overview of those at Trust Board.

Membership & expected attendance	Required roles	Required other roles (**Includes)
Trust Board Executive Members (Voting and non-voting) required to be in attendance	• (Group) Chair • (Group) Chief Executive Officer • Voting Non-Executive Directors (6 excluding Chair) • Voting Executive Directors (4 + CEO)*	*Voting Executive Directors comprising: • Chief Operating Officer • Chief Medical Officer • Group Chief Finance Officer • Group Chief Nursing Officer Non-Voting Executive Directors comprising: • Group Chief Medical Officer • Group Chief People Officer • Group Chief Strategy Officer
Board Director Member (non-voting) required to be in attendance	• Associate Non-executive Directors • Group Company Secretary	**Comprising: • Director of Finance • Director of Midwifery • Director of Nursing • Director of People • Group Director of Assurance • Group Director of Communications and Stakeholder Engagement • Group Director of Place
Directors and others required to be in attendance for specific items		Potentially including (but not exclusive): • Associate Chief Technology Officer • Group Director of Research • Group Director of Education • Group Head of Safeguarding • Group Director of Estates Development • Director of Infection Prevention and Control (DIPC) • Clinical Director of Pharmacy & Medicines Optimisation • Director of Infection Prevention • Freedom to Speak Up Guardian
Others as required/appropriate		

The Royal Wolverhampton NHS Trust

THE ROYAL WOLVERHAMPTON NHS TRUST

STANDING FINANCIAL INSTRUCTIONS

February 2022

Document Control

Name: Standing Financial Instructions	**Version:** V8 December 2022		**Status:** Final	**Author: Head of Financial Governance and Transactions** **Director Sponsor: Chief Financial Officer**
Version / Amendment History	Version	Date	Author	Reason
	V1	December 2010	Deputy Chief Financial Officer	Initial document
	V2	June 2014	Deputy Chief Financial Officer	Update of limits for West Midlands CRN;
	V3	September 2014	Deputy Chief Financial Officer	Update of limits for West Midlands CRN; certain payroll documents; and Capital Business Case approval limits
	V4	March 2015	Deputy Chief Financial Officer	Update to Appendix A – Authorised Limits
	V5	May 2017	Financial Controller	Update to Appendix A – Authorised Limits
	V6	April 2019	Head of Financial Control & Assurance	Review by Head of Financial Control & Assurance including updates to job titles, inclusion of document control and general relevant update Update to Appendix A – Authorised Limits
	V7	November 2021	Deputy Chief Finance Officer	Scheduled review of policy
	V8	December 2022	Head of Financial Governance and Transactions	Update to Appendix A – Authorised Limits

Intended Recipients: This policy will apply to all persons employed by The Royal Wolverhampton NHS Trust. This incorporates community, acute staff, employees from other health or social care providers, educational establishments, volunteers, private contractors, agency workers working within Trust premises.	
Consultation Group / Role Titles and Date: Company Secretary; Finance and Performance Committee, Audit Committee, Chief Financial Officer, Deputy Chief Financial Officer.	
Name and date of Trust level group where reviewed	Audit Committee 13th December 2022 Trust Policy Group 6th January 2023
Name and date of final approval committee	Trust Board February 2023
Date of Policy issue	February 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	January 2024 annually
Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees and dissemination via Intranet.	
To be read in conjunction with: Standing Orders, Scheme of Reservation and Delegation, Conflicts of Interest Policy, and Anti-Fraud and Anti-Bribery Policy	
Initial Equality Impact Assessment (all policies): **Completed Yes** **Full Equality Impact assessment (as required):** **Completed NA** If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.	
Contact for Review	Head of Financial Governance and Transactions
Implementation plan / arrangements (Name implementation lead)	Chief Financial Officer
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board

Document summary / key issues covered:

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 SFIs 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 Trust's Standing Orders (SOs).

These SFIs detail the financial responsibilities and policies 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 adopted by the Trust.

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendment.

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STANDING FINANCIAL INSTRUCTIONS

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STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 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 SFIs 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 Trust's Standing Orders (SOs).

1.1.2 These SFIs 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 adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and any constituent organisations. 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.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.5 The failure to comply with SFIs and SOs can in certain circumstances be regarded as a disciplinary matter.

1.1.6 If for any reason these SFIs 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 by the Chief Financial Officer to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non- compliance with these SFIs to the Chief Financial Officer as soon as possible.

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

1.2 Responsibilities and Delegation

1.2.1 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 Reservation and Delegation document.

The Board has resolved that certain powers and decisions may only be exercised by the Board in a formal session. These are set out in the Scheme of Reservation and Delegation and SOs.

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.

1.2.2 The Chief Executive and Chief Financial Officer

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

Within the SFIs, 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.

1.2.3 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.4 The Chief Financial Officer

The Chief Financial Officer is responsible for:

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

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

(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.

(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 include.

(a) the provision of financial advice to other members of the Board and employees.

(b) the design, implementation and supervision of systems of internal financial control.

(c) 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.

1.2.5 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; and

(d) conforming with the requirements of SOs, SFIs, Financial Procedures and the Scheme of Reservation and Delegation.

1.2.6 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.

1.2.7 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.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with SOs, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services.

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments.

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

(d) monitoring compliance with SOs and SFIs.

(e) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

2.1.2 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 this may need to be referred to NHS England and the Department of Health and Social Care, but this should be via the Trust Chief Financial Officer in the first instance.

2.1.3 It is the responsibility of the Chief Financial Officer 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.

2.1.4 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.

2.1.5 Matters pertaining to fraud, bribery and/or corruption must be reported to the LCFS for investigation in accordance with the Trust's Local Anti-Fraud and Anti-Bribery Policy.

2.2 Chief Financial Officer:

2.2.1 The 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 NHS mandatory audit standards.

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

(d) ensuring that an annual internal audit report is prepared by the Internal Audit service provider for the consideration of the Audit Committee. The report must include:

(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.

2.2.2 The Chief Financial Officer, designated auditors, or LCFS 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, members of the Board or employees of the Trust.

(c) the production of any cash, stores or other property of the Trust under the control of any member of the Board or an employee's control; and

(d) explanations concerning any matter under investigation.

2.2.3 The Trust's Chief Executive and Chief Financial Officer 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 the Government Functional Standard 013: Counter Fraud.

2.3 Role of Internal Audit and Counter Fraud

2.3.1 The purpose and objectives of the Internal Audit service provider are to 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.

(d) the efficient and effective use of resources.

(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.
(iv) Any form of risk, especially business and financial risk but not exclusively so.

(f) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care.

2.3.2 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 must be notified immediately.

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

2.3.4 The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, 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 Audit Code and the DHSC Group Accounting Manual. The reporting system shall be reviewed at least every three years.

2.3.5 Internal Audit terms of reference shall have effect as if incorporated within these SFIs. The terms of reference cover the scope of the internal audit work, authority and independence, management responsibilities, coordination of assurance work, reporting and key outputs and the operational responsibilities.

2.4 External Audit

2.4.1 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.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Chief Financial Officer shall monitor and ensure compliance with the Government Functional Standard 013: Counter Fraud on fraud and corruption as specified in the NHS

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist and shall work with staff in NHS Counter Fraud Authority in accordance with the guidance issued by NHS Counter Fraud Authority.

2.5.3 The LCFS shall report to the Trust Chief Financial Officer and shall work with staff in the NHS Counter Fraud Authority in accordance with guidance issued by NHS Counter Fraud Authority.

2.5.4 The LCFS will provide a written report, at least annually, on counter fraud work within the Trust.

2.5.5 The Local Counter Fraud Specialist will complete the annual Counter Fraud Functional Standard Return (CFFSR), which reviews the Trust's compliance against the the Government Functional Standard 013: Counter Fraud. Any non or partial compliance against the standards will be reported to the Chief Financial Officer and Audit Committee, and action plans will be put in place with the aim of developing the level of compliance.

2.6 Security Management

2.6.1 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.

2.6.2 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.

3. PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(i) A statement of the significant assumptions on which plan is based.

(ii) Details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Chief Financial Officer 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 Trust's aims and objectives set out in the Trust's business plan and its long term financial model.

(b) accord with financial and other targets, and with workload and manpower plans.

(c) be produced following discussion with appropriate budget holders.

(d) be prepared within the limits of available funds.

(e) identify potential risks.

3.1.3 The Chief Financial Officer shall monitor financial performance against budget and

business plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled and financial performance against budgets to be monitored.

3.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 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; and

(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 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.

3.2.4 Non-recurring expenditure or income 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.

3.3 Budgetary Control and Reporting

3.3.1 The Chief Financial Officer 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) movements in cash and capital.

(iv) capital projects spend and projected outturn against plan.

(v) explanations of any material variances from plan.

(vi) details of any corrective action where necessary and the chief Executive's and/or Chief Financial Officer' 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.

3.3.2 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 appropriate authorisation;

(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 appropriate approval other than those provided for within the available resources and manpower establishment.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of a balanced budget.

3.4 Capital Expenditure

3.4.1 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.

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organization in accordance with the prescribed deadlines.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Chief Financial Officer, 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.

4.2 The Trust's Annual Report, Annual Accounts and financial returns to NHS England must be audited by an external auditor appointed by the Audit Committee in accordance with appropriate International Accounting Standards.

4.3 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors or by the Audit Committee (when specially delegated power to do so, under the authority of the Board).

4.4 The Annual Report and Accounts (including the auditor's report) is submitted to NHS England (in accordance with its timetable) by the Chief Financial Officer.

4.5 The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual report and accounts (including the auditor's report) will be published and presented to the public Annual General Meeting (typically before or round the end of September) (or earlier if specified by NHS England) each year and made available to the public for public inspection at the Trust's Headquarters and made available on the Trust's website.

4.6 The Chief Nursing Officer will prepare the Annual Quality Report in the format prescribed by NHS England/Care Quality Commission and in accordance with DHSC General Accounting Manual. The Quality report presents a balanced picture of the Trust's performance over the financial year and up to the agreed submission date.

4.7 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.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Chief Financial Officer 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/Directions issued from time to time by the Department of Health and Social Care.

5.1.2 The Board will review and approve the banking arrangements as specified by the Department of Health and Social Care.

5.2 Bank and GBS Accounts

5.2.1 The Chief Financial Officer is responsible for:

(a) establishing separate bank accounts for the Trust's non-exchequer funds/charitable funds.

(b) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made.

(c) reporting to the Board all arrangements and instances where the bank accounts become or may have become overdrawn, and the arrangements made with the Trust's bankers.

(d) monitoring compliance with DHSC guidance on the level of cleared funds.

(e) ensuring covenants attached to bank borrowing are adhered to.

5.3 Banking Procedures

5.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of all Trust bank accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated, including the overdraft limit if applicable.

(b) those authorised to approve payments, bank transfers, sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 No-one but the Chief Financial Officer shall open a bank account in the name of the Trust.

5.4 Tendering and Review

5.4.1 The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

5.5 External Borrowing

5.5.1 The Chief Financial Officer will advise the Board concerning the Trusts ability to pay dividend on and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the public dividend capital (PDC) debt and all loans and overdrafts.

5.5.2 Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee so delegated by them.

5.5.3 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.5.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing required must be authorised by the Chief Financial Officer.

5.5.5 All long-term borrowing must be consistent with the plans outlines in the current approved financial plan as reported to the Department of Health and Social Care.

5.6 Investments

5.6.1 Temporary cash surpluses must only be held in such investments as authorised by the Department of Health and Social Care and authorised by the Board.

5.6.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance and investments held.

5.6.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall comply with any Department of Health and Social Care advice in setting prices for service agreements.

6.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care 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 and Social Care's Commercial Sponsorship – Ethical Standards in the NHS shall be followed.

6.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions in order to facilitate the timely raising of invoices and collection of debt.

6.2.4 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.

6.3 Debt Recovery

6.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 The Chief Financial Officer 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.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Chief Financial Officer 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.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 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.

6.4.4 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.

6.5 Free of Charge/Donated Goods/Services

6.5.1 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.

6.5.2 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.

6.5.3 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.

6.5.4 The donation of clinical equipment shall undergo the same rigour as applied to an NHS funded purchase.

6.5.5 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 in respect of the revenue consequences.

6.6 Payment in Kind to the Trust

6.6.1 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.

7. TENDERING AND CONTRACTING

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

7.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and SFIs (except where Standing Order No. 5.13 Suspension of SOs is applied).

7.1.2 In particular, directors and officers should be aware of the definition of "pecuniary interest" as set out in Standing Order 9.3. 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.

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in SOs Orders and SFIs.

7.3 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.

7.4 Capital Investment Manual and other Department of Health and Social Care Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care "Capital Investment Manual" and "Estate code" in respect of capital investment and estate and property transactions.

7.4.1 Management Consultancy

In the case of management consultancy contracts the Trust is required to seek prior approval from NHSE and 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 NHS England.

7.5 Formal Competitive Tendering

7.5.1 General Applicability

Except where identified under 7.5.3 below, the Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles.

(b) the rendering 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) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens).

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these SOs and SFIs shall apply as far as they are applicable to the tendering procedure and should be read in conjunction with Standing Financial Instruction No. 8.

7.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures **need not be applied** where:

(a) the estimated total expenditure or income does not, or is not reasonably expected to, exceed £50,000.

(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with.

(c) regarding disposals as set out in SFIs No. 7.13; 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 purchasing 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 is generally recognised as having sufficient expertise in the area of work for which they are commissioned.

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.

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.

7.5.4 Items which subsequently breach thresholds after original approval

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, and be recorded in an appropriate Trust record.

7.6 Contracting/Tendering Procedure

7.6.1 Fair and Adequate Competition

Other than where the exceptions set out in this SFI 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 two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

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.

Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.2 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 it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

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 invited. 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.

For building and engineering construction works, invitations to tender shall be made only to firms included on the approved list of tenderers complied in accordance with this instruction or on the separate maintenance lists compiled in accordance with Estatecode guidance (Health Notice HN(78)147).

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 Equality Act 2010 and any amending and/or related legislation.

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. For building and engineering construction works, firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.6.3 Financial Standing and Technical Competence of Contractors

The Chief Financial Officer 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.

7.6.4 Exceptions to using Approved Contractors

If in the opinion of the Chief Executive and the Chief Financial Officer 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.

7.6.5 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.

7.6.6 Opening 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.

7.6.7 Admissibility

i) 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.

(iii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.8 Late Tenders

(i) 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 Chief Executive is satisfied that there is no reason to doubt the bona fides of the tender concerned.

(iii) 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.

7.6.9 Acceptance of Formal Tenders

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.

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. A report explaining any such reasons shall be produced by the officer evaluating the tender responses and 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:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) 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.

The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; and

(b) that best value for money was achieved.

All tenders should be treated as confidential and should be retained for inspection.

7.7 Quotations: Competitive and Non-Competitive

7.7.1 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 £10,000, but not exceed £50,000. Where the intended expenditure or income is not reasonably expected to exceed £10,000, competitive prices only are required. If however the competitive prices which are received do exceed £10,000, then three written quotations shall be required.

7.7.2 Competitive Quotations

Wherever practical 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.

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.

All quotations should be treated as confidential and should be retained for inspection.

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.

7.7.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) 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;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

7.7.4 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 SFIs except with the authorisation of either the Chief Executive or Chief Financial Officer.

7.8 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 NHS Supply Chain 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 - 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.

7.9 Private Finance for 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 agency, as required by current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.10 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 SOs and SFIs;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;

(d) such of 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.

7.11 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.

7.12 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, other than those with a Foundation Trust, 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 of healthcare in line with a commissioning plan approved by the Board.

7.13 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 building concerning which DHSC guidance has been issued but subject to compliance with such guidance.

7.14 In-house Services

7.14.1 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.

7.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(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 representative. The evaluation team should include a non-

executive member of the Board, particularly if annual expenditure is over £250,000.

7.14.3 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.

7.14.4 The evaluation team shall make recommendations to the Board.

7.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.15 Applicability of SFIs on Tendering and Contracting to Funds held in Trust

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's funds and private resources.

8. SERVICE AGREEMENTS FOR PROVISION OF SERVICES

8.1 Service Level Agreements (SLAs) and Contracts

8.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with commissioners for the provision of NHS services.

All SLAs and contracts should aim to implement the agreed priorities contained within the Commissioning Agreement or the strategy of the Trust. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected;

(b) the relevant national service framework (if any);

(c) the provision of reliable information on cost and volume of services;

(d) the NHS National Performance Assessment Framework.

8.2 Involving Partners and jointly managing risk

8.2.1 A good agreement 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 agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.2.2 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.

9. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

9.1 Payment to Board Members (Chairman and Non-Executive Directors)

9.1.1 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.

9.2 Remuneration and Terms of Service Committee (Executive Directors and Staff)

9.2.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.2.2 The Committee will:

(a) Be responsible for overseeing and ratifying the appointment of candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.

(b) Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, as applicable, with regard to any changes.

(c) Establish and keep under review a remuneration policy in respect of executive board directors and senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay.

(d) In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors and senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay, including:

i. Salary, including any performance-related pay or bonus;

ii. Annual salary increase

iii. Provisions for other benefits, including pensions and cars;

iv. Allowances;

v. Payable expenses;

vi. Compensation payments.

(e) Ensure the annual performance of Board Directors is undertaken and evaluate on an exceptional basis the performance of Board Directors on the advice of the Chief Executive/Chairman. This will include consideration of this output when reviewing changes to remuneration levels.

(f) Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

9.2.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for its decisions but remain accountable for taking decisions on the remuneration and terms of service of executive members. Minutes of the Board's meetings should record such decisions.

9.2.4 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.

9.3 Funded Establishment

9.3.1 The manpower plans incorporated within the annual budget will form the funded establishment.

9.3.2 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 Finance Officer or their delegated officer.

9.4 Staff Appointments

9.4.1 No Executive Director, 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 unless:

(a) unless authorised to do so by the Chief Executive;

(b) within the limit of their approved budget and funded establishment.

(c) he or she is exercising economy and efficiency in the use of human resources.

9.4.2 Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

9.4.3 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

9.5 Payroll Arrangements

9.5.1 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method 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.

9.5.2 The Chief Financial Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records, expense claims and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

The Chief Financial Officer 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, expenses and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, national insurance 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 direct 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 from them to the Trust.

Appropriately nominated managers have delegated responsibility for:

(a) submitting and authorising time records, travel, subsistence and removal expenses claims and other notifications in accordance with agreed timetables;

(b) completing and authorising time records, travel, subsistence and removal expenses claims and other notifications in accordance with the Chief Financial Officer instructions and in the form prescribed by the Chief Financial Officer;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees 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 must be informed immediately.

9.6 Contracts of Employment

9.6.1 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;

(b) dealing with variations to, or termination of, contracts of employment.

9.7 Agency, Self-employed or Third Party Workers including Contract for Services

9.7.1 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 shall be consulted if the contractor is not on the current list of authorised suppliers; and

(c) the Director of 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.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 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.

10.1.2 The Scheme of Reservation and Delegation 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.

10.1.3 The Scheme of Reservation and Delegation shall set out procedures on the seeking of professional advice regarding the supply of goods and services and this shall be followed when entering into any agreement. Contract terms and conditions used in contract shall only be those approved by the Trust.

10.1.4 Before entering in to contracts for the supply of goods and services or works contracts and especially overseas contacts, taxation advice (including where appropriate customs advise) shall be obtained from the Chief Financial Officer. Agreement of the Chief Financial Officer and also where relevant the Director of Estates and Facilities shall be obtained before entering into any potentially novel or contentious arrangement with a supplier or contractor.

10.2 Requisitioning

10.2.1 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 (and/or the Chief Executive) shall be consulted.

10.3 System of Payment and Payment Verification

10.3.1 The Chief Financial Officer 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.

10.3.2 The Chief Financial Officer 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 SOs, Scheme of Reservation and Delegation, and SFIs and regularly reviewed;

(b) prepare procedural instructions or guidance within the 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.

(ii) Certification that:

(i) goods have been duly received, examined and are in accordance with specification and the prices are correct;

(ii) 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;

(iii) 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;

(iv) 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;

(v) where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

(vi) the account is arithmetically correct, with discounts having being taken as appropriate;

(vii) VAT has been correctly accounted for with the recovery being identified where appropriate; and

(viii) the account is in order for payment.

(iii) A timetable and system for submission to the 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.

(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 **10.4** below.

10.4 Prepayments

10.4.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) 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;

(b) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the prevailing procurement rules (EU or otherwise) where the contract is above a stipulated financial threshold);

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.4.2 Exceptions to the requirements of section a and b 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.

10.5 Official orders

10.5.1 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Financial Officer;

(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.

10.6 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 Reservation and Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with the prevailing rules on public procurement (EU or otherwise);

(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 England;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e)they declare any pecuniary interests in contracts or potential contracts (as set out in SFI 7.1.(b)

(f) Other than the above exceptions, any officer receiving such an offer shall notify his/her manager as soon as possible, who will in turn, notify the Chief Financial Officer. This provision needs to be read in conjunction with the principles outlined in the national guidance contained in HSG 93(5) “Managing Conflicts of Interest” Feb 2017);

(g) Details of authorised hospitality shall be entered in a register maintained by the Chief Executive. Visits at suppliers’ expense to inspect equipment etc., must not be undertaken without the prior approval of the Chief Executive.

(h) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

(i) 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 items brought using purchase cards. For clarification the Chief Financial Officer will determine the nature of expenditure which does not require control through an official purchase order and review this on an annual basis;

(j) 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 which is clearly marked "Confirmation Order";

(k) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(l) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(m) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Financial Officer;

(n) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer;

(o) petty cash records are maintained in a form as determined by the Chief Financial Officer.

11. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital Investment

11.1.1 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) shall ensure that the capital investment is not undertaken without confirmation of affordability;

(c) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

11.1.2 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 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 are in place;

(iv) the appropriate Trust Personnel and external agencies have been involved; and

(v) that the Chief Financial Officer 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.

11.1.3 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.

11.1.4 The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue & Customs guidance.

11.1.5 The Chief Financial Officer 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.

11.1.6 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.

11.1.7 The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

11.1.8 The Chief Executive will issue a scheme of delegation for capital investment management and the Trust's SOs.

11.1.9 The Chief Financial Officer 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 notified by the Department of Health and Social Care.

11.2 Private Finance (see SFI No. 7.9)

11.3 Contract Framework agreements

11.3.1 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.

11.3.2 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.

11.3.3 The Contractual Framework Agreement shall be subject to formal tender procedures and shall comply with the prevailing directives governing public procurement (EU or otherwise).

11.3.4 The Chief Financial Officer shall issue procedure notes governing the control, management, reporting and audit arrangements of the Contract Framework Agreement.

11.3.5 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.

11.3.6 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.

11.4 External Borrowing (see SFI No 5.5)

11.5 Investments (see SFI No 5.6)

11.6 Leases

11.6.1 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 before acceptance of any offer;

(c) The Chief Finance Officer shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the Chief Finance Officer 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.

11.7 Asset Registers

11.7.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer 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 once a year.

11.7.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health and Social Care.

11.7.3 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, architects certificates, suppliers 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.

11.7.4 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).

11.7.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.7.6 The value of each asset shall be established and indexed to current values in accordance with methods consistent with the requirements issued by the Department of Health and Social Care.

11.7.7 The value of each asset shall be depreciated using methods and rates as specified by the Department of Health and Social Care.

11.7.8 The Chief Financial Officer of the Trust shall calculate and pay PDC dividend as specified by the Department of Health and Social Care.

11.8 Security of Assets

11.8.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.8.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. 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.

11.8.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

11.8.4 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.

11.8.5 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.

11.8.6 Where practical, assets should be marked as Trust property.

12. STORES AND RECEIPT OF GOODS

12.1 General Position

12.1.1 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;

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, Condemnations and Disposal

12.2.1 Subject to the responsibility of the Chief Financial Officer 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 him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of any

Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

12.2.2 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. Wherever practicable, stocks should be marked as NHS property.

12.2.3 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer 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.

12.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

12.2.6 The designated manager shall be responsible for a system approved by the Chief Financial Officer Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated manager shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.3 Goods Supplied by NHS Supply Chain

12.3.1 For goods supplied via the NHS Supply Chain 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 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 or delegated officer to avoid overpayments where such discrepancies cannot be resolved via the procurement team.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations

13.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

13.1.2 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 of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer 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.

13.1.4 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 who will take the appropriate action.

13.2 Losses and Special Payments

13.2.1 Procedures

The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their supervisor, line manager and head of department, except where fraud, bribery or corruption is suspected in which case a referral must be made to LCFS for investigation in accordance with the Trust's Local Anti-Fraud and Anti-Bribery Policy. The senior officer must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer and Chief Executive.

13.2.3 Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved.

13.2.4 In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Financial Officer must inform the relevant LCFS, NHS Counter Fraud Authority and the External Auditor of all frauds.

13.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

(a) the Board,

(b) the External Auditor.

13.2.6 Within limits delegated to it by the Department of Health and Social Care, the Board shall approve the writing-off of losses.

13.2.7 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.8 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

13.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

13.2.10 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

13.2.11 All losses and special payments must be reported to the Audit Committee and the Trust Board at regular intervals.

14. INFORMATION TECHNOLOGY

14.1 Responsibilities and Duties of the Chief Financial Officer

14.1.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust:

(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 1998 and GDPR 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 audit trail exists through the computerised system and that such computer audit reviews as the Director or Data Protection Officer (DPO) may consider necessary are being carried out.

14.1.2 The Chief Financial Officer 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.

14.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

14.2.1 The Medical Director shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner.

14.2.2 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer:

(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.

14.3 Contracts for Computer Services with other health bodies or outside agencies

14.3.1 The Chief Financial Officer 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 (in line with GDPR), accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

14.3.3 Where computer systems have an impact on corporate financial systems the Chief Financial Officer 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's staff has access to such data, and;

(d) such computer audit reviews as are considered necessary are being carried out.

14.4 Risk Assessment

14.4.1 The Chief Executive 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.

15. PATIENTS' PROPERTY

15.1 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.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The Chief Financial Officer 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.

15.4 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. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

15.5 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), 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.

15.6 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.

15.7 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.

15.8 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.

16. FUNDS HELD ON TRUST

16.1 Corporate Trustee

16.1.1 The discharge of the Trust's corporate trustee responsibilities is 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.

16.1.2 The Chief Financial Officer 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.

16.1.3 The Trust will comply with Charities Commission latest guidance and best practice.

16.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

16.2.1 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.

16.2.2 The Schedule of Matters Reserved to the Board and the 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.

16.3 Applicability of Standing Financial Instructions to funds held on Trust

16.3.1 In so far as it is possible to do so these SFIs will apply to the management of funds held on trust.

16.3.2 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.

17. ACCEPTANCE OF GIFTS BY STAFF

17.1.1 The Chief Financial Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff (see SFI 10.6 (d)) This policy follows the guidance contained in the Department of Health and Social Care circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these SOs and SFIs.

18. RETENTION OF RECORDS

18.1 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 guidelines.

18.2 The records held in archives shall be capable of retrieval by authorised persons.

18.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or Chief Financial Officer. Proper details shall be maintained of records and information so destroyed.

19. INTERNATIONAL FINANCIAL REPORTING STANDARDS (IFRS)

19.1 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 and his team should be consulted for advice in such instances.

20. RISK MANAGEMENT AND INSURANCE

20.1 Programme of Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.

20.1.2 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 decision of which risks shall be insured;

(g) arrangements to review the risk management programme;

(h) appropriate levels of external accreditation.

20.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis for the effectiveness element under the Annual Governance Statement (within the Annual Report and Accounts) as required by current Department of Health and Social Care guidance.

20.2 Insurance: Risk Pooling Schemes

20.2.1 The Board shall decide if the Trust will insure through the various schemes administered through the NHS Resolution (NHSR) or self-insure for some or all of the risks. If the Board decides not to use the NHSR 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.

20.3 Insurance arrangements with commercial insurers

20.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, four exceptions when Trusts 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.

20.4 Arrangements to be followed by the Board in agreeing Insurance cover

20.4.1 Where the Board decides to use the risk pooling schemes administered by the NHSR 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.

20.4.2 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.

20.4.3 All the NHSR risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible' element). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

APPENDIX A

SCHEDULE OF AUTHORISED LIMITS

TENDERING, ORDERING, CONTRACTING – EXPENDITURE

Competitive quotations to apply	£20,000 to £50,000
Competitive tendering to apply	above £50,000

Authority to waive competitive process:-

Head of Procurement/Estates	up to £25,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	above £25,000

Authority to accept other than lowest quote:-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	up to £1,000,000
Trust Board	above £1,000,000

Approval to contract awards (including extensions):-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	up to £1,000,000
Trust Board	above £1,000,000

NB – All contract awards above £50,000 to be reported to Trust Board for information

Evaluation Panel to include a Non-Executive Director	£1,000,000 & above

Note – The above limits apply equally to asset disposals.

CONTRACTING – Income

Approval to sign contracts other than for the provision of Healthcare by RWT:-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	up to £1,000,000
Trust Board	above £1,000,000

CONTRACTING – Agreements for the Provision of Healthcare Services by RWT:-

Approval to sign contracts where RWT is the provider of Healthcare services to NHS and other Commissioners:-

Executive Director	up to 10% of Trust turnover
Trust Board	above 10% of Trust turnover

REQUISITIONS

Revenue:-

Budget Manager eg Ward Manager	up to £5,000

Senior Budget Manager –

Senior Matron/Matrons/Head of Midwifery	}	
Heads of Nursing (Nursing Budgets Only)	}	
Group Manager/Directorate Manager (Non-Nursing Budgets)	}	up to £15,000
Deputy HR Director	}	
Head of Education & Development	}	

Budget Holder –

Senior Pharmacist/Principle Pharmacist (drugs only)	up to £25,000
Deputy and Assistant Director of Pharmacy (drugs only)	up to £50,000
Director of Pharmacy Services (drugs only)	up to £100,000

Deputy Chief Operating Officer	}	
Divisional Medical Director	}	up to £50,000
Head of IT Services	}	
Divisional Manager Estates and Facilities	}	

Clinical/Research Network –

Lead Research, Management & Governance Manager	up to £5,000
Research Delivery Divisional Managers	up to £5,000
Industry Operations Manager	up to £15,000
Chief Operating Officer	up to £50,000

Black Country Pathology Services –

Budget Holder	up to £5,000
Service Manager	up to £10,000
Deputy Group Operational Manager	up to £15,000
Group Operational Manager	up to £25,000
Clinical Director	up to £50,000

Executive Responsible Budget Officer –

Executive Director	up to £100,000
Chief Executive and Chief Financial Officer	over £100,000

Capital:-

Team Manager (Capital)/Team Manager (Project and Estates)	up to £50,000
Head of Estates Development	up to £500,000
Chief Financial Officer	up to £750,000
Chief Executive **and** Chief Financial Officer	over £750,000

NB – Above capital limits are subject to agreement of Business Cases (where Applicable) and inclusion within a Board approved Capital Programme

Capital schemes requiring Business Cases to be approved by value
Trust Board

£1,000,000 capital and/or £1,000,000 revenue cost (whether non-recurrent or recurrent), and above

Capital schemes requiring Business Cases to be approved by NHSEI, DHSC and HM Treasury

£20,000,000 up to £35,000,000 capital value for all categories of investment except IM&T which has a lower upper threshold of £30,000,000 (The delegated limit for a Trust is the lower of 3% turnover and £20,000,000 and is reviewed annually. This may be reduced should the Trust go into deficit.) to be approved by NHSEI
Capital values above these upper limits and up to £50,000,000 require additional approval from DHSC, and above £50,000,000 then requires HM Treasury approval.

Note – Officers will need to judge where schemes below this level will require Board approval, because of other issues of significance

Charity Funds – following approval from Charity Trustees of the commitment of charitable funds the delegated officers below authorise payment as per the values set out:–

Divisional/Directorate Funds -	
Group Managers/Directorate Managers	up to £5,000
Deputy Chief Operating Officer	up to £10,000
Chief Executive and Chief Financial Officer	up to £50,000
General Funds -	
Chief Executive and Chief Financial Officer	up to £50,000
All Funds -	
Trust Board, acting as Trustees	above £50,000

PAY

All Starter, Change and Termination Forms:–

Clinical Directorates and Divisions –
Senior Matron/Matron/Head of Midwifery/Head of Nursing (Nursing Budgets Only)
Group Manager/Directorate Manager (Non Nursing Budgets Only)
Divisional Manager Estates and Facilities
Deputy Chief Operating Officer
Divisional Medical Director

Division 4
Heads of Service that directly report to Deputy Chief Operating Officer

Corporate Functions –
Executive Director (or delegated Deputies at Executive Director's discretion)

Clinical Research Network –
Lead Research, Management and Governance Manager
Industry Operations Manager
Research Delivery Divisional Managers
Chief Operating Officer

Subject to:

- **Consultant appointments to be countersigned by Medical Director**
- **Any appointment/changes outside National Terms and Conditions/Agreed Trust Policy to be countersigned by HR Director and Chief Financial Officer (or in exceptional circumstances, where the Executive Director is absent, to delegated Deputies, named at Executive Director's discretion).**

Junior Doctors (ROTATION ONLY) and Temporary Bank Medical Staff – Starter and Termination Forms: -
Head of Workforce
Senior Resourcing Manager/Head of Resourcing
Resourcing Manager

Bank Nurses – Starter, Change and Termination Forms:-
Head of Workforce
Senior Resourcing Manager/Head of Resourcing
Resourcing Manager

Trust Volunteers – Starter and Termination forms

(Required for the purpose of payment of volunteer expenses only)
- Head of Patient Experience

All turnaround documents, timesheets and expenses forms:-
As above prime payroll documentation authorised officers plus

Budget Managers

For Community Services and other Services where the Services are provided 'Off Site'
The Budget Manager is able to devolve responsibility for the sign off to a Delegated Senior Manager.

For Removals Expenses only – Director/Deputy of Human Resources/Head of Workforce, and additionally, for Medics Removals and Interview Expenses, specifically Senior Resourcing 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

LOSSES COMPENSATIONS AND SPECIAL PAYMENTS

Approval limit of Chief Financial Officer/Deputy Chief Financial Officer	up to £5,000
Audit Committee	above £5,000

Note – all losses, compensation and special payments to be reported to the Trust Board

EXCEPTIONAL AUTHORISATION ARRANGEMENTS

In the absence of the Chief Executive and Chief Financial Officer
(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

The Royal Wolverhampton NHS Trust

Document Control

Reference Number and Policy name: Scheme of Reservation and Delegation	**Version:** V5		**Status:** Final	**Author:** Group Company Secretary and Deputy Chief Financial Officer **Director Sponsor:** Chief Financial Officer
Version / Amendment History	Version	Date	Author	Reason
	V1	March 2009	Financial Controller	Implementation of Scheme of Reservation and Delegation
	V2	April 2019	Company Secretary and Head of Financial Control and Assurance	Review of document in line with amendments made to SO's and SFI's
	V3	June 2021	Company Secretary and Head of Financial Control and Assurance	Review of document in line with amendments made to SO's and SFI's
	V4	November 2021	Company Secretary and Deputy Chief Financial Officer	Review of document in line with amendments made to SO's and SFI's
	V5	December 2022	Group Company Secretary and Head of Financial Governance and Transactions	Review of document in line with amendments made to SO's and SFI's
Intended Recipients: This policy will apply to all persons employed by The Royal Wolverhampton NHS Trust. This incorporates community, acute staff, employees from other health or social care providers, educational establishments, volunteers, private contractors, agency workers working within Trust premises.				
Consultation Group / Role Titles and Date: Company Secretary; Finance and Performance Committee, Audit Committee, Chief Financial Officer, Deputy Chief Financial Officer.				
Name and date of Trust level group where reviewed	Audit Committee December 2022 Trust Policy Group – March 2023			
Name and date of final approval committee	Trust Board February 2023			
Date of Policy issue	February 2023			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	February 2024 annually			

Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees and dissemination via Intranet.	
To be read in conjunction with: Standing Orders, Standing Financial Instruments, Conflicts of Interest Policy, and Anti-Fraud and Anti-Bribery Policy	
Initial Equality Impact Assessment (all policies): **Completed Yes** **Full Equality Impact assessment (as required):** **Completed NA** If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.	
Contact for Review	Head of Financial Governance and Transaction -
Implementation plan / arrangements (Name implementation lead)	Chief Financial Officer
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board
Document summary / key issues covered: This document sets out the powers (be that decisions, authorities or duties) reserved to the Board of Directors and the powers which may be delegated to sub committees, directors and other officers. The Scheme of Reservation and Delegation together with the Standing Orders, the Standing Financial Instructions and all other Trust policies provides a comprehensive framework for the Trusts business conduct. It sets out levels of decision-making in the current management structure of the Trust.	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

THE ROYAL WOLVERHAMPTON NHS TRUST

SCHEME OF RESERVATION AND DELEGATION

NOTE: For authorised limits see Appendix A to Standing Financial Instructions February 2023

SCHEME OF RESERVATION AND DELEGATION

CONTENTS

NOTE: For authorised limits see Appendix A to Standing Financial Instructions

SCHEME OF RESERVATION AND DELEGATION

DECISIONS RESERVED TO 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.

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 (or Vice-Chairman) and Chief Executive in public session in accordance with SO 7.2

5. Approve a scheme of delegation of powers from the Board to committees as per the approved terms of reference**.**

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.

8. Approve arrangements for dealing with complaints.

9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.

10. 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.

11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers.

12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.

14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 7.6.

16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.

Appointments

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 the Chief Executive.
4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
5. Appoint Executive Directors.

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.
3. Approve the Trust's policies and procedures for the management of risk.
4. Approve Outline and Full Business Cases for Capital Investment.
5. Approve budgets.
6. Approve Trust's proposed organisational development proposals.
7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.
8. Approve PFI proposals.
9. Approve the opening of bank accounts.
10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over the period of the contract. For Revenue Only contracts the limit required for board approval is £250,000.
11. 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) approved by the Board.
12. Approve Trust Strategic Documents in line with Trust Strategic Objectives.
13. Partnership Agreements

Policy Determination

1. Approve management policies as delegated within the Scheme of Delegation.

Audit

1. Approve the appointment (and where necessary dismissal) of External Auditors and advise the Audit Committee on such matters.
2. Receive the annual management letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee.

Annual Reports and Accounts

1. Receive and approve the Trust's Annual Accounts.
2. Receive and approve the Annual Accounts for funds held on trust.

Monitoring

1. Receive such reports as the Board sees fit from committees in respect of their exercise of delegated powers.
2. Continuously appraise the affairs of the Trust by means of the provision of information to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements.
3. Receive reports from Chief Financial Officer on financial performance.

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

AUDIT COMMITTEE	The Committee will: **1. Internal Control** The Committee shall review the establishment and maintenance of an effective system of internal control. In particular, the Committee will review:- • The Annual Governance Statement, and the related Head of Internal Audit Opinion, prior to the endorsement of the Annual Accounts by the Trust Board. In order to undertake such a review, the Audit Committee will need to seek assurance from the activities of the Quality Governance Assurance Committee (QGAC), Performance and Finance Committee (P&FC), and the People and Organisational Development Committee (PODC), not least to ensure that, between the Audit Committee and the QGAC, full coverage is achieved. • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and the operational effectiveness of such policies and related procedures • the policies and procedures for all work related to fraud, bribery and corruption as set out in the Government Functional Standard 013: Counter Fraud and as required by the NHS Counter Fraud Authority. • the timeliness of the implementation of agreed action plans arising from all audit reports within the purview of the Committee • the policies and procedures for security within the Trust **2. Internal Audit** The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board. This will be achieved by: • The consideration of the provision of the Internal Audit service, the audit fee and any questions of resignation and dismissal • The review and approval of the Internal Audit strategy and annual plans, ensuring that these are consistent with the audit needs of the Trust, including the needs of the QGAC, P&FC and PODC. • The review of progress against the agreed annual internal audit plan • The consideration of the major findings of internal audit reviews and management's response • Ensuring that the quality of the Internal Audit service is maintained and that the service has appropriate standing within the Trust • Ensuring co-ordination between the Internal and External Auditors to optimise audit resources • The review of an Annual Report, provided by the Head of Internal Audit, summarising audit activities during the year • Note: for the purposes of the above section, references to Internal Audit are deemed to include Counter Fraud work **3. External Audit** The Committee shall review the work and findings of the External Auditor and consider the implications of, and management response to, their work. This shall be achieved by: The consideration of the appointment and performance of the External Auditor The discussion with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Audit

	Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy Reviewing External Audit reports, including the agreement of the annual audit letter before its submission to the Trust Board, together with the appropriateness of management responses. Reviewing and agreeing any additional work beyond the review of the accounts and Annual Report/Annual Quality reports **4. Financial Reporting** The Audit Committee shall review the Annual Accounts before submission to the Board, focusing particularly on: The Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee Changes in, and compliance with, accounting policies and practices; Unadjusted mis-statements in the Annual Accounts Major judgmental areas Significant adjustments resulting from the audit. Review and approval of the Value For Money (VFM) statement. Undertake reviews of single tenders as and where appropriate at each meeting. The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. In line with the Code of Governance for NHS Provider Trusts (2023) the Audit Committee will ensure it satisfies and addresses the provisions that define the main role and responsibilities under section D as reflected in the appropriate sections of the annual accounts and Annual Report. **Counter Fraud** The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. The Committee should review arrangements by which staff of the Trust may, in confidence, raise concerns about possible improprieties in matters of financial reporting or other matters. The Audit Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. Note: for the purposes of the above section, references to counter fraud are deemed to also include arrangements to counter bribery and corruption. **Security Report** The Audit Committee shall receive regular reports regarding all aspects of security in the Trust specifically relating to physical security of people, buildings and property. Incidents reporting including severity actions and learning. Role and function of security staff. Any other security related oversight. **Losses and Compensations** The Committee shall approve all Losses and Compensations. The Chair will be informed prior to the meeting of any novel or high value losses and compensations as agreed with the Chief Financial Officer (CFO). **Other**

	The Committee shall review proposed changes to Standing Orders, the Scheme of Reservation and Delegation, and Standing Financial Instructions, and advise the Board accordingly. The Committee shall examine the circumstances associated with each occasion when Standing Orders are waived. Where requested by the Board, the Committee should review the content of the Annual Report/ Quality Account and Accounts and advise the Board on whether, taken as a whole, it is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance and strategy In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this should include the Quality Governance and Assurance Governance Committee and any risk management committees that are established. The Audit Committee Chair will actively consult with and take recommendations from the Chairs of other Committees of the Board for the internal audit programme. Where an internal audit or other audit is undertaken where responsibility crosses with other Committees of the Board the report recommendations and actions will be shared with the respective and appropriate Committees. It may be agreed that those Committees then agree oversight for the Governance of the completion of the actions and resulting impact. The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities. The trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans

	• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services. Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy. The board should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report. The board should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report. In the annual accounts, the board should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.
REMUNERATION AND TERMS OF SERVICE COMMITTEE	The Committee will: 1. To make such recommendations on the remuneration and terms of service of the Chief Executive and Executive Directors to ensure they are fairly rewarded for their contribution to the organisation, having proper regard to the organisation's circumstances and performance and to the provision of any national arrangements for staff where appropriate. 2. To monitor and evaluate the performance of the Chief Executive and individual Executive Directors as to the corporate performance of the Trust. The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
QUALITY, GOVERNANCE ASSURANCE COMMITTEE	The Committee will: 1. To review all relevant indicators of patient experience/satisfaction, patient care and patient safety and to assure itself that good practice is being disseminated and that any deficiencies are put right. 2. Promote continuous quality improvement through a culture which encourages open and honest reporting and an educative and supportive approach to the management of risk. 3. To approve the Terms of Reference and membership of its reporting subgroups (and oversee the work of the sub-groups, receiving reports for consideration and action as necessary. 4. Co-ordinate the monitoring of risks utilising the Board Assurance Framework (BAF)/Trust Risk Register framework (TRR) to assess the effectiveness of controls, assurances/gaps in assurance and further action. 5. To manage specific BAF risks delegated to the committee, providing assurance updates to Trust Board. 6. Utilise the assurance reporting processes to inform the Audit Committee and Trust Board on the management of risk and proposed internal audit work. 7. To oversee the Governance and Risk Management Framework and any supporting delivery plans and Risk management policies OP10 across the Trust. 8. To review the Annual Governance Statement together with any accompanying Head of Internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. 9. To receive the Clinical Audit annual report and annual Clinical Audit plan ensuring it is consistent with the audit priorities of the Trust. 10. To examine any relevant matters referred to it by the Board of Directors or Audit Committee. 11. To monitor and report on quality and safety performance to the Trust Board. 12. To review a report on themes from incidents, claims, complaints and related areas, to inform risk management or improvement actions.
CHARITY COMMITTEE	The Committee will: <u>Assurance</u> a) Manage the affairs of The Royal Wolverhampton NHS Trust Charity within the terms of its declaration of trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations. b) Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law. c) Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations. d) Receive and approve periodic income and expenditure statements. e) Receive and approve Annual Accounts and consider the Annual Report from the auditors, before submission to the Board of Directors

	Investments f) Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations. g) Appoint and review external investment advisors and operational fund managers. h) Review the performance of investments on a regular basis with the external investment advisors to ensure the optimum return from surplus funds. Fundraising i) Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation. j) Ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law. k) Ensure systems, processes and communications are in place around fundraising, staff engagement and funding commitments. l) Ensure a cohesive policy around external media and communication. m) Ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds.
TRUST MANAGEMENT COMMITTEE	The Trust Management Committee is the senior cross Trust operational management meeting. It reports to the Executive Directors meeting Chaired by the CEO who reports a summary of activities to the Trust Board. The Committee will: 1. The TMC will advise on and be responsible to the Trust Board on all matters relating to Trust operations. This will include responsibility for the following activities:- • Direct and monitor progress with implementation of key Trust strategies • Approval of Trust wide policies and procedures • Recommend to Trust Board strategies for the Trust for approval. • Approve business cases to deliver key Trust strategies and the corporate business plan which are in excess of £100,000 but below £500,000. • Monitor delivery of the Trusts Estate strategy • Monitor and redress as appropriate financial performance across operational service areas • Monitor the delivery of the Trust Nursing & Midwifery programme, ensuring effective integration into operational areas • Monitor the operational performance and implementation of the ICT Digital strategy • Receive advisory reports on the operation of governance, risk management and compliance deliverables across the Trust. • Approve annual sign off of the IG Toolkit requirements. • Receive regular updates and advice from the Finance, HR, Governance Chief Officers to ensure effective operational integration with the following: - Policy – Strategy - Developments - National & local strategies, policies and developments - Legal issues 2. To monitor the delivery of the Trust Strategic aims and objectives. 3. To review and act upon operational performance information including the Quality and Performance KPI/Activity Report, financial

	position and key governance reports. 4. Receive and comment upon service delivery change plans. 5. Review Divisional risk registers to be assured on the progressive management and identification of risks. 6. To approve the Terms of Reference annually and membership of its reporting subgroups and oversee the work of the sub-groups, receiving reports for consideration and action as necessary. 7. Review all reports to the Committee with a view to extrapolating risks to inform the Board Assurance Framework (BAF)/Trust Risk register or Divisional risk registers. 8. Review new/existing red and high amber risks across the Trust to inform appropriate progression and/or escalation. 9. Promote a culture within the Trust which encourages open and honest reporting of risk and an educative and supportive approach to the management of risk. 10. To examine any relevant matters referred to it by the Board of Directors or other Board Sub Committee. 11. Seek opinions on potential innovation and development opportunities. 12. Ensure the Committee undertakes an effectiveness self-assessment at least every 2 years (as a minimum).
PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE	The Committee will: The purpose of the committee is to provide the Board with assurance that: • The organisational development and workforce strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care • Processes are in place to support optimum employee, engagement, wellbeing and performance to enable the delivery of strategy and business plans in line with the trust's values • The Trust is meeting its legal and regulatory duties in relation to its employees • Where there are human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee. • The organisational culture is diagnosed and understood and actions are in place to ensure continuous improvements in culture. To provide assurance on the following key areas of workforce governance: • Resourcing • Skills • Leadership & organisational effectiveness • Engagement & Culture • Wellbeing • Productivity

PERFORMANCE & FINANCE COMMITTEE	The Committee will: 1. Utilise the assurance reporting processes (BAF/TRR) to inform the Trust Board of Finance, performance, investment or related risk and redress actions. 2. Review annual plan modelling assumptions and in particular capital and revenue allocations as well as activity and investment assumptions. 3. Review and endorsement of the annual revenue and capital budgets before they are presented to the Board for approval. 4. Approve the development of financial and contractual reporting in line with best practice. 5. Monitor income and expenditure against planned levels and make recommendations for corrective action should excess variances occur. 6. To receive and review the trust wide and divisional reports on finance and contractual performance and CIP before they are presented to the Board. The focus will be on forecast outturn, risks to delivering the plan and the mitigation plans. 7. Review expenditure against the agreed capital plan. 8. Review any matters which impact adversely on the financial performance or reputation of the Trust. 9. Oversee the development of Service line reporting. 10. Approve financial returns prior to submission to any external accountable authority, e.g. reference costs, ERIC, etc. (other than NHSE monthly returns due to timeliness) 11. Ensure the appropriate training and support is in place for budget holders/managers. 12. To make arrangements as necessary to ensure that all members of the Board and senior officers of the trust maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust. 13. Periodically review financial policies and procedures including scheme of delegation etc. to ensure that they are still relevant and appropriate. 14. Review financial and contractual performance against the main healthcare contracts. 15. Receive reports regarding contract negotiations and progress in agreeing contracts with the Commissioning bodies. 16. In line with the NHSE, assess if any proposed investments should be reported to NHSE/ICS in the annual planning process or in year prior to financial closure. 17. To receive and undertake investment appraisals of submitted developments and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and external requirements to ensure that capital investments and transactions comply with the latest NHSE guidance. Ensure risks of any investments are properly evaluated and risk management arrangements put in place, including:- • Obtaining independent professional advice where appropriate. • Evaluate, scrutinise and monitor investments. • Ensure Investments are supported by relevant stakeholders. • To examine any relevant matters referred to it by the Board of Directors. 18. To examine any relevant matters referred to it by the Board of Directors. 19. To receive reports regarding new business and tender opportunities and the progress of tenders. 20. To receive and discuss updates regarding STP/ICS developments and requirements.

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. 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.
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.
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."
CHAIRMAN	Implement requirements of corporate governance.
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).
CHIEF FINANCIAL OFFICER	Operational responsibility for effective and sound financial management and information.
CHIEF EXECUTIVE	Primary duty to see that CFO discharges the above function.
CHIEF EXECUTIVE	Ensure that expenditure by the Trust complies with Parliamentary requirements.
CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Chief Executive, supported by Chief Financial Officer, ensures appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
CHIEF EXECUTIVE	If CE 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 refer to the Department of Health and Social Care, NHS England

CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that he/she is overruled it is normally sufficient to ensure that the advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the Department of Health and Social Care, NHS England. In such cases, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

DELEGATED TO	AUTHORITIES/DUTIES RESERVED OR DELEGATED
BOARD	Approve procedure for declaration of hospitality and sponsorship.
BOARD	Ensure proper and widely publicized procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe to Code of Conduct.
BOARD	Board members share corporate responsibility for all decisions of the Board.
CHAIR AND NON EXECUTIVE/ OFFICER MEMBERS	Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
BOARD	The Board has six key functions for which it is held accountable by the Department of Health and Social Care 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; 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 RESERVED OR 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 Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committees, 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 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.
CHAIR AND DIRECTORS	Declaration of conflict of interests.
BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health and Social Care, NHS England on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. The Board must on a comply, demonstrate or explain basis, ensure it is aware of and acting in accordance with the NHS Code of Governance for NHS Provider Trust (2023).

SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES RESERVED OR DELEGATED
SECTION A - 2	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
4.4	BOARD	Appointment of Vice Chairman
5.1	CHAIRMAN	Call meetings.
5.9	CHAIRMAN	Chair all Board meetings and associated responsibilities.
5.10	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
5.12	CHAIRMAN	Having a second and casting vote
5.13	BOARD	Suspension of Standing Orders
5.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders
5.14	BOARD	Variation or amendment of Standing Orders
7.3	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference.
7.2	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has reserved to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive.
7.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
7.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
9.1	THE BOARD	Declare relevant and material interests.
9.2	CHIEF EXECUTIVE	Maintain Register of Interests.
9.4	ALL STAFF	Comply with national guidance contained in HSG (93/5) “Standards of Business Conduct for NHS Staff” and with any Trust policy derived therefrom and The NHS Code of Governance for NHS Provider Trusts (2023).

SO REF	DELEGATED TO	AUTHORITIES/DUTIES RESERVED OR DELEGATED
9.3	ALL	Disclose any pecuniary interest (direct or indirect) in any contract entered into (or about to be entered into) by the Trust.
9.4 (2)	ALL	Disclose relationship between self and candidate for staff appointment. (CEO to report the disclosure to the Board.)
9.5	CHIEF EXECUTIVE / DEPUTY CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
9.9	CHIEF EXECUTIVE/EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1.3	CHIEF FINANCIAL OFFICER	Approval of all financial procedures.
1.1.4	CHIEF FINANCIAL OFFICER	Advice on interpretation or application of SFIs.
1.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Duty to disclose any non-compliance with Standing Financial Instructions to the Chief Financial Officer as soon as possible.
1.2.2	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the System of Internal Control.
1.2.2	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.2.3	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
1.2.4	CHIEF FINANCIAL OFFICER	Responsible for: a) ensuring that the Standing Financial Instructions are maintained and regularly reviewed; b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies; 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; 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 include:

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		(a) the provision of financial advice to other members of the Board and employees; (b) the design, implementation and supervision of systems of internal financial control; (c) 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.
1.2.5	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, Standing Financial Instructions, financial procedures and The Scheme of Reservation and Delegation.
1.2.6	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 is made aware of these instructions and the requirement to comply.
2.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control.
2.1.2	CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3 & 2.2.1	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.)
2.2.1	CHIEF FINANCIAL OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
2.2.3	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Responsible for ensuring access rights are given to NHS Counter Fraud Authority where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with the Government Functional Standard 013: Counter Fraud.
2.3	INTERNAL AUDIT SERVICE PROVIDER	Review, appraise and report in accordance with guidance from Department of Health and Social Care and Social Care and best practice.
2.4	AUDIT COMMITTEE	Ensure cost-effective, efficient External Audit.
2.5	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Monitor and ensure compliance with the Government Functional Standard 013: Counter Fraud on fraud and corruption as specified in the NHS Tackling Fraud, Bribery & Corruption Policy & Corporate procedures.
2.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.
3.1 & 3.2	CHIEF FINANCIAL OFFICER	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
3.1.6	CHIEF FINANCIAL OFFICER	Ensure adequate training is delivered on an on going basis to budget holders.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.2.1	CHIEF EXECUTIVE	Delegate budgets to budget holders.
3.2.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
3.3.1	CHIEF FINANCIAL OFFICER	Devise and maintain systems of budgetary control.
3.3.2	BUDGET HOLDERS	Ensure that: (a) no overspend or reduction of income that cannot be met from virement is incurred without appropriate consent; (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 appropriate approval other than those provided for within available resources and manpower establishment.
3.3.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities.
3.5	CHIEF EXECUTIVE	Ensure the submission of monitoring returns
4.1	CHIEF FINANCIAL OFFICER	Preparation of annual accounts and reports.
5.1	CHIEF FINANCIAL OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
5.5.1	CHIEF FINANCIAL OFFICER	The CFO will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
5.5.2	CHIEF FINANCIAL OFFICER	Any application for a loan or overdraft will only be made by CFO or by an employee delegated by them
5.5.3	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
5.5.4	CHIEF FINANCIAL OFFICER	Ensure that the process for approving short term borrowings is consistent with the Board-approved Treasury Management Policy/Guidelines.
5.6.2	CHIEF FINANCIAL OFFICER	Will advise the Board on investments and report, periodically, on performance of same.
5.6.3	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions on the operation of investments held.
6.1	CHIEF FINANCIAL OFFICER	Responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collecting and coding of all monies due

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
6.3	CHIEF FINANCIAL OFFICER	Responsible for appropriate recovery action on all outstanding debts
7.6.3	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	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.
7.6.7	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	Where one tender is received will assess for value for money and fair price.
7.6.9	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 SFIs except with the authorisation of the Chief Executive.
7.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
7.7.4	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 or Chief Financial Officer.
7.9	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
7.9	BOARD	All PFI proposals must be agreed by the Board.
7.10	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
7.11	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
7.14	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.
7.14.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
8.1.1	CHIEF EXECUTIVE	Shall ensure that the Trust enters into suitable Service Level Agreements (SLAs) with commissioners for the provision of NHS services
8.2	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from SLAs
9.2.1	BOARD	Establish a Remuneration Committee
9.2.2	REMUNERATION COMMITTEE	Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments. Advise the Board on and make recommendations on the remuneration and terms of service of the CE, and other executive members employed by the Trust. Monitor and evaluate the performance of individual executive members.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
9.2.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and the basis for recommendations.
9.5	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.
9.6	NOMINATED MANAGER	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.
10.1	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.
10.2	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.
10.3.1	CHIEF FINANCIAL OFFICER	Shall be responsible for the prompt payment of accounts and claims.
10.3.2	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 SFIs 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) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
10.4(a)	APPROPRIATE OFFICER	Make a written case to support the need for a prepayment.
10.4(b)	CHIEF FINANCIAL OFFICER	Approve proposed prepayment arrangements.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.4(c)	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered).
10.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
10.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer.
11.1.1	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) shall ensure that the capital investment is not undertaken without confirmation of affordability; (c) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
11.1.2	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
11.1.4	CHIEF FINANCIAL OFFICER	Assess the requirement for the operation of the construction industry taxation deduction scheme.
11.1.5	CHIEF FINANCIAL OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
11.1.7	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 delegation for capital investment management.
11.1.9	CHIEF FINANCIAL OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
11.7.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from CFO).
11.7.5	CHIEF FINANCIAL OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
11.7.8	CHIEF FINANCIAL OFFICER	Calculate and pay PDC dividend in accordance with Department of Health and Social Care and Social Care requirements.
11.8.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
11.8.2	CHIEF FINANCIAL OFFICER	Approval of fixed asset control procedures.
11.8.4	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.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
12.2.1	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.
12.2.1	CHIEF FINANCIAL OFFICER	Responsible for systems of control over stores and receipt of goods.
12.2.1	CLINICAL DIRECTOR OF PHARMACYAND MEDICINES OPTIMISATION	Responsible for controls of pharmaceutical stocks
12.2.1	DIVISIONAL MANAGER, ESTATES AND FACILITIES	Responsible for control of stocks of fuel oil and coal.
12.2.3	CHIEF FINANCIAL OFFICER	Set out procedures and systems to regulate the stores.
12.2.4	CHIEF FINANCIAL OFFICER	Agree stocktaking arrangements.
12.2.5	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
12.2.6	CHIEF FINANCIAL OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
12.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to CFO evidence of significant overstocking.
12.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain stores.
13.1.1	CHIEF FINANCIAL OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
13.2.1	CHIEF FINANCIAL OFFICER	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
13.2.2	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 CE and CFO.
13.2.2	CHIEF FINANCIAL OFFICER	Where a criminal offence is suspected, CFO must inform the police if theft or arson is involved. In cases of fraud and corruption CFO must inform the relevant LCFS.
13.2.3	CHIEF FINANCIAL OFFICER	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.2.6	BOARD	Approve write off of losses (within limits delegated by DHSC).
13.2.8	CHIEF FINANCIAL OFFICER	Consider whether any insurance claim can be made.
13.2.9	CHIEF FINANCIAL OFFICER	Maintain losses and special payments register.
14.1.1	CHIEF FINANCIAL OFFICER	Responsible for accuracy and security of computerised financial data.
14.1.2	CHIEF FINANCIAL OFFICER	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.
14.2.1	CHIEF MEDICAL OFFICER	Shall publish and maintain a Freedom of Information Scheme.
14.2.2	RELEVANT OFFICERS	Send proposals for general computer systems to CFO
14.3	CHIEF FINANCIAL OFFICER	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.
14.3.3	CHIEF FINANCIAL OFFICER	Where computer systems have an impact on corporate financial systems the Chief Financial Officer 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's staff has access to such data, and; (d) such computer audit reviews as are considered necessary are being carried out.
14.4	CHIEF EXECUTIVE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
15.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
15.3	CHIEF FINANCIAL OFFICER	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.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
15.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
16.1.2	CHIEF FINANCIAL OFFICER	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.
17.1	CHIEF FINANCIAL OFFICER	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff.
18.1	CHIEF EXECUTIVE	Retention of document procedures in accordance with NHSE and DHSC Guidelines
20.1.1	CHIEF EXECUTIVE	Risk management programme exists.
20.1.1	BOARD	Approve and monitor risk management programme.
20.2.1	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
20.4	CHIEF FINANCIAL OFFICER	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. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any 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 that will not be reimbursed.

(Scheme of reservation & delegation February 2023)

Reference(s):

Code of governance for NHS provider trusts – https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/

Document Control

<table>
<tr><td>Reference Number and Policy name:

Budget Management Principles and Guidance</td><td colspan="2">Version:

V3.1</td><td colspan="2">Status:

Final</td><td>Author: Deputy Chief Finance Officer

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<tr><td rowspan="6">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td colspan="2">Reason</td></tr>
<tr><td>V1</td><td>September 2010</td><td>Deputy Chief Financial Officer</td><td colspan="2">Initial set-up of SOP</td></tr>
<tr><td>V2</td><td>April 2019</td><td>Head of Financial Control and Assurance</td><td colspan="2">Review of SOP to ensure meets current process, with tweaks to reflect current practice</td></tr>
<tr><td>V3</td><td>November 2021</td><td>Deputy Chief Finance Officer</td><td colspan="2">Scheduled review of policy</td></tr>
<tr><td>V3.1</td><td>April 2022</td><td>Deputy Chief Finance Officer</td><td colspan="2">Update made to hyperlink on page 23.</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="6">Intended Recipients: All managers with budgetary responsibility</td></tr>
<tr><td colspan="6">Consultation Group / Role Titles and Date: Finance & Performance Committee; Audit Committee; Trust Management Committee; Chief Financial Officer; Deputy Financial Officer; Head of Financial Management</td></tr>
<tr><td colspan="3">Name and date of Trust level group where reviewed</td><td colspan="3">Trust Policy Group – January 2022
Trust Management Committee – January 2022</td></tr>
<tr><td colspan="3">Name and date of final approval committee</td><td colspan="3">Audit Committee – December 2022
Trust Board – February 2022</td></tr>
<tr><td colspan="3">Date of Policy issue</td><td colspan="3">February 2022</td></tr>
<tr><td colspan="3">Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)</td><td colspan="3">Annually</td></tr>
<tr><td colspan="6">Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees and dissemination via Intranet.</td></tr>
<tr><td colspan="6">To be read in conjunction with: Standing Orders, Scheme of Delegation, Conflicts of Interest Policy, and Anti-Fraud and Anti-Bribery Policy</td></tr>
</table>

Initial Equality Impact Assessment (all policies): **Completed Yes** **Full Equality Impact assessment (as required):** **Completed NA** If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.	
Contact for Review	Head of Financial Control and Assurance
Implementation plan / arrangements (Name implementation lead)	Chief Financial Officer
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board
Document summary / key issues covered: It is the Trust Board's philosophy that the responsibility for achieving the Trust's objectives should be devolved to the lowest practical level. Accordingly, departmental managers are responsible for their departments' contributions towards overall objectives - including the provision of services within specific resource levels. This document identifies budget responsibilities that are consistent with the Trust's management structure and philosophy. Each executive director of the Trust is accountable for the financial performance of their area of responsibility.	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

THE ROYAL WOLVERHAMPTON NHS TRUST

BUDGET MANAGEMENT PRINCIPLES AND GUIDANCE

CONTENTS

SECTION 1 - FOREWORD

1. It is the Trust Board's philosophy that the responsibility for achieving the Trust's objectives should be devolved to the lowest practical level. Accordingly, departmental managers are responsible for their departments' contributions towards overall objectives - including the provision of services within specific resource levels.

2. This document identifies budget responsibilities that are consistent with the Trust's management structure and philosophy. Each executive director of the Trust is accountable for the financial performance of their area of responsibility.

3. Although devolution is the Board's philosophy, it must be remembered that ultimate responsibility for the Trust's overall budgetary and cash control lies with the Board. Budget Holders must strictly observe the budgetary limits and control procedures defined by the Board.

4. You are also advised to read the Budget Manager Training booklet, which is available from your Finance Manager. It provides a basic explanation of the information that appears on budget reports, how to interpret them and how to complete some of the financial processes that ensure that your reports are timely and accurate.

5. The Finance and Information Directorate are happy to provide training on any aspect of budgetary control or financial procedures. This can be arranged for individual managers or groups of staff. Please speak to your Finance Manager for further details, or Deputy Chief Financial Officer (ext. 85376).

SECTION 2 - STANDING FINANCIAL INSTRUCTIONS

1. Standing Financial Instructions are issued for the regulation of the conduct of the Trust, its directors, officers and agents in relation to all financial matters. The Board is responsible for ensuring that adequate Standing Financial Instructions are adopted and adhered to.

2. This document is written to supplement the broad policy statements relating to budgets, as documented in Section 3 of Standing Financial Instructions.

3. Notwithstanding the budgetary limits identified within this budget policy document, the Authorised Limits (particularly as they apply to requisitioning, procurement and payment) identified in Standing Financial Instructions must always be observed.

SECTION 3 - FINANCIAL ADVICE

1. The Chief Financial Officer's duties, powers and responsibilities in relation to the Trust's overall financial performance are set out in Statutory Financial Regulations and in the Trust's Standing Financial Instructions.

2. In order to discharge such responsibilities, the Financial Management Section of the Finance Department has been organised into teams, each headed by a Finance Manager to provide financial monitoring, advice and support to budget managers. Thus each budget holder in the Trust will have a named contact point on day-to-day budget issues, and will also have access to a designated senior member of the Department, a Finance Manager, for detailed professional advice and support. Regular contact with both is essential and is encouraged.

3. Financial advice and support will include:-

   - Assistance with variance analysis, supporting managers to understand under or overspends.
   - Provision of estimated resource allocations, revenue consequences of capital proposals, other developments and changes in activity levels.
   - Costing of changes to services, including the impact on service level agreements or contracts with commissioners.
   - Development of annual cost improvement programme savings initiatives.
   - Assistance in the development of the budget holder's services in line with agreed strategic priorities and policies
   - Evaluating planning proposals emanating from the budget holder for inclusion in the annual budget and strategic and annual planning cycle
   - Developing business plans and business cases
   - Training in financial issues

4. In the modern NHS it is likely that most major decisions made by budget holders or managers in the Trust will have some impact upon either spending or income levels. As part of the management process, early identification and full discussion and disclosure of the financial effects of development or savings proposals is of great importance. In the clinical arena this will include the impact of significant changes to drug therapies, care pathways or clinical techniques etc. In support of this, all reports should indicate clearly the financial effects of any proposals - both on the income and expenditure of the budgets directly affected and on other areas or departments - prior to implementation. These financial implications MUST be agreed with the Finance Directorate in advance of submission for approval and the figures reported shown as having been so agreed (see also Service Developments and Business Cases under Section 5 below)

5. To comply with these requirements it is obviously necessary for any report which has a financial impact to be agreed with finance staff at as early a stage as possible.

SECTION 4 - BUDGETS - GENERAL PRINCIPLES

1. A number of general principles underpin the Trust's approach to financial management and will impact on the further development of budgets within the Trust.

(a) Levels of budgetary responsibility

It is important to clarify individual responsibilities and to ensure both that accountability lines are clear and that such accountabilities are consistent with the Trust's wider management arrangements. Levels of responsibility are:

Budget Holder:-

Budget holders will normally be ward/departmental managers, who are responsible for day to day management of the budget.

Monitoring Officer:-

Monitors performance of a designated group of budget holders, ensuring that action is taken to bring about individual and collective balance. In the clinical operational areas, monitoring officers would normally be members of the Clinical Directorate teams.

Divisional/Corporate Director:-

Monitors performance of his/her division or directorate, ensuring that appropriate action is being taken and that, as a minimum, the division's/directorate's overall position is in balance.

It follows from the above that the budget holder is responsible for ensuring that his/her department operates within budgetary limits. In the exceptional cases where there is a possibility of this not being the case, discussion needs to take place with monitoring officer/director to identify how such a position will be accommodated within an overall balanced division/directorate.

A detailed list of these is available from Finance.

(b) Openness

In the interests of "no surprises", it is important that issues impacting upon the ability to achieve budgetary targets are communicated at an early stage – both up and down the Trust.

(c) Scope of budgetary responsibility

Activity and Income

The Trust's ability to spend is constrained by the amount of income it can reasonably expect to generate from its commissioners and the risk associated with such expectations. It is, therefore, important that expenditure levels respond to changes in service level agreements and contracts and to in year activity levels. The Trust will incorporate - where appropriate - income into budget reports and budget managers will be responsible for ensuring a balanced position across both income and expenditure.

Ability to control and internal recharges

It is a basic budgetary principle that responsibility should rest where control can actually be exercised, although there are circumstances where this is impractical from a systems viewpoint e.g. postage. However, there are areas where it is felt that internal recharging arrangements may have some beneficial impact (as demonstrated, for example by the devolution of the drugs budget).

This approach will only be pursued where there are significant benefits in accountability and decision-making and where recharges can be supported by robust activity data.

(d) Value for Money and Efficiency

Measurement of Performance at Service Level

The Trust will develop measures that allow performance to be measured at service level e.g. specialty or HRG. This will assist in identifying areas for operational improvement and growth or where savings in expenditure may be possible. Directorates are expected to contribute to this process by working with the Finance Directorate to analyse this information and develop action plans. Directorates should work with the Service Efficiency team to develop their pipelines of efficiency; the Service Efficiency team will support the development of PIDs. This should support the transaction of financial efficiency.

This will include benchmarking data on clinical performance and reference costs, for instance under the Trust's Model Hospital, Clinical Excellence and Getting It Right First Time programmes and will develop productivity measures that link budget performance with activity and outcome indicators.

This work is supported by the Trust's Patient Level Costing and Service Line Reporting systems (see Section 12).

SECTION 5 – TRUST BUSINESS PLANNING AND BUDGET SETTING PROCESS

Business Planning

1. Budget setting is part of the wider Trust business planning process. The income to fund budgets comes from contracts with commissioners (CCGs and NHSE/LA), service level agreements (SLAs), and from charges (e.g. catering, accommodation etc.). Income from commissioners makes up over 90% of the total. One of the main aims of Business planning is to identify service developments, cost pressures and levels of activity required to achieve national and local targets. Actual levels of activity achieved by the Trust will determine the level of funding available to fund these plans. The Trust is now moving towards forms of contract with a shared risk basis e.g. Shared Aligned Incentives Contract. This is in line with National Guidance and the Standard NHS Contract also increasingly moving towards shared risk basis. Negotiations take place with commissioners each year to agree target levels of activity. Trust will always seek to work with Commissioners for maximum income to meet activity completed with the NHS standard Contract being used as a last resort.

2. Contracts with commissioners consist of funding for agreed activity levels, and include an uplift determined each year to fund:

   - Pay award and inflation increases.
   - National cost pressures (e.g. new drugs).
   - Less a real reduction in funding in anticipation of increased efficiency.

3. The implication of the efficiency requirement in contract pricing is that the Trust must achieve a productivity gain each year. This will require either reductions in cost, or increases in activity that produce more income than increased cost. This increased productivity is the only mechanism available to the Trust to fund new developments and cost pressures. It is important that service developments, whether avoidable or unavoidable, are identified as early as possible to include in the business planning process (see Section 7**:** Cost Pressures/ Unfunded Developments).

4. The annual process of identifying service developments, cost pressures and levels of activity required to achieve national and local targets, and agreeing these with commissioners takes place according to an agreed timetable in order that contracts with commissioners and an income and expenditure (I&E) plan can be approved by the Trust Board prior to the start of the financial year, as well as to enable submission of plans to monitoring organisations. The Chief Financial Officer is responsible for establishing a Trust Budget each year for approval by the Trust Board.

5. The Long Term Financial Model (LTFM) will also be updated each year to assist the forward planning process.

Budget Setting

6. Meetings will be held, in accordance with an agreed timetable, between budget holders/monitors and members of the Finance Department designed to establish a package of agreed budgets for inclusion in the Trust's Annual I&E plan. This process will normally take place between November and February. A more detailed set of guidance on budget setting is embedded as an Appendix at the end of this section.

7. Budgets will be based on planned levels of activity and income, based on the outcome of contract agreements, and priorities agreed by the Trust Board that are reflected in the Trust's strategic objectives and business plans. Budgets will be drawn up so that at aggregate level they are contained within income levels and are consistent with the achievement of the Trust's overall financial targets.

8. The Finance Department is responsible for assisting budget holders in the preparation of budgets. This will normally entail a two stage process, as follows:-

(a) Baseline budget

This is essentially a calculation of the costs of sustaining existing levels of agreed recurrent staffing and non-pay expenditure. The full year effect of part year changes will be incorporated and any non recurrent adjustments will be negated. The bases of producing baseline budgets will be:-

- agreed establishment costed using -

(i) Pay rates prevailing at budget setting, including actual incremental points of staff in post (subject to these being consistent with funded establishment); and

(ii) Effect of forecast increments (subject to the Trust's overall financial position). Posts vacant at the point of budget setting will be funded at minimum of scale.

(iii) Anticipated "vacancy factor" (see Section 6)

- Non pay budgets at full year effect "rollover" levels.

Whilst discussions around baseline budgets may identify cost pressures, these can only be accommodated at this stage if self-funded within the budget.

Where appropriate, the baseline activity level underpinning the baseline expenditure budget will be explicitly agreed.

(b) Post-baseline adjustments

These adjustments are significantly linked to income from planned activity and contracts and would include, subject to funding being identified:-

- Service developments

- Changes in activity (both increases and decreases)

- Cost pressure funding
- Cost improvements

9. Once budgets have been agreed, they will be updated normally for changes in pay rates or price levels. Such changes will always be subject to the Trust's overall financial position.

10. The Finance and Information Directorate will be responsible for agreeing the monthly phasing of income and expenditure plans with operational divisions and directorates at the start of the year. In order for this to be undertaken on an informed basis, divisions/directorates will need to develop phased plans for delivering agreed activity levels. The "default" option for monthly budget phasing will be twelfths – and any changes from that position will only be implemented where it is agreed that such a change will make a significant impact.

Cost Improvement Programme

11. The Trust will need to achieve financial efficiencies each year (see Section 3). This leads to a gap between planned income and planned expenditure each year which will need to be filled by efficiency savings. Plans to achieve efficiency savings are summarised in the Trust's Cost Improvement Programme and savings otherwise known as CIPs. CIPs may relate to income or expenditure, though income CIPs are likely to require engagement with the paying organisation.

12. Once identified CIPs are taken from budgets recurrently or non-recurrently. Non-recurrent CIPs are reflections of underspends in year where there is no ongoing plan to reduce costs or increase income. Non-recurrent CIPs demonstrate to regulators that the Trust has identified ways to improve its financial position in year, but they do nothing to improve the underlying financial position. Amounts saved non-recurrently in one year will need to be saved again in the following year and will need to be added to the CIP requirement for the following year.

13. The budget setting process will identify the financial gap between planned income and planned expenditure. The Board will then need to take a view on the level of CIP that should be delivered to address this gap. This will depend on the size of the gap, whether financial mitigations can be found outside of the Cost Improvement Programme, and on the level of CIPs that the Board considers can be delivered without adversely affecting patient care. CIPs greater than 5% of budgets are widely considered unachievable and are likely to be challenged by regulators.

14. Responsibility for managing the delivery of the Trust's Cost Improvement Programme rests with the Service Efficiency Team. Service transformation is the key to delivering sustainable, high-value CIPs. It is essential that operational and financial managers make a significant contribution to this through their understanding of services. Operational teams will need to identify and develop proposed schemes alongside the Service Efficiency Team and consider their impact on patient care. Financial support will be required to evaluate the deliverability and realism of schemes and also to use financial information to identify opportunities.

15. The earlier CIPs can be identified; the more likely they are to be delivered at the time they are needed, so work on identifying efficiencies needs to be ongoing throughout the year. A successful CIP programme is likely to plan more than one year in advance. If we only start to identify CIPs at the start of the financial year, we are unlikely to reach our target.

15. Once the Trust-wide CIP target has been set, targets will be set for Divisions and Directorates. The default for this is that a percentage target will be applied proportionally to reach the required total. Certain areas will be exempted from this, usually where the costs are not controllable or are matched equally by income.

16. Monitoring and approval of the CIP is discussed further in Section 8 below. Once a CIP is identified as likely it will generate a Project Initiation Document (PID) and subsequent budget changes will need to be consistent with this PID.

17. Once identified and implemented, CIPs are removed from budgets recurrently or non-recurrently to reflect the fact that spend is no longer required or additional income has been generated. There are three special cases:

- Where budget can be removed due to never been spent in recent years. This helps to reduce the planned financial gap at budget setting, by removing budgets that are no longer required, but has no impact on actual spend. Savings of this type should be declared where possible to assist with realistic planning but will not improve the Trust's actual financial performance.
- Where savings can be made but cannot be taken out of budgets, because they relate to reducing overspends. In some cases the Trust may consider funding cost pressures on agency or WLI payments, which will allow CIPs to be identified against these areas. In any case the Trust's financial position will improve if costs are reduced, so savings of this type should be pursued with equal importance as savings from budgets, even if they are not counted against the Trust's CIP target.
- Where spend can be reduced but is linked to reduction in income, or where income can be increased but at a cost. In these cases the net position should be considered in budget setting.

Planned Activity Changes

18. Planned changes to activity levels will clearly affect the budgets that divisions/directorates require. A review of the impact of activity will take place each year according to a process agreed by the Chief Operating Officer with the Chief Financial Officer.

19. Increases in planned income that are agreed to be recurrent by the Chief Financial Officer (following discussion with the Chief Operating Officer) can be used to fund recurrent developments, subject to the procedure on business cases (see below). They can also be used (net of any additional recurrent expenditure) to meet annual recurrent cost improvement (CIP) targets.

20. The process around in-year income performance is described in Section 8 below. The main distinction to income variances is that they will not normally be treated as recurrent within the financial year.

Service Developments and Business Cases

21. It is essential that service developments/improvements/changes are not actioned without (a) a clear identification of potential impacts on income and costs and (b) agreement over funding (c) demonstration of efficient use of resources. A business case procedure and documentation has been developed and is available on the intranet to ensure that there is a clear statement of the impact of any proposed change and that the case is approved at the appropriate level with the Trust.

22. Recurrent developments/changes must not be agreed unless the business case (detailing, amongst other things, income and expenditure impact) has been authorised in accordance with the agreed approval process.

23. The Trust's Business Case Process should be utilised and this can be obtained from relevant Finance Managers.

24. Budge-setting guidance is updated on an annual basis and the latest guidance can be obtained via relevant Finance Manager.

SECTION 6 – STAFFING ESTABLISHMENTS

1. Staffing costs represent a significant proportion of the budget. It is extremely important that managers control and operate within their agreed establishments and net pay budgets (i.e. after reduction for vacancy factor*).

2. Ability to recruit to funded posts may also be subject to the overall (i.e. including non pay) position of a manager's budget. Managers are required to refer to the Trust's existing vacancy control procedure before any new or replacement post is advertised, and this must be approved at Divisional and Executive Directors vacancy panels, which must include appropriate finance managers.

Definition

3. An establishment is a maximum number and grade/mix of staff that a manager is permitted to employ. Agreed establishments include (where appropriate) an element for annual leave, study leave and sickness cover. In no case may a budget manager exceed establishment and/or pay budget without prior approval.

Funding

4. Given that baseline budget funding will be by reference to actual increment point of staff in post, it follows that, within a grade, should staff at a higher point be replaced by those at a lower point, then no CIP can be declared. However, this "one off" gain will be available for budget holders to use to offset the vacancy factor (see below), as no funding adjustments to reflect in-year changes in incremental points would normally be made. Any excess budget over and above vacancy factor can be declared none recurrently to CIP.

Manpower Statistics

5. Budget and actual manpower information is produced on a whole time equivalent (WTE) basis. These are derived by taking the hours actually worked (including paid leave and sickness) and dividing by the standard hours in a working week for that grade. Thus, for any member of staff covered by Agenda For Change, the WTE of that individual, if working for 45 hours per week would be:

Actual hours worked	45		
----------	----	=	1.20 WTE
Standard hours for grade	37½		

Vacancy Factor

6. In costing pay budgets, in many areas an explicit reduction is made to gross establishment costings in respect of a "vacancy factor". This acknowledges the fact that staff turnover will result in vacancies; that vacant posts are not always filled immediately; and that leavers are often replaced by staff at a lower incremental point.

7. It should be noted that without this vacancy factor, the Trust's budgets would not be financially sustainable and that establishments would then need to be reduced. The real terms value of the vacancy factor will be maintained by annual uplifts to reflect the rate of increase in the paybill (both inflation and any incremental drift).

8. Vacancy factors are normally rolled over from year to year within individual budgets and are not therefore sensitive to changing circumstances in each area. As part of the annual budget setting process, divisions/directorates have the freedom to reallocate vacancy factor within their overall areas of control; however, the requirement to achieve aggregate vacancy factor remains.

Changes to Establishment

9. These may only occur

   (a) as part of an approved and funded change in service provision, reflected in an agreed Business Case

   (b) As a consequence of an agreed virement (requesting a transfer of resources within or between budgets – see also section 10), identifying source of internal funding

   (c) As part of a Cost Improvement Programme (CIP) which has been approved via a "Project Initiation Document", through the Financial Recovery Group (FRG).

   (d) No change will be reflected in budgets or establishments unless specific approval has been obtained and funding identified, as confirmed by one of the above completed processes – if in doubt, please consult your Finance Manager. All costings of changes to establishments must be undertaken by the Financial Management Department.

10. Changes to the grades attached to posts must be agreed in accordance with Trust HR policies, and any increased cost will normally fall to be met from within the department or directorate.

11. It should be noted, that due to the greater levels of difficulty in controlling non-pay budgets, establishment variation proposals involving the transfer of funds from non-pay to pay are unlikely to be approved without a clear demonstration of the recurring non-pay cost reduction.

SECTION 7 - COST PRESSURES/UNFUNDED DEVELOPMENTS

1. A significant element of the financial pressures experienced by the Trust emanates from so-called "cost pressures". In reality, a large proportion of such pressures would more accurately be called "unfunded service developments"- often arising from changes in clinical practice and/or product designed to improve the quality of patient care.

2. Clearly, implementing such changes - where resulting in an increased cost - is likely to have a detrimental impact on the budget holder's responsibility not to overspend.

3. It is important, therefore, to pre-empt and any such changes should be identified in advance. The procedure on business cases provides a framework for considering service changes that potentially impact on costs reviewing this guidance may help in considering cost pressures. It is important that the budget holder takes a view on whether the cost pressure can be financed by virement (see Section 10) within his/her budget. Should this not be the case, discussions will need to be held within the directorate or division to agree whether the development should proceed and, if so, how funding will be provided. In exceptional cases, the relevant director may wish to bring a proposal to the Executive Directors' Team, it is expected that this would be in the form of a business case, prior to the service change.

4. It is important to identify any cost pressures arising from changes in activity levels, revised national guidance (e.g. NICE) and inflationary pressures as part of the annual budget setting process (see Section 5). This will enable the finance team to work with departments, directorates and divisions to ensure the financial pressure is either built into budget or mitigated in other ways.

SECTION 8 - MONITORING

1. All levels of Trust management shall receive monthly statements detailing actual performance against income and expenditure budgets. The level of detail will vary according to need, with, for instance, budget holders having the greatest level of detail and the Trust Board receiving summarised information. At each level reported there will be exception reports detailing material variances.

2. Although it is the budget holder's responsibility to manage within the agreed budget, monthly budget reports will also be monitored, in summary form, by the monitoring officer/director as part of the accountability relationship within the Directorate/Divisional structure. The monitoring officer must ensure that where overspending is occurring the necessary corrective action is taken.

3. At a Directorate and Divisional level it is important to monitor both Income and Expenditure. The combined total of income minus expenditure is referred to as contribution. By taking the values for budgeted income and expenditure (including CIP reduction), the planned contribution is known. This would then be compared to the actual values and the variance must remain positive. An example is shown below:

	Plan/ Budget	Actual	Variance	
Income	3,000	3,200	200	Over performance
Expenditure				
Pay	(1,500)	(1,400)	100	Underspend
Non Pay	(750)	(850)	(100)	Overspend
CIP Target	150		(150)	
Sub Total	**(2,100)**	**(2,250)**	**(150)**	Overspend
	900	**950**	**50**	Net contribution greater than plan

4. In order to avoid problems and mitigate financial risks, budget holders will be included in forecasting to project income and spending forward to the year end. This will take into account performance to date and any known future issues. Finance staff will lead this process and agree forecasts with budget holders. Corrective actions may be required to ensure that the planned contribution for each Division and Directorate is achieved by year end

5. Formal processes of forecasting the Divisional/Directorate and Trust end of year positions will take place regularly during the financial year.

In Year Variances

5. The policy for reflecting budget changes relating to planned changes to activity and income is stated in Section 5 above. Where there is an in-year variance

(either positive or negative) against planned income levels the relevant directorate will need to work with their Finance Manager to identify the financial impact.

6. The Payment by Results (PbR) mechanism ensures that the Trust is paid for actual activity undertaken. Commissioners will normally, however, expect the Trust to work within agreed targets for planned activity e.g. elective admissions, and divisions/directorates cannot assume that over-performance will be paid. However nationally moving towards a shared risk basis so providers and commissioners will be discussing activity and performance removing PbR.

7. Whilst Payment by Results is predominantly paid on a Cost and Volume basis with each activity generating a tariff and income, some activity is paid for under block contracts or alternative arrangements such as collar and cap, or marginal prices. The finance team will work with Directorates to ensure that they are aware of how specific activities are funded by commissioners so that financial impact of changing activity levels can be understood.

8. The Finance Directorate will provide monitoring information on performance against all contract targets in terms of both financial and activity detail. This will include quarterly reconciliations with commissioners to ensure activity levels are agreed with and monitoring alongside the shared aligned incentives contracts.

9. Meetings are held regularly with commissioners to monitor contracts and agree action on variances. Any such action will be communicated to divisions/ directorates to enable activity plans to be amended in-year if necessary.

Cost Improvement Programme (CIP)

10. The monitoring of budgets will also include monitoring the delivery of CIP, to ensure the targets set during budget setting are achieved.

11. As CIP's are achieved the CIP target within a directorate will be reduced, crediting budgets where the CIP has been identified from.

12. In order to achieve the required contribution for a directorate the balance of unmet CIP will be shown within the overall position as a budget reduction

13. The system for monitoring CIP delivery is maintained by the finance team in conjunction with the Service Efficiency Team. Monthly reports are produced for each directorate to enable their ongoing monitoring and review.

14. Directorate and Divisional CIP delivery is monitored through the Service Efficiency team in collaboration with Financial Management. This is reported through Finance Recovery Group (FRG) to Finance and Performance Committee.

SECTION 9 - OVER AND UNDERSPENDS

1. Managers are required to ensure that budgets are managed in such a way as to avoid overspends. In exceptional circumstances, should overspends against individual budgets occur it will be the relevant director's responsibility to ensure that such overspends are justified and can be accommodated within an overall balanced position across the division/directorate and the overall required contribution is maintained (where a service is income generating).

2. Underspends will be available for use by the manager/directorate in accordance with the policy on virement, as set out in Section 10. Within this general policy, the following should be noted:-

   (a) Underspends arising from activity shortfalls that result in reduced income levels will be applied to offset such income losses through the calculation of variances against contribution, including the requirement to achieve a cost improvement programme.

   (b) Development reserves not required for their original purpose cannot automatically be retained and a written proposal for any alternative use should be approved by the Chief Executive and Chief Financial Officer.

   (c) The ability to retain underspends within a particular department/directorate will be subject to the Trust's overall financial position as determined by the Chief Financial Officer.

   (d) Due to the inflexible nature of the NHS financial regime, the ability to carry underspends from one year into another is very limited, and will only be exercised in exceptional circumstances (e.g. "Earmarked" funding) as agreed in advance by the Chief Financial Officer, via the relevant finance team.

SECTION 10 - VIREMENT

1. Virement is the movement of funds from one budget head to another. Thus virement could be between expenditure lines in the same budget or between two (or more) separate budgets, either within or across directorates. Virement will also be either in-year only (non-recurrent) or recurrent.

2. A virement policy exists to ensure that budget adjustments have been carried out with the approval of the budget holder and, where appropriate, with the approval of the responsible Divisional team, Director, Chief Executive and Chief Financial Officer.

3. This virement policy excludes the re-phasing of budgets, the input of baseline budgets at the start of the year and release of Trust reserves into budgets

4. Subject to virement being in accordance with the Trust's overall objectives, the delegated limit for an individual budget manager and Division or Corporate Directorate) is set out below, and is in line with authorised signatory levels as dictated in Standing Financial Instructions.

5. As outlined in Section 6, paragraph 11, it is unlikely that proposals to transfer from non-pay to pay budgets will normally be approved. Should such a request be made this will require 'sign off' by both the Divisional Manager (and Corporate Directorate equivalent) and the designated Finance Manager.

Authorisation level	Authorisation Required
Up to £5,000 (Within an individual budget Holders area of responsibility)	Budget Holder Finance Manager
= £5,000 up to £14,999 (Or less than £5,000 across Budget Holders responsibility)	Releasing Budget Holder Receiving Budget Holder Receiving Directorate Manager Releasing Directorate Manager Finance Manager
= £15,000 up to £99,999	as above plus Divisional Manager (Or Corporate Directorate equivalent)
= £100,000	as above plus Chief Executive Chief Financial Officer

All virements which include Nursing Staff must also be authorised by the relevant Head of Nursing (who will have agreed changes with Nursing Directorate).

6. A virement may be requested through one of the following routes:

   (a) Using the form provided by your Finance Manager. Assistance in completing this can be gained from your Financial Management team. The authorisation of this form can be done either by physical signature or email from the relevant signatories to the Finance Team.

(b) An email describing the budget transfers required, forwarded through the relevant signatories to the Finance Team.

(c) Minutes/Notes of a 'budget surgery' meeting which have been signed/approved by the relevant signatories and sent on to the Finance Team

6. All virements which include a movement of pay budgets will be sent from finance to Human Resources (HR), to ensure that establishment records retained in HR and the Electronic Staff Record System are updated.

7. Where virement is used for non-recurrent purposes (e.g. purchase of equipment) any consequent recurrent costs should be established, and funding identified, before the funds are committed.

SECTION 11 - RESERVES

1. Limited reserves will be held at Board level under the control of the Chief Financial Officer. These will include a reserve to fund the in-year effects of pay awards and non-pay inflation. Other specific corporate reserves may be established with the approval of the Trust Board.

2. At the start of the year, and as part of the agreed income and expenditure plan, a reserve will be agreed for activity changes and service developments (largely in the Operations Directorate). Funding from this reserve will normally only be released into budgets as and when appointments are made (pay) or the service commences (non-pay).

3. In the event that specific reserves (e.g. for pay and prices) prove to be insufficient the Board will determine the appropriate course of action.

4. Within the constraints of the available resources, the creation of contingency reserves at divisional/directorate level is encouraged. Clearly, such reserves should be identifiable and the position on these should be included in the monthly reporting processes.

SECTION 12 – PATIENT LEVEL COSTING/SERVICE LINE REPORTING

1. The Costing Team produce patient level financial (and operational) information each month using Patient Level Information and Costing System (PLICS) software. Because the information is produced at patient level, it can also be grouped together to look at the financial characteristics of e.g. all of a specific consultant's patients, or all patients of a particular specialty. Dividing all of the Trust's patients into their relevant Service Lines (i.e. collection of one or more specialties) also enables Service Line Reporting (SLR).

2. The key aims of Patient Level Costing (PLC) are:

   - To provide better information on the Trust's activities to support local decision-making.
   - To ensure the costing process is as transparent as possible and that any areas needing improvement are more easily located.
   - To improve the level of accuracy of Reference Costs and therefore the national tariff which is based upon Reference Costs.

3. The key roles of the Costing Team within this process are:

   - To produce PLICS reports in a timely fashion at the end of each month.
   - To ensure that these reports are loaded into Qlikview documents on the intranet where they can be viewed and manipulated by Trust staff.
   - To communicate via e-mail to colleagues within and outside the Finance Department when the new Qlikview reports are available each month at: https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf
   - To look to constantly improve the reports' accuracy by e.g. internal/external benchmarking, using more refined costing methods.
   - To work with colleagues within and outside the Finance Department to enable greater understanding of the Qlikview documents.
   - To communicate to colleagues where there are anomalies within the reports requiring further investigation.

4. The key roles of the users of PLICS reports within this process are:

   - To provide timely patient activity and financial data each month where necessary for the production of the PLICS reports.
   - To familiarise themselves with the Qlikview documents and seek assistance from the Costing Team or Finance colleagues where necessary in order to use them fruitfully.
   - To feedback to the Costing Team where there are concerns about the accuracy of the model.

- To communicate to colleagues where there are anomalies within the reports requiring further investigation.

APPENDIX A

SCHEDULE OF AUTHORISED LIMITS

TENDERING, ORDERING, CONTRACTING – EXPENDITURE

Competitive quotations to apply	£10,000 to £50,000
Competitive tendering to apply	above £50,000

Authority to waive competitive process:-

Head of Procurement/Estates	up to £25,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	above £25,000

Authority to accept other than lowest quote:-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	up to £250,000
Trust Board	above £250,000

Approval to contract awards (including extensions):-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	up to £250,000
Trust Board	above £250,000

NB – All contract awards above £50,000 to be reported to Trust Board for information

Evaluation Panel to include a Non-Executive Director	£1,000,000 & above

Note – The above limits apply equally to asset disposals.

CONTRACTING – Income

Approval to sign contracts other than for the provision of Healthcare by RWT:-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer	up to £250,000
Trust Board	above £250,000

CONTRACTING – Agreements for the Provision of Healthcare Services by RWT:-

Approval to sign contracts where RWT is the provider of Healthcare services to NHS and other Commissioners:-

Executive Director	up to 10% of Trust turnover
Trust Board	above 10% of Trust turnover

REQUISITIONS

Revenue:-

Budget Manager eg Ward Manager	up to £5,000

Senior Budget Manager –

Senior Matron/Matrons/Head of Midwifery	}	
Heads of Nursing (Nursing Budgets Only)	}	
Group Manager/Directorate Manager (Non-Nursing Budgets)	}	up to £15,000
Deputy HR Director	}	

Head of Education & Development }	
Budget Holder –	
Senior Pharmacist/Principle Pharmacist (drugs only)	up to £25,000
Deputy and Assistant Director of Pharmacy (drugs only)	up to £50,000
Director of Pharmacy Services (drugs only)	up to £100,000
Deputy Chief Operating Officer }	
Divisional Medical Director }	up to £50,000
Head of IT Services }	
Divisional Manager Estates and Facilities }	
Clinical/Research Network –	
Lead Research, Management & Governance Manager	up to £5,000
Research Delivery Divisional Managers	up to £5,000
Industry Operations Manager	up to £15,000
Chief Operating Officer	up to £50,000
Black Country Pathology Services –	
Budget Holder	up to £5,000
Service Manager	up to £10,000
Deputy Group Operational Manager	up to £15,000
Group Operational Manager	up to £25,000
Clinical Director	up to £50,000
Executive Responsible Budget Officer –	
Executive Director	up to £100,000
Chief Executive and Chief Financial Officer	over £100,000

Capital:-

Team Manager (Capital)/Team Manager (Project and Estates)	up to £50,000
Head of Estates Development	up to £500,000
Chief Financial Officer	up to £750,000
Chief Executive **and** Chief Financial Officer	over £750,000

NB – Above capital limits are subject to agreement of Business Cases (where Applicable) and inclusion within a Board approved Capital Programme

Capital schemes requiring Business Cases to be approved by value
Trust Board

£500,000 capital and/or
£500,000 revenue cost
(whether non-recurrent or
recurrent), and above

Capital schemes requiring Business Cases to be approved by NHSEI, DHSC and HM Treasury

£20,000,000 up to £35,000,000 capital value for all categories of investment except IM&T which has a lower upper threshold of £30,000,000 (The delegated limit for a Trust is the lower of 3% turnover and £20,000,000 and is reviewed annually. This may be reduced should the Trust go into deficit.) to be approved by NHSEI
Capital values above these upper limits and up to £50,000,000 require additional approval from DHSC, and above £50,000,000 then requires HM Treasury approval.

Note – Officers will need to judge where schemes below this level will require Board approval, because of other issues of significance.

Charity Funds – following approval from Charity Trustees of the commitment of charitable funds the delegated officers below authorise payment as per the values set out:–

Divisional/Directorate Funds -	
Group Managers/Directorate Managers	up to £5,000
Deputy Chief Operating Officer	up to £10,000
Chief Executive and Chief Financial Officer	up to £50,000
General Funds -	
Chief Executive and Chief Financial Officer	up to £50,000
All Funds -	
Trust Board, acting as Trustees	above £50,000

PAY

All Starter, Change and Termination Forms:–
Clinical Directorates and Divisions –
Senior Matron/Matron/Head of Midwifery/Head of Nursing (Nursing Budgets Only)
Group Manager/Directorate Manager (Non Nursing Budgets Only)
Divisional Manager Estates and Facilities
Deputy Chief Operating Officer
Divisional Medical Director

Division 4
Heads of Service that directly report to Deputy Chief Operating Officer

Corporate Functions –
Executive Director (or delegated Deputies at Executive Director's discretion)

Clinical Research Network –
Lead Research, Management and Governance Manager
Industry Operations Manager
Research Delivery Divisional Managers
Chief Operating Officer

Subject to:

- **Consultant appointments to be countersigned by Medical Director**
- **Any appointment/changes outside National Terms and Conditions/Agreed Trust Policy to be countersigned by HR Director and Chief Financial Officer (or in exceptional circumstances, where the Executive Director is absent, to delegated Deputies, named at Executive Director's discretion).**

Junior Doctors (ROTATION ONLY) and Temporary Bank Medical Staff – Starter and Termination Forms: -
Head of Workforce
Senior Resourcing Manager/Head of Resourcing
Resourcing Manager

Bank Nurses – Starter, Change and Termination Forms:-
Head of Workforce
Senior Resourcing Manager/Head of Resourcing
Resourcing Manager

Trust Volunteers – Starter and Termination forms

(Required for the purpose of payment of volunteer expenses only)
- Head of Patient Experience

All turnaround documents, timesheets and expenses forms:-
As above prime payroll documentation authorised officers plus

Budget Managers

For Community Services and other Services where the Services are provided 'Off Site'
The Budget Manager is able to devolve responsibility for the sign off to a Delegated Senior Manager.

For Removals Expenses only – Director/Deputy of Human Resources/Head of Workforce, and additionally, for Medics Removals and Interview Expenses, specifically Senior Resourcing 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

LOSSES COMPENSATIONS AND SPECIAL PAYMENTS

Approval limit of Chief Financial Officer/Deputy Chief Financial Officer	up to £5,000
Audit Committee	above £5,000

Note – all losses, compensation and special payments to be reported to the Trust Board

EXCEPTIONAL AUTHORISATION ARRANGEMENTS

In the absence of the Chief Executive and Chief Financial Officer
(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

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	Tuesday 7th February 2023
Title:	Update from the Black Country Provider Collaboration Programme
Action Requested:	Following discussions held at the Provider Collaboration Board over recent months, the Board is asked to: • Approve the report including next steps regarding configuration
For the attention of the Board	
Assure	• The proposals contained within the reports have been considered by The Chief Executive and Chair via the Programme Board
Advise	• The governance work to develop the Joint Committee and Scheme of Delegation will be presented to the Trust Board for approval prior to agreement
Alert	• Work on the corporate improvement programme is still being scoped and is under development
Author + Contact Details:	Tel 01902 694290 Email simon.evans8@nhs.net Group Chief Strategy Officer
Links to Trust Strategic Objectives	1. Excel in the delivery of Care 2. Support our Colleagues 3. Effective Collaboration 4. Improve the health and wellbeing of our Communities
Resource Implications:	There is a commitment from all organisations to commit resources in terms of time for key roles. As a minimum this includes the roles identified so far: CEO, Chair, CMO, CPO, GDoC and GCSO.
CQC Domains	Safe: patients, staff and the public are protected from abuse and avoidable harm. Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. Caring: staff involve and treat everyone with compassion, kindness, dignity and respect. Responsive: services are organised so that they meet people's needs. Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	Health Equalities are considered are considered within the draft proposals.
Public or Private:	Public
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Provider Collaboration Programme – December Update

1. Programme Update

Clinical Improvement programme

The Clinical Improvement Programme is focused on delivering a range of Transformation Projects, Critical Milestones and Tasks which support delivery of key priorities for the system. The progress updates confirmed that 65-70% of priorities should be completed by March 2023.

It was agreed that the Collaborative Executive would do a 'deep dive' into each of the 13 projects over the next few meetings.

Corporate Improvement Programme

This programme is being re-energised to explore options productivity and efficiency opportunities for functional corporate services across the ICS, Pan-ICS and regionally where appropriate.
It has been suggested that the SRO consider scale beyond the ICS boundaries where appropriate, and the ICB has also made a plea that its functions could / should also be included in this work as part of a review of the Systems Operating Model.

Update on Governance

Issues of 'delegations' and optimal form (a move from a 'Committee in Common to a 'Joint Committee') are being explored with a view to limiting the bureaucracy and enhancing the speed of decision making alongside clearly defining the parameters of any such arrangements.
A paper / proposal will be presented to the Collaborative Board and Executive for consideration in the near future. This will cover a principles-based set of delegations from Sovereign Trust Boards which would support faster decision making to implement proposals from Clinical Networks centred around key clinical pathways, protocols, and standards.

There was general consensus from the Board that moving towards a '*Joint Committee'* arrangement may be the best and most logical option, which was largely in keeping with the general direction of a 'Single Chair and Group Model' in the near future and would provide a vehicle for any future ICB delegations.

There was general agreement that further information was required, and an options appraisal needed developing, focusing on the key implications of moving to a '*Joint Committee'* model, any risks that sovereign Boards needed to be sighted on. Trust Board Secretaries and Directors of Governance/Strategy from all partners would be involved in the development of this.

2. Strengthening Collaboration within the Black Country

An update on DIHC was received. The ICB is now exploring an options appraisal which will identify the most suitable solutions to deliver the agreed models of care, including primary care development and support.

3. Workforce Update

The key components of the workforce work programme cover:

- Aligning workforce processes & systems
- Reducing vacancies
- Supporting easier staff movement

An update was also presented on the work undertaken to align 'Waiting List Initiative' (WLI) rates which are now broadly consistent across the Black Country. Work is also underway to explore options around the nurse bank alignment.

There has been good success with International Recruitment efforts with large system targets for recruitment of Nurses, Midwives, Diagnostic Radiographers and Podiatrists & OTs yielding positive results.

It was also noted that there is a lot of good work going on across the system on 'alignment' of things like 'Hot meals' and 'Pop-up Shops'.

4. Digital update

It was acknowledged that Black Country providers have a varying level of Digital maturity, but there was good working between the CIO's to stock-take Digital, Data and Technology priorities with most solutions across the system converging over time.
Clinical viewpoints vary (depending upon specialty) on the need to converge to same systems, with some comfortable with read only access, whilst others requiring the ability to both read and edit functionality. There is further work required in this area as it will be important to have a more robust view as we develop system wide solutions.

It was noted that a divergence will occur with the necessary implementation of a PAS for RWT, which has been in the procurement process for some time and is urgently required to address a possible future clinical safety concern. However, it was acknowledged that there were no known contractual barriers preventing convergence if a preferred system solution was identified in the future.

Significant capacity and resource challenges remain as barriers to delivering at speed and it was recognised that there will need to be some form of prioritisation on areas of collaboration, a report due in the final quarter of 22/23.

5. Communications Update

It is hoped that the new Black Country Provider Collaborative website will be visible in a draft and iterative form from January, the public and staff will be able to learn more about the activities of the Provider Collaborative and its programmes of work.

Current sections such as 'About Us' and insights to the Clinical Networks and their work priorities are being developed, and it is intended that performance reports, newsletters, and ways in which staff and the public can get involved will be highlighted.

6. Service Transformation – 'Development of Centres of Excellence' progress update

A paper was presented focused on transformation through the creation / establishment of 'Centres of Excellence' across the Black Country, these include:

- Orthopaedics at Walsall and Dudley as a consequence of implementing the North Hub 'elective cold site' at Cannock Chase Hospital
- The implementation of Surgical Robotics at DGFT and SWBH (to complement those already at RWT & WHT) which would see the creation of 'centres of excellence' at SWBH (Gynae-oncology), RWT (Urological pelvic cancer work), and DGFT (Renal Cancer surgery) in the first instance
- MoHs Surgery for SKIN Cancer resection at RWT
- Networking of surgical services for ENT and Bariatric Surgery across the Black Country

The journey towards the development of these 'centres of excellence' will commence early in the New Year, the implications of the proposed service changes will be presented and discussed with

respective Sovereign NHS Trusts. The next phase of the work will be overseen by the Collaborative Executive.

7. Next Steps

PC Innovators Scheme – An application was submitted to NHSE in December we expect to hear the outcome of the application in Q2 2022/23. If successful, NHS England will provide hands-on support for between 7 and 9 selected provider collaboratives to accelerate the benefits in the quality and efficiency of patient care.

'Away Afternoon' – This is planned for 15th February. The intent is to reflect on the journey to date, priorities established and progressed, and next steps for the forthcoming year, aligning capacity and resources in the process.

Clinical Summit – A final 'Clinical Summit' for the 22/23 financial year is planned for March at the Grand Station in Wolverhampton. This will continue the good work underway with the clinical programme.

8. Recommendations

The Board are asked to:

- Note the progress of the Provider Collaboration
- Take assurance that all proposals regarding future governance will require approval of the board prior to agreement

The Royal Wolverhampton NHS Trust

Trust Board Report	
Meeting Date:	7th February 2023
Title:	Sustainability Report
Purpose of the Report:	To provide an update on the progress of the implementation of the Trust Green Plan.
Action required:	To note the Trust Green Plan update.
Assure	• To provide assurance that the Trust's Green Plan continues to be aligned with the priorities of the Greener NHS agenda and will enable the Trust to evidence that we are working towards achieving the NHS commitment to achieve net zero carbon status by 2040.
Advise	• To advise on the potential opportunities to the Trust in the next five years and to continue to raise the profile of the Trust Sustainability Group in helping to move forward and meet the Greener NHS targets. • Advise on opportunities to promote the Trust Sustainability Agenda. • To strengthen the working relationship with the Black Country ICS Sustainability Group and other national and international sustainability Groups to maximise opportunities for shared learning and best working practices.
Alert	• To note, react and adapt to emerging factors affecting the delivery of Sustainable Healthcare in the next five years
Clinical implications and view	N/A
Patient, carer, public impact, and views	N/A
Author + Contact Details:	Simon Evans, Chief Strategy Officer Ext 84290 Email: simon.evans8@nhs.net Janet Smith, Head of Sustainability Ext 55350 Email: janetsmith3@nhs.net
CQC Domains	**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.
Trust Strategic Objectives	1. To have an effective and well-integrated health and care system that operates efficiently 2. Seek opportunities to develop our services through digital technology and innovation 3. Attract, retain, and develop our staff, and improve employee engagement 4. Deliver a safe and high-quality service 5. Maintain financial health – appropriate investment to patient services
Resource Implications:	Revenue and Capital funding required to implement sections of the Green Plan, but external funding sources will continue to be targeted for future investment in technologies, equipment, training and supplies to reduce the Trust's Carbon footprint.
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.

Equality and Diversity Impact	N/A
Risks:	All NHS Service providers are mandated to report quarterly and annually on performance towards meeting the Greener NHS Targets.
Risk register reference:	N/A
Other formal bodies involved:	Black Country and West Birmingham ICS Sustainability Network Midlands Net Zero Estates Delivery Hub
References	N/A

Brief/Executive Report Details

Brief/Executive Summary Title: Sustainability Report

1.0

This report outlines the progress of the Trust Green Plan implementation as of 31 December 2022.

1. **Greener NHS Data Collection Return Q3** – The Trust continues to deliver all the national deliverables as detailed in attachment 1. Medical gas carbon footprint reduction remains to be a challenging area to resolve. An audit of Nitrous Oxide and Entonox usage at point of use has commenced. The result will determine if the usage shown in the table below reflects consumption at the point of use or if it includes wastage through the distributions system. It will enable the Medical Gas Group to agree and implement measures to reduce usage.

Other Type of Inhalation Anaesthetic Usage 1 April 2019 - 31 December 2022

Other Type of Inhalation Anaesthetic	Volume Per Year				Cost Per Year			
	2019-20	2020-21	2021-22	2022-23*	2019-20	2020-21	2021-22	2022-23*
Nitrous Oxide	1,143,000	1,081,800	1,557,000	808,200	£4,134	£4,023	£7,274	£5,108
Entonox	3,843,100	3,654,300	3,055,600	3,141,600	£13,936	£13,820	£14,650	£13,236

*Usage from 1 April - 31 December 2023

2. **Inhaler Recovery Scheme –** RWT and WHT has secured a grant funding of £13,000 Black Country ICS to implement an inhaler recovery scheme. A further £25,000 was also allocated by Black Country ICS to take the scheme region wide after the pilot phase. The scheme will be implemented in partnership with a global company Plastics Europe, GSK, Wolverhampton LPC, Black Country ICB and Recycling Future.
3. **Desflurane use as of November 2022 is 1.9% which is 62% lower than the 5% Greener NHS target.** The Trust is using the remaining canisters (4 bottles remains in stock) of Desflurane that we cannot return to the supplier. Once this remaining stock are used, no new supply will be provided to the theatres.
4. **Greening Services Scheme**.
   a. **Gloves Rationalisation Scheme** spearheaded by the Infection Prevention and Control Team was successfully launched on 21st November in partnership with Walsall Healthcare NHS Trust. Departments such as Speech and Language Therapy is reviewing their use of non-sterile gloves to support the scheme. **The funding for nationally supported PPE has been extended to March 2024. This gives the Trust a reprieve on the anticipated cost pressure of funding its PPE requirement.**
   b. **Waste Management and Recycling Services** has reported a 36% waste recycling rate with cardboard, confidential and paper recycling contributing 21% of the total rate. 37% of the Trust waste go to Energy for Waste which is used to power households in Wolverhampton. Despite its limited coverage (5 departments) mixed recycling has contributed 5 tonnes to the total Trust recycling rate.
   c. **Cannock Hospital Estates & Facilities Management** has replaced 70% of the lighting fixtures in public access areas in the hospital including the bridge and the car park without capital funding support. The spend of £29,152 was

	paid for by new works and maintenance monies. A recurrent saving annual of £1,520 is achieved from this initiative. No carbon reduction is realised because the Trust energy supply is from 100% renewable source. d. **Greening Therapy Services** – The Therapy Services virtual clinic sessions has generated 418tonnes C02e with 2,328,240 patient travel miles saved. This equates to travelling around the world 90 times. 135,249 hours of patient time saved through avoidance of face-to-face appointments and 1.4 quality-adjusted life saved. A full report on cost improvement and carbon emissions reduction outcomes of sustainability initiatives will be available May 2023.
20.	**Net Zero Estates Delivery Plan – Actions and Targets** Attachment 2 shows an update of the Trust position vis-à-vis the actions and targets that the Trust are expected to deliver by 31 March 2024 listed below. There is a need for Estates Development Department and Estates & Facilities Division to prioritise the actions required to deliver them. a. Installation of building level energy and water metering. b. Incorporation of energy use accountability in estates staff induction. c. Trust Board approved heat decarbonisation plan. d. Clear plan to transform waste in line with HTM 07-01. e. All construction and capital spend includes 10% social value and sustainability weighting. f. Ensure that all applicable new builds and major refurbishments are compliant with the NHS Net Zero Building Standards. g. Adapt menus to offer healthier, lower carbon options for patients, staff, and visitors. h. Ensure that existing travel plans included support for walking and cycling specifically as it relates to estates infrastructure. i. Incorporate Net Zero capital projects in line with the 4-step plan into organisation budgets and reports through ERIC.
2.0	**Sustainability initiatives implementation challenges** Revenue funding is required for Trust-wide sustainability initiatives that do not qualify for capital funding. The implementation of the mixed recycling scheme for New Cross Hospital and the community sites has been delayed due to funding issues. The scheme doesn't qualify for capital funding because the cost per item is less than £5k. The scheme was submitted for funding from Charitable Funds but was also rejected because the committee members believe that it should be funded by the Trust. There is no budget line within the waste and recycling services to cover the implementation cost.
3.0	**Action priorities for the next 6 months:** 1. Support the implementation of the mandatory PPN06/20 2. Update the Trust building, mechanical and electrical standards to align with the Greener NHS Estates Net Zero Delivery Plan. 3. Recruit more clinical and non-clinical services in "Greening Services Scheme". 4. Implementation of mixed recycling in New Cross Hospital and the community 5. Expand the implementation of walking aids reuse scheme to the community. 6. Implement a metered dose inhaler recovery and recycling scheme. **Initiatives that require capital funding are:** 1. Transition of Trust grey fleet to zero emissions vehicle. The 2022-23 NHS Standard Contract requires the Trust to put in place a transition plan. 2. Provision of EV charging infrastructure in Trust facilities. 3. Refurbishment of Orthotics department – adaptation of the facilities required to combat the effect of climate change and comply with clinical standards 4. Implementation of the Estates Net Zero Delivery Plan and the NHS Net Zero Building Standards.

4.0	**Partnership and Collaborative Working** The Trust profile in Sustainability field has risen in the last 18 months. This is demonstrated by the Head of Sustainability being invited to judge the Health Service Journal's Partnership Awards twice as well as judging in the forthcoming Digital Innovation Awards 2023. The Trust achievement in reducing its carbon footprint by targeting business as usual is lauded nationally as evidenced by the Trust becoming a regular presenter in the Institute of Health & Social Care Management national conferences and special interest groups. Healthcare Financial Management Association (HFMA) invited the Trust to present its journey to net zero in as part of its "Towards Net Zero" series of webinars. The webinar was rated 4.8 out of 5. The Trust participated as speaker in further 11 national webinars and conferences and has so far received 5 invitations to speak in 5 national webinars and conferences this year. HSJ also consulted the Trust Head of Sustainability in finalising the programme for its HSJ Strategic Estates Forum in June 2023. The Trust Head of Sustainability has been appointed as one of the Midlands Coordinator for the NHS Estates Net Zero Delivery Hub as well as workstream lead for the Freecycle Workstream of the Black Country ICS Sustainability Network. The Trust is one of the first in the NHS to develop its own Climate Change Impact Adaptation Plan which is being use as a template by the Black Country ICS Sustainability Network members and 18 other Trust up and down the country. The Trust sustainability tools have been shared, adapted, and utilise by over 30 NHS Trust and one healthcare organisation in Denver, U.S.A 15 NHS Trust and other organisations has so far signed up to the quarterly "Sustainability Share and Learn" session that the Head of Sustainability is organising.
5.0	Funding opportunities 1. Public Sector Decarbonisation Scheme (PSDS) future funding rounds. 2. Innovate UK KTN - Net Zero Heat Programme – funding to enable faster roll-out of decarbonised heat for buildings SBRI Healthcare Competition 23 – funding on clinical innovation to decarbonise clinical pathway

Greener NHS Data Q3 Collection January 2023

Attachement 1

No	Question	Select Answer by highlighing the appropriate column									Division/Department Responsible
1	Does your organisation purchase 100% of its electricity from renewable sources?	Yes	No								Estates & Facilities Management
2	Have you (a) undertaken the piped nitrous oxide waste audit, as illustrated by the nitrous oxide waste reduction toolkit, (b) identified wasted nitrous oxide by comparing clinical use of nitrous oxide and procurement data and (c) acted on the findings?	**Yes** – audit undertaken (a), waste identified (b) and measures taken to reduce waste (c), including manifold decommissioning	**Yes** – audit undertaken (a), waste identified (b) and measures taken to reduce waste (c), but without manifold decommissioning	**Yes** – audit undertaken (a), waste identified (b), measures yet to be taken	**Yes** – audit undertaken (a) but usage not compared to procurement data	**Yes**, audit undertaken but with a different methodology	**No**, we have not addressed nitrous oxide waste	**N/A** – our organisation doesn't use nitrous oxide			Estates & Facilities Management/ Medical Gas Group - Lindsay Ibbs-George/Adrian Evans/Nick Riedy
3	Does your organisation purchase or lease solely vehicles (under 3.5 tonnes) that are Ultra-Low Emission vehicles (ULEVs) or Zero Emission Vehicles (ZEVs)? *ULEV are defined as having less than 75 grams of CO2e per kilometre from the tail pipe. Meets Euro 6d standards. Zero Emissions Vehicles (ZEVs) are pure electric vehicles, and other plug-in electric vehicles, that when driving in the electric mode, produce no tailpipe CO2*	**Yes**: our organisation only purchases or leases ULEVs or ZEVs, though our current fleet may include some vehicles which are not ULEVs or ZEVs.	**No**: our organisation purchases or leases vehicles which are not ULEVs or ZEVs, though we may purchase some ULEVs and ZEVs.	**We do not purchase or lease any cars or vans under 3.5t**: our organisation does not purchase or lease any vehicles, and we do not intend to in the next 12 months.							Estates & Facilities Management - Brendan Houston/Andrew Bellingham
4	Does your organisation's salary sacrifice scheme for vehicles allow for the purchase of only ULEVs or ZEVs?	**Yes**, only ULEV/ZEV are available through our salary sacrifice scheme for vehicles	ULEV/ZEV are available alongside non ULEV/ZEV options through our salary sacrifice scheme for vehicles	We employ staff but do not have a salary sacrifice scheme	We do not employ any staff						Human Resources - Carol Perry/Cheryl Lear
5	What travel-related schemes do you operate across your organisation?	**Park & Ride:** Employees in our organisation can access a service where they can park off-site and then take a bus to their workplace. Include either a trust-operated service or a local scheme with service for your site(s). The scheme may also be accessible by patients & visitors shuttle bus may also transport patient and visitors.	**Shuttle buses between two or more sites**: Employees in our organisation have access to a service where they can travel between sites using a dedicated bus service. Includes either a trust-operated service or a local scheme with service for your site(s). The shuttle bus may also transport patient and visitors.	**Salary sacrifice cycle-to-work or bike rental scheme**: Examples of a salary sacrifice scheme include the Department for Transport cycle to work scheme or bike rental schemes. Salary sacrifice and rental schemes may offer pedal bikes and/or electric bikes which allow the rider to pedal.	**Cycle training**: Our organisation has delivered training to employees within the last 3 months, or an ongoing scheme is available. Training may include safe cycling, maintenance, guided rides, and bike buddying scheme.	**Discounted public transport scheme**: Our organisation provides employee access to a scheme that enable employees to purchase discounted tickets for local public transport (bus, tram, train) for their commute or personal travel.	**Third-party operated car club**: Our organisation has entered into an agreement with an external provider for car club cars to be based at, or accessible from one of their sites. Information on trust-operated pool cars are	**E-bike/E-scooter hire**: Our organisation operates either a trust-led hire scheme or private scheme with a dedicated docking station/parking area on our site.	**Staff travel survey within the last 12 months**: Our organisation has surveyed all organisation employees to understand travel patterns and attitudes in the last 12 months and the results have been shared with relevant audience	**None of the above**	Finance/Procurement/ Workforce/EFM - Brendan Houston, Carol Perry/Cheryl Lear
6	Which local transport partners does your organisation work closely with?	**Local Transport Authority**: This is usually the local authority responsible for strategic coordination of transport, local bus services, road safety or wider sustainable travel promotion	**Local Highways Authority**: This is usually the local authority responsible for road / footpath / cycle path maintenance, traffic lights and road signage	**Local Bus Operator(s)**: Outside London, these are the bus companies providing services in your area – e.g. Arriva, First, Go Ahead, etc. In London, coordination of bus services is the responsibility of TfL	**None of the above**						Human Resources - Carol Perry/Cheryl Lear
7	What facilities does your organisation offer for people who arrive by a mode of active travel?	Cycle parking for staff.	Lockers for staff	Showers for staff	Cycle parking for visitors	Lockers for visitors	Showers for visitors				Planning and Performance
8	At the site where you have the largest food service, how does your organisation measure the total amount of food waste produced?	a. Measured following the Guardians of Grub approach (https://guardiansofgrub.com/)	b. Measured manually at ward level or in the kitchen but without following the Guardians of Grub	c. Measured using on site food waste processing technology	d. Measured as part of a third-party waste management solution at pickup or off site	e. We do not measure food waste	f. N/A, we do not offer any food services				Catering/Hotel Services - Gene Downes
9	Does your organisation have a digital meal ordering system for patients installed, as recommended by the Independent Review of NHS Hospital Food, to enable more accurate meal planning and reduce food waste?	**Yes**, at all sites.	**Yes**, but only in some sites	**No**, but we plan to in the next 12 months	**No** and we do not plan to in the next 12 months	**N/A**, we do not serve patient meals					Catering/Hotel Services - Gene Downes
10	In your food service, have you identified opportunities to make menu options healthier and lower carbon by increasing the proportion of fruit, vegetables, beans, pulses or other low carbon ingredients/proteins?	**Yes, we have regular reviews and make continuous improvements**: you have reviewed and changed your menu to make menu options healthier and lower carbon where appropriate more than once in the last two years, and have a process in place to make sure this happens on an ongoing basis	**Yes, we have reviewed menus once and implemented the changes**: you have reviewed your menu once and have made changes to make some menu options healthier and lower carbon	**No, but we plan to take action in the next 12 months:** you are planning to review or have reviewed but not yet changed menus	**No and we do not plan to**: you have no plans to review your menus and make changes	**N/A, we do not offer any food services:** you do not provide any food to patients, staff or visitors					Catering/Hotel Services - Gene Downes
11	Have you identified a list of suppliers that will be impacted by the April 2023 Carbon Reduction Plan requirement (PPN 06/21)?	**Yes**, and we have shared the list with the Net Zero procurement team	**Yes**, but we have not shared the list with the Net Zero procurement team yet	**No** but this is in progress	**No**, our data does not enable this	**No**, we have not started to look at this					Procurement - David Allison/Sian Fumorola
12	How are you managing the inclusion of the minimum of 10% on Net Zero and Social Value in every tender?	Included in every tender, with requirements embedded in our contract management approach and defined KPIs for each contract	Included in every tender, with requirements embedded in our contract management approach, but no defined KPIs for each contract	Included in every tender but not yet embedded in our contract management approach	We have not fully developed our processes around embedding Net Zero and Social value in every tender						Procurement - David Allison/Sian Fumorola Contracts and Commissioning - Simon Evans
13	Do you participate in a walking aids return and reuse scheme?	**Yes**, we participate in a return and reuse scheme run locally	**Yes**, we contract a third-party service for return and reuse	**Yes**, we donate to a charity scheme	**Yes**, we have a combined reuse scheme (run locally and third-party service contract)	**No**, we do not participate in any reuse scheme, but plan to implement one in the next 1-2 years	**No**, we do not participate in any reuse scheme and we do not plan to implement one	**NA**, we do not issue walking aids			Physiotherapy/Waste & Recycling Services
14	Does your organisation have a nominated lead who is accountable for adaptation planning and management?	Yes	No								Estates & Facilities Management/ Estates Development
15	Does your organisation have a long-term climate change adaptation plan separate from your business continuity plan?	Yes	No								Head of Emergency Planning & Business Continuity/Trust Decontamination Lead in Green

Summary of actions, dates, and responsible groups (green) in the Estates Net Zero Delivery Plan Technical Annex

Attachment 2

Action	Date	Responsible Groups				RWT Implementation Status	Responsible Department	Comments
		Trusts & FT	Primary Care	ICSs/Regional	National			
Strategic Action 1: Make every kWh and m3 count								
NHS trusts, NHS foundation trusts and primary care to review options to install energy metering at building level (both electricity and heat) and establish a programme to install metering where feasible	2022/23	+	+				EFM Division/ Estates Development	
NHS trusts, NHS foundation trusts and primary care to review options to install energy metering at floor level (both electricity and heat) and establish a programme to install metering where feasible	2026/28	+	+				EFM Division/ Estates Development	Status to be confirmed with EFM Division
NHS trusts, NHS foundation trusts and to review options to install energy metering at department level (both electricity and heat) and establish a programme to install metering where feasible	2028/30	+					EFM Division/ Estates Development	Status to be confirmed with EFM Division
NHSE to establish a central data collection and storage system for energy data for secondary care, followed by primary care	2022/23 (SC) 2025/26 (PC)					N/A		
NHS trusts and NHS foundation trusts to track carbon reduction progress and produce annual reports for their boards (Specified in Green Plan guidance)	2022/23						Group Strategy Officer	
NHS trusts and NHS foundation trusts to incorporate NZ capital projects in line with the 4-step plan into organisation budgets and report through ERIC (Existing requirement in ERIC)	From 2023						Estates Development	
NHSE to establish a process for tracking, evidencing, and sharing the carbon benefits of successful technologies	From 2022/23							
NHS trusts, NHS foundation trusts and primary care to review options to install building-level water metering at all sites	By 2023/24	+	+				EFM Division/Estates Development	
NHS trusts and NHS foundation trusts to review options to install leak detection systems	By 2026	+					EFM Division/Estates Development	
NHS trusts and NHS foundation trusts to carry out sustainable urban drainage system assessments	By 2028	+					EFM Division/Estates Development	
NHSE to develop standard job descriptions, a competency framework, and accountability for energy managers	2022/23					N/A		
NHS trusts and NHS foundation trusts to have access to energy management expertise (at least 0.5 FTE), funded from their own resources (As per existing ERIC reporting field)	2023/24	+					EFM Division	Energy Manager in post
NHSE and Regional Estates Delivery Groups to develop local plans for engaging new energy expertise where required	2023/24					N/A		
NHSE and each region to set up the internal infrastructure, accountabilities, and governance to run its Regional Delivery Group	2022/23					N/A		
NHSE and Regional Estates Delivery Groups to develop a schedule of events and invite external experts to participate	2022/23					N/A		
NHSE to develop an engagement plan to share best practice, upcoming events and encourage membership to the Regional Estates Delivery Groups	2022/23					N/A		
NHSE to explore opportunities to incorporate responsibility for efficient energy use into all EFM job descriptions	2022/23					N/A		
Trusts and Foundation Trusts to incorporate energy use accountability into estates staff inductions	2023/24	+					EFM Division	Need to be incorporated in local induction
NHSE to develop an educational campaign to raise awareness of individual impacts on energy consumption, taking account of individuals' abilities to act in the context of their role	2023/24					N/A		
NHSE to develop NZ content for inclusion in estates inductions	2022/23					N/A		
Strategic Action 2: Run on 100% clean, renewable energy								
NHSE to review options for existing energy contracts and develop standard frameworks for procurement strategies	2022/23					N/A		
NHSE to develop and run campaign to raise awareness of appropriate strategies for energy procurement	2023/24					N/A		
All NHS trusts and NHS foundation trusts to have a heat decarbonisation plan, identifying and prioritising the phasing out of existing systems	2023/24	+					EFM Division/Estates Development	
NHS trusts and NHS foundation trusts to utilise the Heat Decarbonisation Plans to identify opportunities to increase on-site electricity supply for use in heat pump solutions and EV	2023/24	+					EFM Division/Estates Development	
NHSE to measure the impact of progress made towards net zero	From 2023					N/A		
Remove all coal and oil-led primary heating systems (Long Term Plan commitment)	By 2028						EFM Division	
ICSs to develop local and regional plans to increase the amount of renewable energy produced and stored on-site and/or near-site	By 2023/24					N/A		
NHS trusts, NHS foundation trusts and primary care to utilise zero carbon building energy, including renewable on-site or owned sources, to cover at least 80% of their emissions (As set out in the "Delivering a Net Zero NHS" report)	2028-2032						EFM Division	
Strategic Action 3: Increase resource productivity								
NHSE to work with NHS trusts and NHS foundation trusts to improve timeliness and accuracy of waste data	By 2022/23					N/A		
Every organisation to have a clear plan to transform waste in line with HTM 07-01, which is being revised and published in 2022/23	By 2023/24	+	+				Waste & Recycling Team	
NHS Trusts and NHS foundation trusts to eliminate waste sent to landfill	2025/26	+					Waste & Recycling Team	
Ensure every NHS trust and NHS foundation trust has access to waste management expertise (at least 0.5 FTE), funded from their own resources (As per existing ERIC reporting field)	By 2023	+					Waste & Recycling Team	
Strategic Action 4: Reduce volume of residual waste								
NHS trusts, NHS foundation trusts, ICSs and the National NHS Estates and Facilities team to work with procurement and our own supply chain to eliminate waste streams where practical	From 2022/23	+					Procurement, EFM Division, Estates Development	
Strategic Action 5: Using ULEV and ZEV								
NHS trusts, NHS foundation trusts and ICSs to review existing vehicle procurement contracts and develop a standard framework for regional procurement strategies (Long Term Plan commitment)	To meet LTP 2028 targets						EFM Division/Estates Development	RWT Facilities Manager assessing supply availabilty and acquisition option
Strategic Action 6: Establish EV ready estates								
All organisations to have installed EV charging infrastructure to support transition of their owned and leased fleet to zero emission vehicles (excluding ambulances)	2028	+	+				EFM Division/Estates Development	15 EV charging points @New Cross

NHS trusts, NHS foundation trusts and ICSs to plan deployment of EV infrastructure by identifying local/regional grid capacity and work with local network operators and/or local authority to plan for increased capacity where necessary	2025	+					EFM Division/Estates Development	Black Country ICS Travel & Transport workstream is working on this
Strategic Action 7: Ensuring our suppliers meet the minimum standards expected on net zero and social value Strategic Action 8: Ensure all our construction and capital spend is net zero carbon and all tenders included a minimum of 10% weighting for social value								
NHS trusts, NHS foundation trusts, primary care organisations and ICSs to ensure that construction and capital spend includes 10% social value weighting (As set out in "Applying net zero and social value in the procurement of NHS goods and services" report)	From March 2022					😑	Estates Development	Status to be confirmed with Director of Estates Development
NHS trusts, NHS foundation trusts, primary care, and ICSs to use the Economic Case guidance within HM Treasury Green Book Guidance to assess the economic impacts of capital spend and consider the wider environmental impacts (Existing government guidance)	2022/23					😑	Estates Development	Status to be confirmed with Director of Estates Development
National NHS Estates and Facilities team to ensure all applicable new builds and major refurbishments are compliant with the NHS Net Zero Building Standard	2023/24					N/A		The NZ building standards are still in its approval process
Strategic Action 9: Increasing healthier, more sustainable menu choices								
NHSE to deliver national recipe and menu bank to offer healthier, lower carbon options for patients, staff, and visitors	2022/23					N/A		
NHS trusts and NHS foundation trusts to review and adapt menus to offer healthier, lower carbon options for patients, staff, and visitors	2023/24	+				😀	Catering Department	
NHS trusts and NHS foundation trusts to implement approaches to measure and reduce food waste (kitchen spoilage and preparation waste, unserved meal, plate waste)	2023/24	+				😀	Catering Department	
Estates and Facilities teams to have input into their trusts' Food & Drink Strategy, meeting the guidelines set out in the Hospital Food Standards Panel Review	From 2023/24					😇	Catering Department	
Strategic Action 10: Prepare our estates for severe weather events								
NHS trusts, NHS foundation trusts and ICSs to incorporate predicted climatic changes into estates strategies, PCN estates plans, and Business Continuity Plans	As developed					😀	EPRR/Estates Development/EFM Division	
NHSE to develop a climate change risk assessment to share with trusts / ICSs	2022/23					N/A		
ICSs and National NHS Estates and Facilities team to ensure all NHS trusts, NHS foundation trusts, and primary care have specific plans for flooding and overheating where necessary, and monitor their risks/occurrence(s)	2025	+	+			😀	EPRR/Estates Development/EFM Division	
ICSs to use organisational plans for flooding and overheating to develop and prioritise actions in each ICS long term adaptation plan	2025					N/A		
Strategic Action 11: Support and encourage our staff to make lower-carbon travel choices								
NHS trusts and NHS foundation trusts to ensure that existing travel plans include support for walking and cycling specifically as this relates to estates infrastructure	2023/24	+				😀	Human Resources	

Summary of actions, dates, and responsible groups (green) in the Estates Net Zero Delivery Plan Technical Annex. Newly introduced recommended actions for trusts, foundation trusts and primary care are indicated with a +

Delivery status

On Track	😇
Slippage	😟
High Risk Against Delivery	☹
Delivered	😀
TBC	😑

Trust Board Committee/Group Chair's Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee/Group:	People and Organisational Development Committee
Date(s) of Committee/Group Meetings	27 January 2023
Chair of Committee/Group:	Junior Hemans, Non-Executive Director
Date of Report:	7 February 2023
Strategic Aims/Objectives (as related in the Strategy – delete those that do not apply to this report))	• We will embed a culture of learning and continuous improvement at all levels of the organisation • Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff • Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing • Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged • Deliver year on year improvement in Workforce Equality Standard performance

ALERT Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee	• The Board should be aware that there is some risk to the ongoing funding of the Black Country Hub, a central mental health support service accessible to health and social care staff across the Black Country. This will be closely monitored, however, the Trust may need to increase support offer to staff if this cannot be sustained. • The Board will be aware of the current situation in relation to industrial action. A number of trades unions have balloted their membership and from a Trust perspective, only the Hospital Consultants and Specialists Association (HCSA) have secured a mandate for strike action at this stage. The HCSA have 2 members at the Trust. The British Medical Association (BMA) are balloting their junior doctor membership on strike action in a ballot that closes on 20 February 2023. The BMA have indicated that if a mandate for strike action is secured there will be a full walkout for 72 hours in March with the potential for significant impact on elective and non-emergency services.
ADVISE Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought	• As part of the Deep Dive update provided by Division 2, the Committee were made aware that a number of Trust staff had sadly passed away in recent months. The teams and families have been supported as appropriate through this. The Committee thoughts and condolences are with colleagues. • Work has commenced to develop a joint People and OD Strategy for RWT and WHT. A joint Committee development session will be held in March 2023 as part of this work. • The Trust's Equality Objectives have been reviewed and approved by the People and Organisational Development Committee for consideration at the Board.
ASSURE Positive assurances & highlights of note for the Board/Committee	• The Committee has received an update on the Equality Delivery System 2022 together with a plan for completion within the Trust. • Employee Voice Groups continue to develop within the Trust.
Recommendation(s) to the Board/Committee	• The Board is asked to note this report. • The Board will be asked to approve the revised Equality Objectives contained in a separate report.

Changes to BAF Risk(s) & TRR Risk(s) agreed	• The Committee reviewed SR17 *"If Equality Diversity and Inclusion indicators are not improved and considerations and actions are insufficiently embedded across the whole organisation then staff and patient experience improvements may not be realised resulting in inequalities in terms of health outcomes, sub-optimal attraction, retention, and engagement of staff from diverse backgrounds and damage to the Trust reputation in the community"* was reviewed by the committee. No changes were proposed to this risk. • No new strategic risks were identified.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• To receive an update on benchmarked data across workforce indicators in March 2023. • To recommend the updated Equality Objectives to the Trust Board for approval.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	**Retention Deep Dive** • The Committee received a further deep dive in relation to Retention and turnover. The Committee was assured that whilst retention and turnover are not meeting the target the issue is understood within the Trust and actions are in place to support improvements against retention. The Committee noted that retention and increased turning are issues impacting many other organisations and agreed to continue to monitor this through the Executive Workforce Report. The Committee further agreed to receive a wider update including benchmarking of data across a range of indicators, including staff survey indicators, at its March meeting.

	Division 2 Update
	• The Division provided a comprehensive update covering key issues in the Division impacting and impacted by workforce, including; the workforce profile and indicators, culture and Freedom to Speak Up Activity, Staff Survey, Equality Diversity and Inclusion, Health and Wellbeing.
	• Particular discussion arising from this report focused on:
	  ○ The positive work on recruitment, particularly international recruitment, and the importance of supporting these new staff early in their NHS career. The Division continues to invest in practice education and pastoral support for these staff.
	  ○ The Division has established a Health and Wellbeing Group which continues to develop the local offer to staff with responsive input from the Trust's Occupational Health and Wellbeing Team. A number of the Divisions staff have accesses good support from the Black Country Hub and the Committee were keen to ensure that staff continue to be able to access high quality mental health support in a timely fashion.

	Equality Delivery System 2022 • The Committee received an update on the revised Equality Delivery System (EDS) which was launched in late 2022. The Equality Delivery System is a performance framework tool for NHS organisations to assess and improve their equality, diversity and inclusion outcomes. It is based around three domains: o Commissioned/ Provided Services o Workforce Health and Wellbeing o Inclusive Leadership The assessment against the framework is to take place annually with assessment against domain 1 at Integrated Care System Level and at organisation level for the other domains. • The People and Organisational Development Committee received and approved recommendations that: o The Chief People Officer would be the Board Sponsor for the EDS and that delivery of EDS would be through the EDI Steering Group. o The EDS would be integrated into the SR17 on the Board Assurance Framework. o The proposed delivery plan was agreed.
	Employee Voice Groups • The Committee received an update on the work of the Employee Voice Groups (EVGs), this included an update on the work and achievements of the EVGs as well as barriers to progressing their work. The EVGs are in place in respect of Black, Asian and minority ethnic staff, LGBTQ+ staff, Disability and long-term conditions, carers and Armed Forces Community. Each group has an executive sponsor. • A range of key achievements were noted including: o The black, Asian and minority ethnic EVG winning the staff network of the year award o Black History Month art installation and mayoral visit o Launch of the health adjustments passport o Improving the consideration of disability issues in planning o Listening events for staff o LGBTQ+ ally training o Supporting PRIDE 2022 o Carers' passport launch • There are some barriers to engagement with Chairs of groups, particularly, time to undertake the duties of Chair and resources. The Committee were keen to stress commitment to chairs of EVGs having the time to undertake their network duties – any issues to be escalated through the Head of EDI. • Leadership development opportunities have been made available to chairs and the chairs of the black, Asian and minority ethnic and disability and long-term conditions group chairs are undertaking development programmes.

ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	**Workforce Resourcing Report** • The Committee received the regular update on Workforce Resourcing. The report included updates on recruitment and time to hire metrics, recruitment activity, temporary staffing, rostering and job. • Time to hire remained constant against significantly increased volumes in recruitment activity. There has been a 57% increase in the number of applications and a 64% increase in the number of starters over the last year. • There was a recruitment event held on 21 January where potential candidates could attend the Trust to explore vacancies and be recruited on the day. • The Princes Trust 'Get Into' programme will operate across January and February offering four-week placements to 15 young people with a total of 100 placements planned across 2023. The last cohorts of 2023 resulted in 28 young people being offered jobs in the Trust.

	Trust Equality Objectives
	• The Committee received a report on the Trust's equality objectives 2023 – 2027. The objectives are comprised two objectives related to the provision of services and three related to workforce equality:
	  • We will continue to review and improve accessibility to services for those whose first language is not English – to understand the changes in demographics for our patient population and the subsequent provision of interpreting.
	  • Patients (service users) report positive experiences of the service.
	  • We support the health and wellbeing of our staff through the promotion of initiatives and services that support staff to lead healthy lifestyles.
	  • Our People Practices are inclusive, promote belonging, and are supported by actions that address inequitable outcomes for protected groups.
	  • Our Board, leaders, and those with line management responsibilities lead with compassion and inclusion and routinely demonstrate their understanding of and commitment to equality and diversity.
	• These objectives were approved for consideration at the Board.

	Board Assurance Framework Risk Review The Committee reviewed the Board Assurance Framework Risks paying particular attention to SR17 relating to equality and diversity. The Committee were assured that the risk had been reviewed and did not require any further changes at this stage. It was agreed, however, that the EDS 2022 would be integrated into SR17.

Matters presented for information or noting	**Executive Workforce Report** • The Committee received an update on the joint work between RWT and WHT to develop a joint People and OD Strategy in line with the Trust Strategy. A joint People and OD Committee development session will be held with members of RWT and WHT Committees in March 2023 as part of this work. • The People Committee received an update in relation to the current industrial relations situation. A number of trades unions have balloted their membership and from a Trust perspective, only the Hospital Consultants and Specialists Association (HCSA) have secured a mandate for strike action at this stage. The HCSA have 2 members at the Trust. The British Medical Association (BMA) are balloting their junior doctor membership on strike action in a ballot that closes on 20 February 2023. The BMA have indicated that if a mandate for strike action is secured there will be a full walkout for 72 hours with the potential for significant impact on elective and non-emergency services. • Appraisal performance continues to not meet the required 90% compliance level. Further work is required to ensure improvements are seen in this area and staff are able to have high-quality career conversations to support retention, career development and wellbeing.
Self-evaluation/ Terms of Reference/ Future Work Plan	• The committee reflected upon the discussion through the meeting and congruence with the committee objectives in respect of EDI, Retention and Sickness. • There was considerable focus given to EDI and Retention. Additional focus will be provided to sickness absence in line with the Committee Schedule of Business.
Items for Reference Pack	• Operational Workforce Group Minutes • Attract and Retain Group Action Log • Medical Workforce Group Action Log • Staff Survey Oversight Group Action Log

Strategic Aims and Objectives – Map of what is report where and how often.

Strategic Aim	Strategic Objective	Method of assurance	Method of reporting	Frequency	Receiving Committee
Care	- We will embed a culture of learning and continuous improvement at all levels of the organisation	Improvement Plan	CQI Board Report	Quarterly	QGAC
	- We will prioritise the treatment of cancer patients, focused on improving the outcome of those diagnosed with the disease	Cancer action plan	F&P Report and IQPR	Monthly	QGAC & P&F
	- We will deliver safe and responsive urgent and emergency care in the community and in hospital	Emergency Care Action Plan	IQPR	Monthly	QGAC & P&F
	- We will deliver the priorities within the National Elective Care Strategy	Elective Recovery Plan	IQPR and Elective Recovery Report	Monthly	QGAC & P&F
	- We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations	Finance strategy	Finance Report	Monthly	P&F
Colleagues	- Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff	Enabling people strategy	Workforce Report	Monthly	WOD
	- Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing	Enabling people strategy	Workforce Report	Annual	WOD
	- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged	Enabling people strategy	Workforce Report	Monthly	WOD
	- Deliver year on year improvement in Workforce Equality Standard	Enabling people strategy	Workforce Report	Annual	WOD
Collaboration	- Work as part of the provider collaborative to improve population health	Provider colloborative project	Provider colloborative project	Bi-monthly	Joint Committee
	- Improve clinical service sustainability by implementing new models of care through the provider collaborative	Provider colloborative project plan	Provider colloborative project plan	Bi-monthly	Joint Committee
	- Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital				Digital and Innovation Committee
	- Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes	Integration Plan	Integration Plan Update	Bi-monthly	Joint Committee
	- Facilitate research that establishes new knowledge and improves the quality of care of patients	New research and development strategy	Innovation, Research and Improvement Joint Committee		
Communities	- Develop a strategy to understand and deliver action on health inequalities	Health Inequalities Delivery	Update from health inequalities group		QGAC
	- Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025	Sustainability Plan	Sustainability P&F Report	Quarterly	P&F
	- Work together with PLACE based partners to deliver improvements to the health of our immediate communities	Place Action Plan	PBP Monthly Board Report	Monthly	Trust Board

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	**Executive Summary Workforce Report**
Action Requested:	To receive and note
For the attention of the Board	
Assure	• Actions on Recruitment, Retention and Engagement.
Advise	• Progress on delivery of the actions within the People and Organisation Development Strategy 2016 – 2020 to support with the approach to OD.
Alert	• The Trust performance in respect of rolling 12 month and in-month sickness absence, turnover, retention and appraisals against target is red rated.
Author + Contact Details:	Adam Race, Deputy Chief People Officer Tel 01902 695430 Email Adam.Race@nhs.net
Links to Trust Strategic Objectives	Care: Excel in the delivery of Care Colleagues: Support our Colleagues Collaboration: Effective Collaboration Communities: Improve the health and wellbeing of our Communities
Resource Implications:	NONE
Report Data Caveats	Data for this report is taken in large part from the Trust's Electronic Staff Record. This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**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	The Trust Approach to Equality, Diversity and Inclusion addresses actions for WRES, EDS2 and WDES and the Trust approach to EDI and the provisions of the Equality Act 2010 as part of the People and Organisation Development Strategy 2016-2020.
Risks: BAF/ TRR	**BAF SR17 – Workforce Equality, Diversity & Inclusion**
Risk: Appetite	The report seeks to provide Board Assurance and to decrease the Workforce Risks within the Trust.
Public or Private:	**Public**

Other formal bodies involved:	People & Organisational Development Committee (PODC)
References	NONE – National Workforce Strategy currently in consultation phase.
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Brief/Executive Report Details	
Brief/Executive Summary Title:	Executive Summary Workforce Report
Item/paragraph 1.0	This report provides the Trust Board with information and assurance on key workforce metrics and an update on key workforce matters. In relation to Key Performance Indicators, the reports sets out that: • Attendance levels have improved slightly in month over November. The in month performance for this indicator is above the new target at 5.75% (down from 5.81% in October). Levels of absence as a result of COVID-19 and flu had increased over the period and will continue to impact performance in relation to the 12 month rolling absence rate for some time which currently sits at 5.56%. • Normalised turnover is 11.49% improving in month from 12.41% the previous month. The 24 month retention rate has worsened slightly to 80.45% over the last month. • In relation to appraisal, compliance rates have worsened slightly over the last month to 79.70%. This indicator is again rated red and below the target of 90%. The target in relation to appraisal compliance was last met in December 2019. • Performance in relation to generic Mandatory Training continues to meet the external target of 85%. Current performance is slightly worsened at 94.50%. Role specific mandatory training compliance also worsened slightly and at 93.60%, remains above the target. • The vacancy rate has worsened slightly in month driven by an increase of 125WTE in the budget. It continues to meet the target at 3.79%. The report offers a brief overview of a number of key work streams: • Industrial Action • Rostering performance for non-medical staff • eJob Planning, eRostering and Activity Manager for medical staff

Executive Summary Workforce Report

The Royal Wolverhampton NHS Trust

Trust Board
7th February 2023

Safe & Effective | Kind & Caring | Exceeding Expectation

Alan Duffell
Group Chief People Officer

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 are meeting the agreed targets; mandatory training and vacancy rates. Appraisal compliance, sickness 24 month retention and turnover are rated red, albeit with small improvements in turnover and sickness.

- Normalised turnover is 11.49% improving in month from 12.41% the previous month. The 24 month retention rate has worsened slightly to 80.45% over the last month.

- The vacancy rate has worsened slightly in month driven by an increase of 125WTE in the budget. It continues to meet the target at 3.79%. Over the last month the number of staff employed has grown by almost 37 WTE driven by net growth across most staff groups. There were over 20WTE more registered nurses at the end of December when compared with November; in addition to this there are a further 127 WTE staff working towards nursing registration either through the fellowship or as newly qualified nurses awaiting their NMC pin. Recruitment continues to outpace turnover; with the number of staff growing by over 540WTE since the start of the financial year with around 26% of this growth in registered nursing.

- Attendance levels have improved slightly in month over November. The in month performance for this indicator is above the new target at 5.75% (down from 5.81% in October). Levels of absence as a result of COVID-19 and flu had increased over the period and will continue to impact performance in relation to the 12 month rolling absence rate for some time which currently sits at 5.56%.

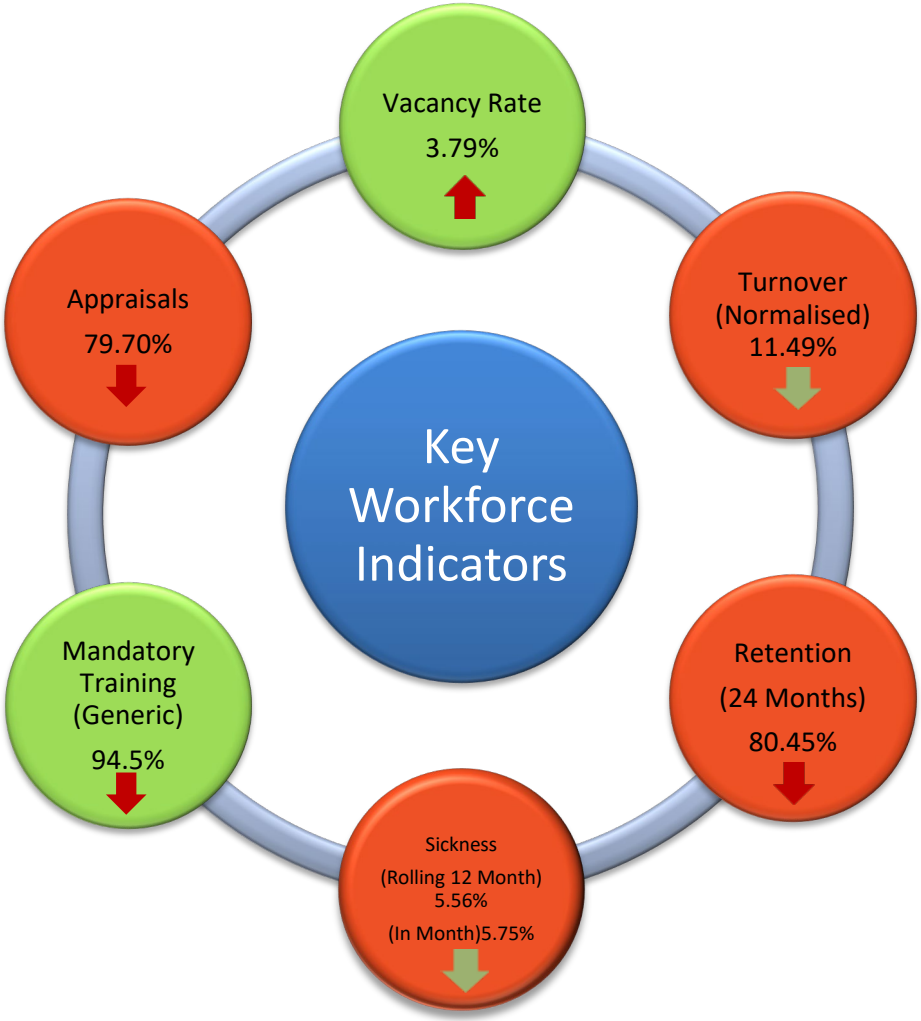
- Performance in relation to generic Mandatory Training continues to meet the external target of 85%. Current performance is slightly worsened at 94.50%. Role specific mandatory training compliance also worsened slightly and at 93.60%, remains above the target. In relation to appraisal, compliance rates have worsened slightly over the last month to 79.70%. This indicator is again rated red and below the target of 90%. The target in relation to appraisal compliance was last met in December 2019.

- The fill rate through the bank in December was 55% for registered nursing staff and 74% for healthcare assistants. The medical bank fill rate was 59% exceeding the target of 50% for the fourth consecutive month.

- The report offers a brief overview of a number of key matters and work streams:

    - Industrial Action
    - Rostering performance for non-medical staff
    - eJob Planning, eRostering and Activity Manager for medical staff

Key Workforce Metrics



Two of the six workforce indicators are meeting the agreed target; vacancy rate and mandatory training compliance. Sickness absence, 24 month retention, turnover and appraisal compliance are rated red.

Turnover has improved to 11.49%. Turnover performance is now meeting the standard only for Medical and Dental staff groups with elevated levels particularly in AHP and Healthcare Scientist and Additional Professional. Whilst turnover remains elevated for Additional Professional, Scientific, and Technical staff, it is improving for this group.

The vacancy level has worsened slightly in month, driven by an increase in budget, although continues to meet the target. It is slightly above target for healthcare scientist and infrastructure support (A&C and estates and facilities) staff groups.

In month absence levels remain high following the impact of COVID-19 with a similar trend shown in relation to rolling 12 month attendance levels. Both indicators continue to exceed the target following elevated levels of absence as a result of COVID-19 and seasonal absence.

Mandatory training (generic) compliance continues to exceed the 85% target.

Appraisal compliance has worsened slightly and is not meeting the Trust target of 90%.

Key Workforce Matters

Summary Update

Industrial Action

Board members will be be aware of the current industrial relations situation in the NHS and the wider public sector. Thus far there has been limited impact at the Trust. As part of ballots across the country:

- The Royal College of Nursing (RCN), Royal College of Midwives (RCM), UNISON and the Chartered Society of Physiotherapy (CSP) balloted their membership at RWT. The turnout did not meet the threshold for industrial action.
- The Hospital Consultants and Specialist Association (HCSA) balloted their membership and a mandate for strike action was achieved. There are two members of the HCSA in the Trust.
- The British Medical Association (BMA) are currently balloting their membership in a ballot that closes on 20 February 2023. Should that ballot achieve a mandate for industrial action the BMA have indicated that their industrial action will take the form of a 72 hour full walkout in March (dates to be confirmed). The BMA anticipate that cover will be provided by Consultant and Specialty and Specialist (SAS) medical staff and this could have significant impact on planned services particularly.

Considering the wider impact of health sector strikes, the GMB Union and UNITE secured a mandate for industrial action in the West Midlands Ambulance Service and have taken a number of days of industrial action to date. UNISON narrowly missed the threshold for turnout and are undertaking a further ballot of their membership in that organisation. The ballot closes on 16 February 2023. Key dates of industrial action for the Trust to be aware of are:

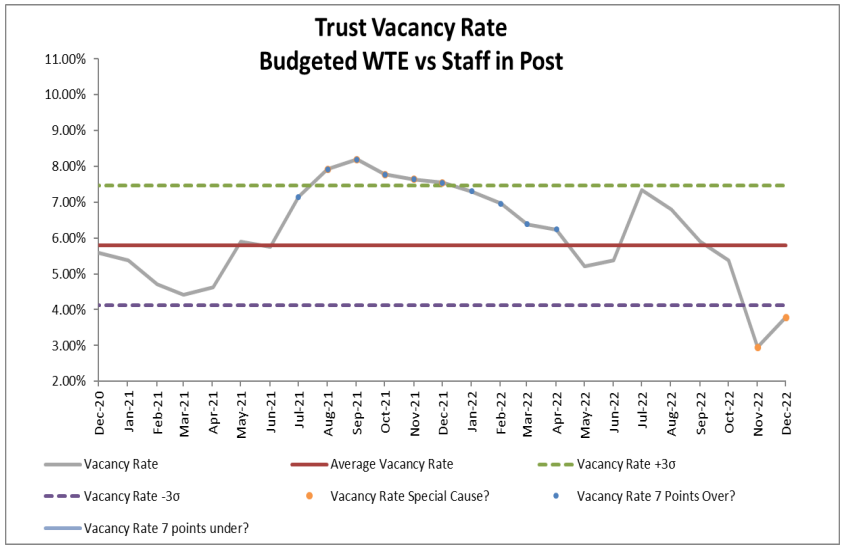
- 6 February 2023 – ambulance service strike (GMB and UNITE)
- 6 and 7 February 2023 – RCN impacting 73 Trusts in England.
- 9 February 2023 – Physiotherapists Strike, most locally impacting Sandwell and West Birmingham
- 17 and 22 February 2023 – ambulance service (UNITE)
- 6 and 20 March 2023 – ambulance service (UNITE and GMB)

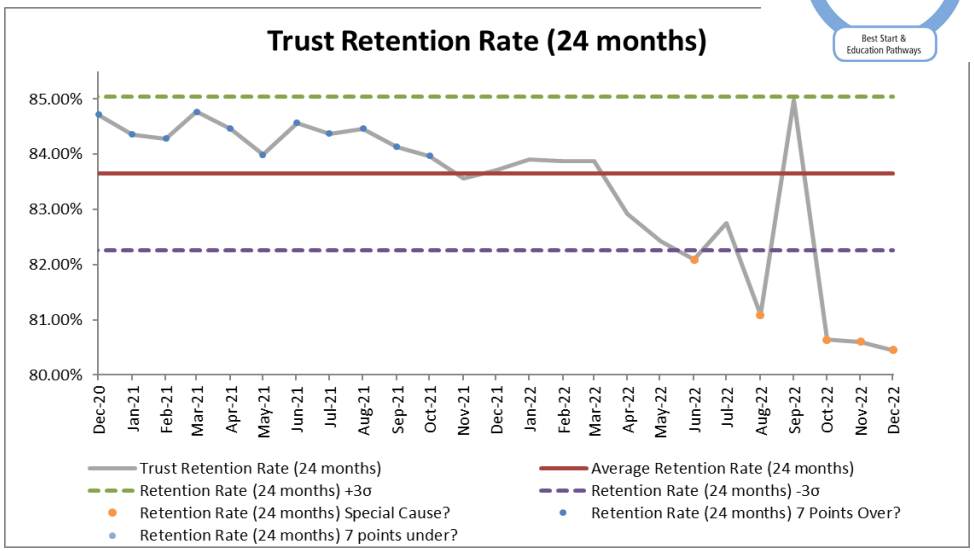
The National Education Union (NEU), the teachers union has announced a series of strikes which may impact Trust staff. For the West Midlands these strikes will take place on:

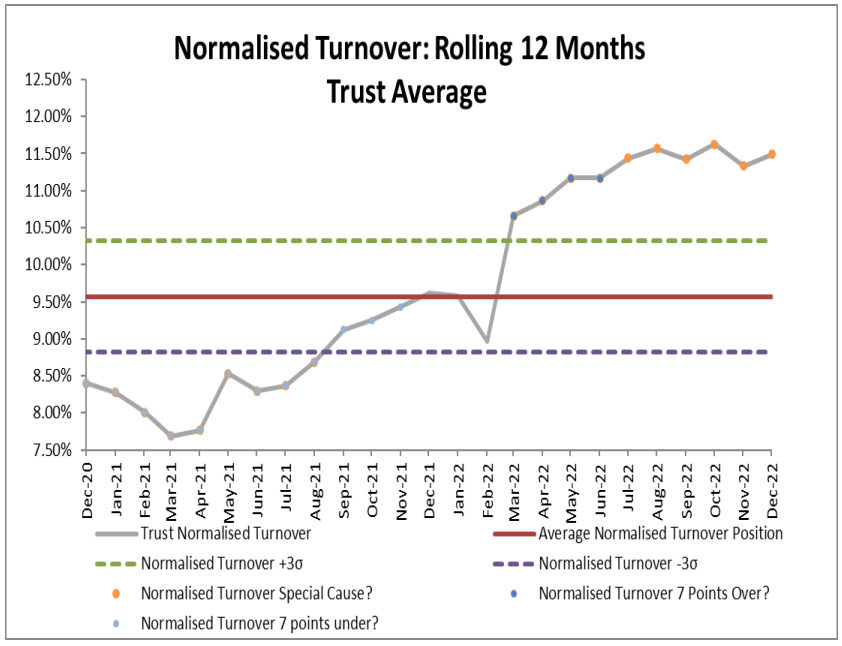
- 1 February 2023
- 1 March 2023
- 15 and 16 March 2023

The Trust has established business continuity arrangements to ensure safe service continue to be maintained through any industrial action and the Trust is engaged with local and regional Trades Unions Officials as part of this.

Attract, Recruit & Retain







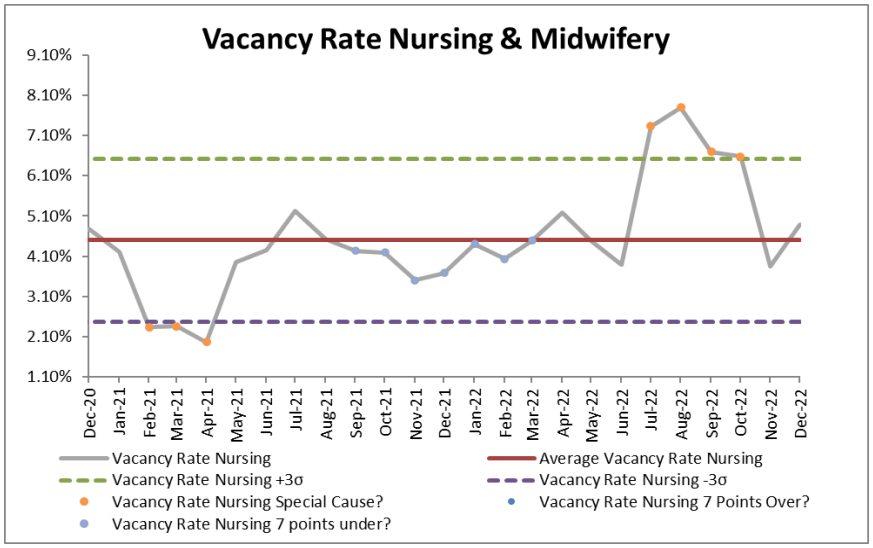
Key Issues & Challenges

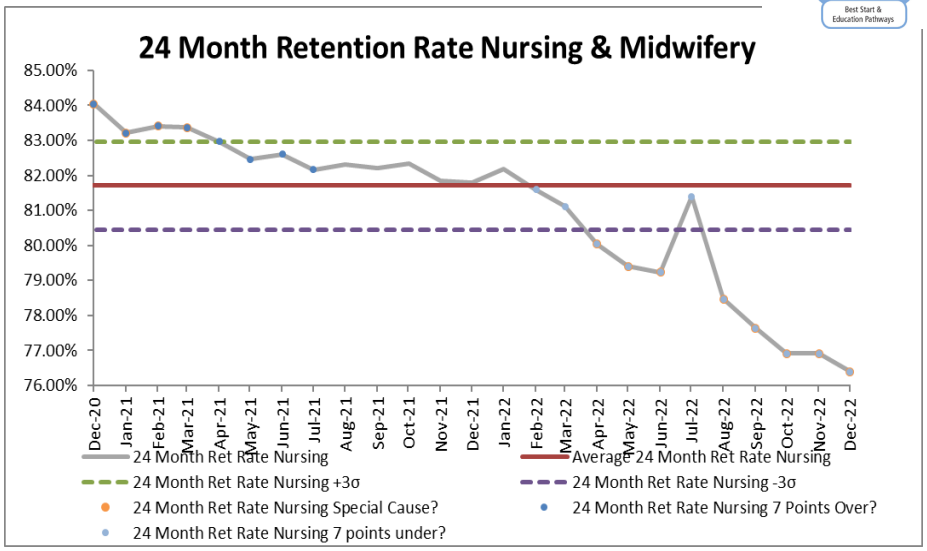
- The Retention Rate at 24 months continues to be below the 85% target at 80.45%. Turnover also exceeds the target at 11.49%.
- The vacancy rate remains slightly elevated for Healthcare Scientists, NHS Infrastructure Support staff groups and is rated amber for these areas.
- Whilst the vacancy levels continue to improve, there is a lead time, particularly in relation to international and newly qualified nurses where the recruitment will have reduced the vacancy level, but a period of consolidation is required before they can take on the full range of required duties as a registered healthcare professional. There continue to be issues relating to the first time OSCE pass rate for international nurses and this is closely monitored with actions in place.

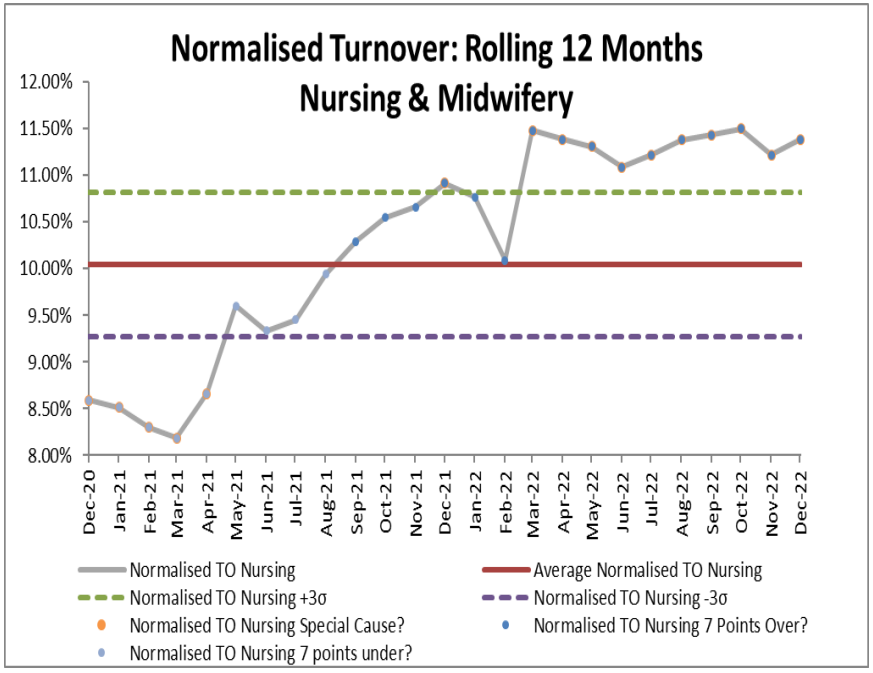
Key Actions & Progress

- The vacancy rate is now meeting the target.
- Active work continues to identify hard to fill posts and this will also focus on AHP, and Healthcare science posts where there have been improvements in month.
- Starters continue to outpace leavers with a net increase of almost 540WTE staff since the start of the financial year.
- The ‘effective rostering’ project continues. The focus is shifting to ensuring effective rostering and confirm and challenge meetings have been established with the Rostering Lead and Head of Nursing Workforce with Divisional Head Nurses.

Attract, Recruit & Retain







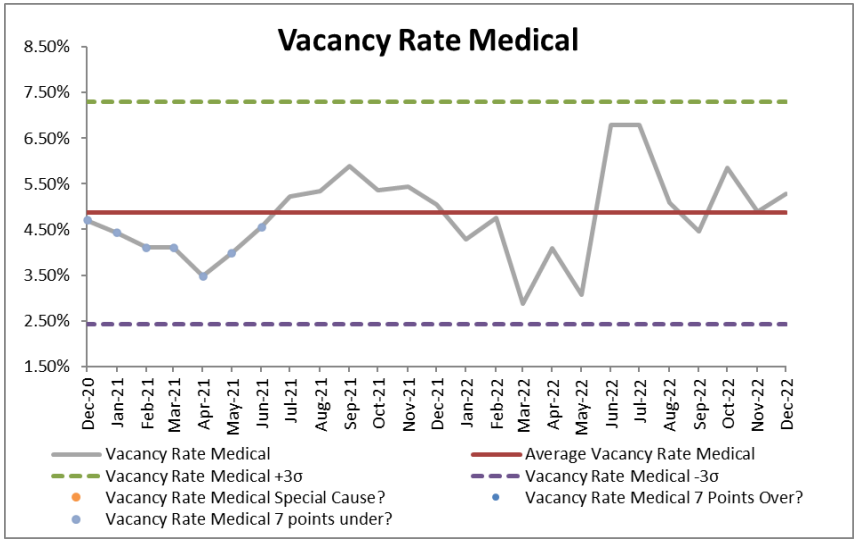
Key Issues & Challenges

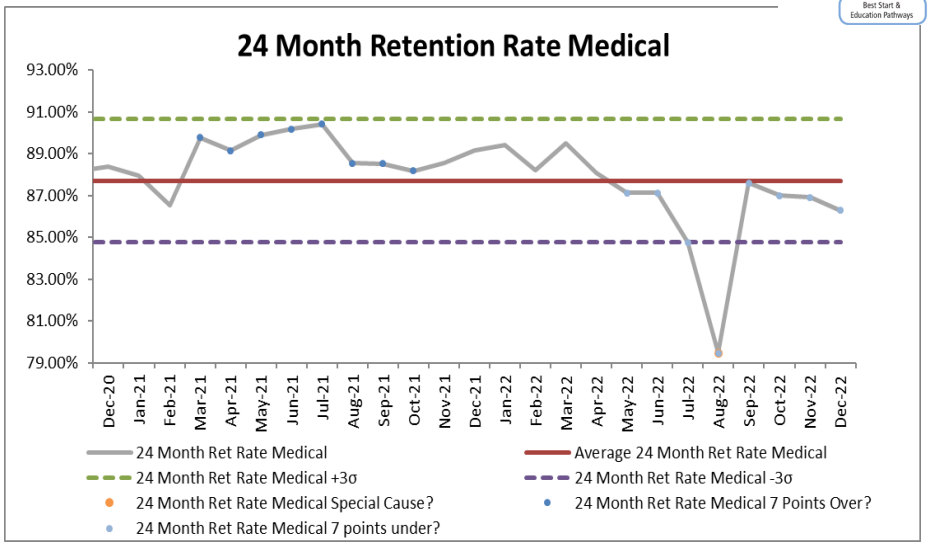
- Nursing turnover is above target at 11.38%, increasing slightly from the prior month. Work life balance is a key driver of turnover. Increased turnover is also driven by staff who deferred retirement/ may otherwise have left in 2020/21 now leaving the service/ Trust in an increased number. Wider review of this suggests it is rebalancing and is likely to stabilise in the near term, however, this will need close monitoring.
- Over the last 2 years, there has been a year on year increase in the number of staff accessing retire and return.
- In relation to international nurses there continue to be challenges with flight availability and cost and there has been an increase in the number of international nursing staff not passing their OSCE on the first attempt following changes made to the assessment by the NMC.

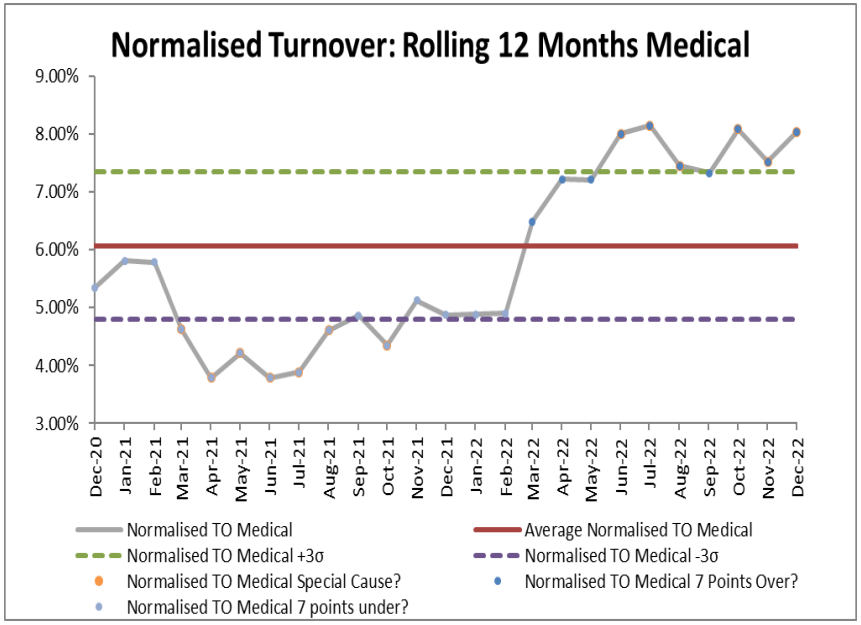
Key Actions & Progress

- Recruitment continues at pace for this staff group with an increase of 37 international nurses over January 2023 and 127 WTE nursing staff working towards their pin.
- Further work has been undertaken to understand the issues contributing to staff not passing their OSCE and actions are in place in response to the changes to the OSCE from an educational perspective.

Attract, Recruit & Retain







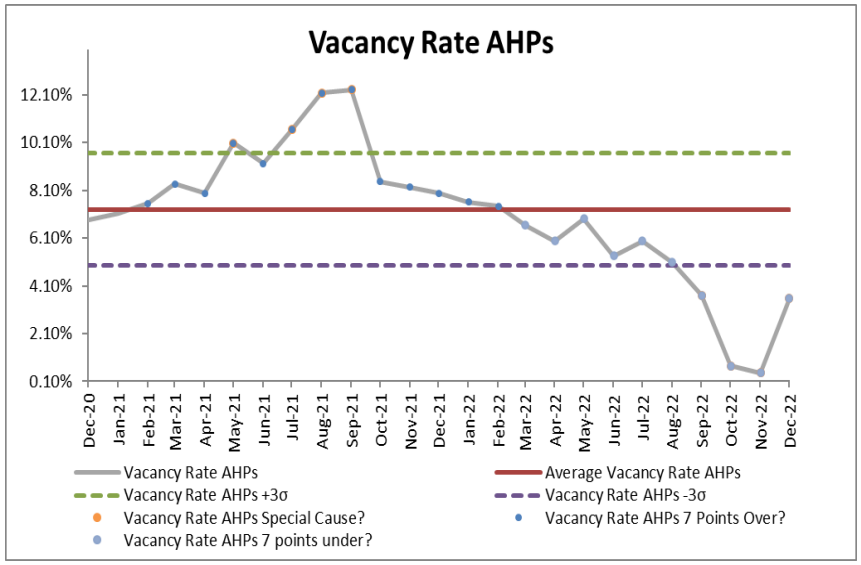
Key Issues & Challenges

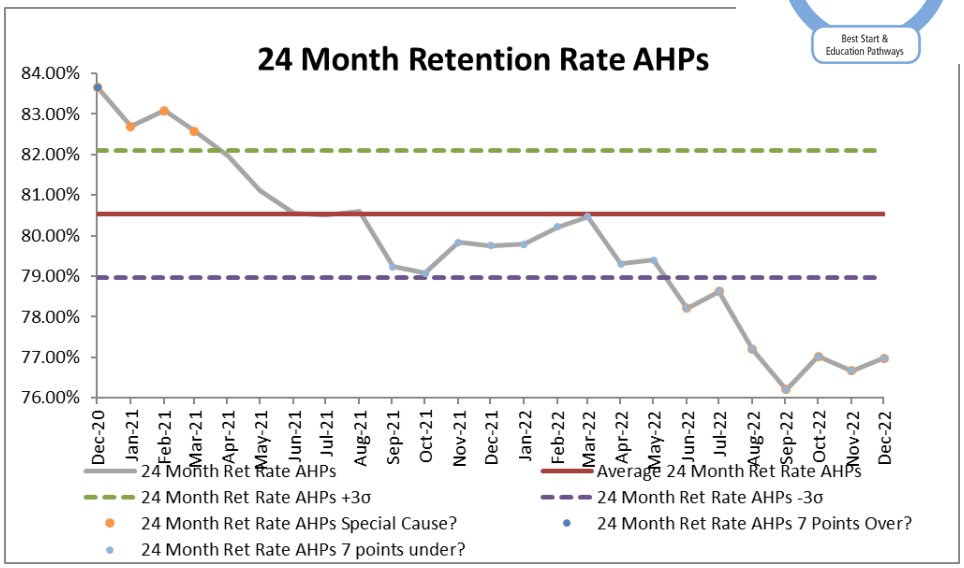
- Whilst the overall vacancy position is hugely positive, there are some hotspots in key services where vacancy levels give cause for concern, such as in clinical oncology, emergency medicine and microbiology.

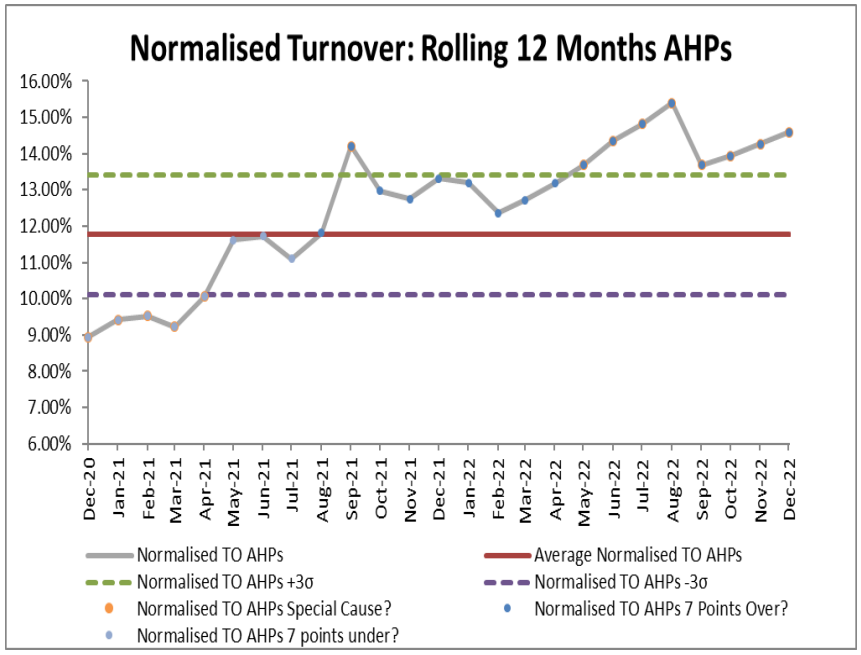
Key Actions & Progress

- All recruitment and retention metrics for medical staff are being met.
- The targeted work in oncology continues and one experienced consultant has been appointed. There is now an interview scheduled for a Professor of Medical Oncology, an appointment that is to be made with Aston University as part of the Trust's partnership with that institution.
- A Hard to Fill report has been fully established with targeted work in a number of specialities. This is managed through the Operational Workforce Group with assurance provided to the People and OD Committee.

Attract, Recruit & Retain





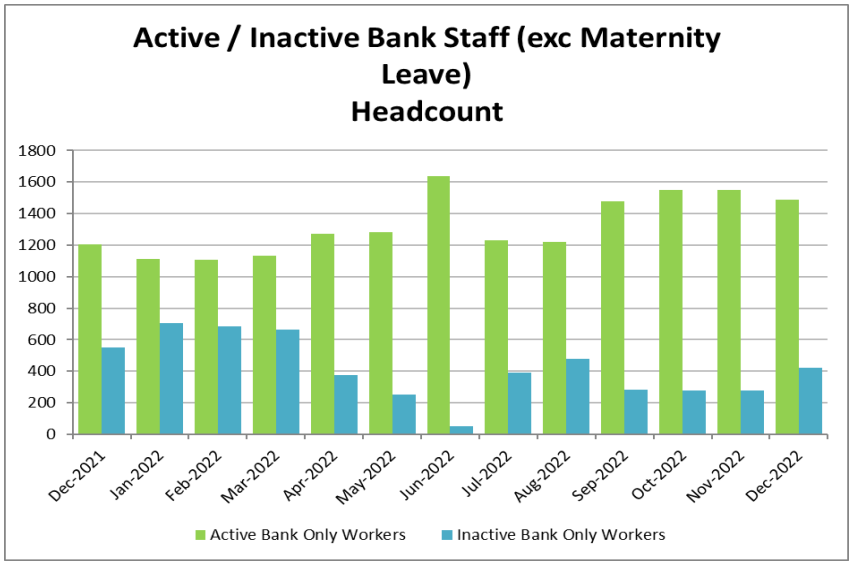


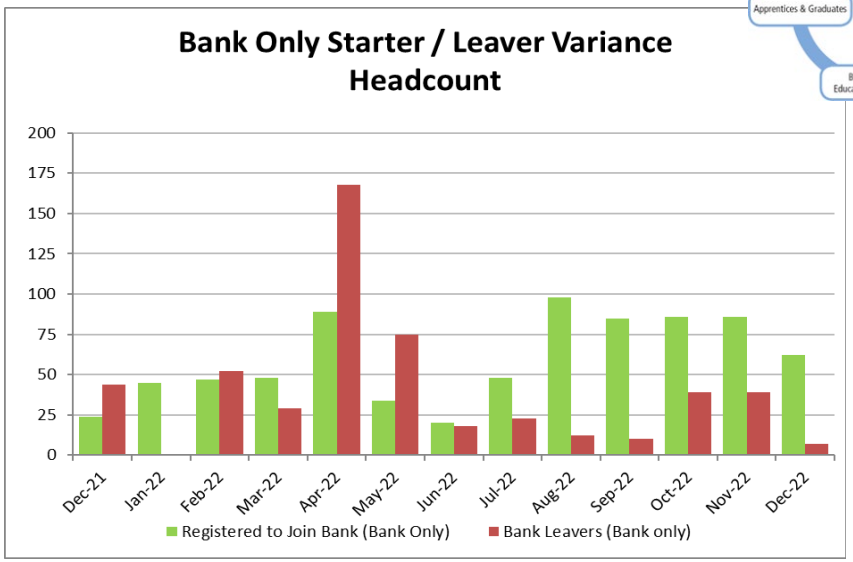
Key Issues & Challenges

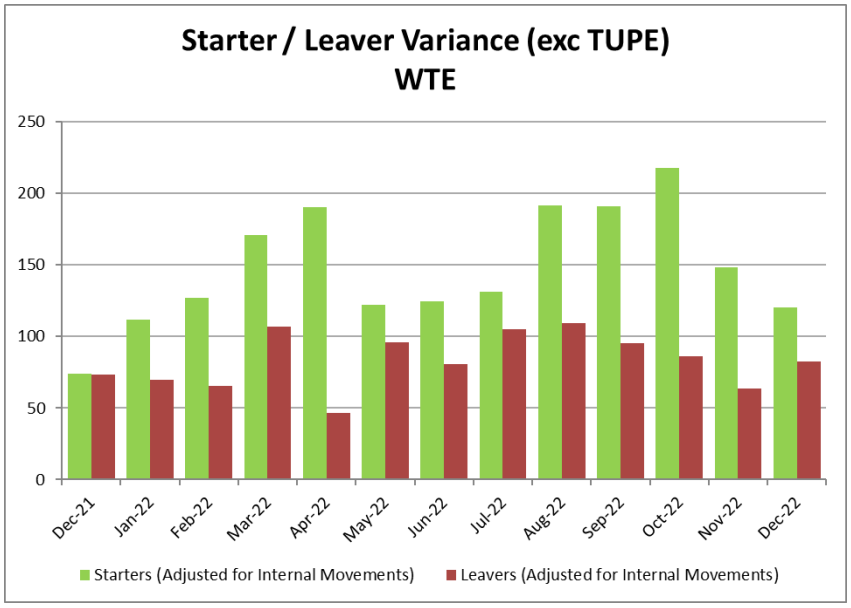
- Metrics for AHPs cover Podiatry, Dietetics, Occupational Therapy, Physiotherapy, Orthoptics, Radiography (diagnostic and therapeutic), Orthotics, Speech and Language Therapy (SaLT), and Operating Theatres.
- There are hotspots in particular staff groups, specifically, Dietetics (2.86 WTE 11%, down from 14%) and, Occupational Therapy (12.55WTE, 15%), Operating Department Practitioners (15.35WTE, 16%) following an increase of 18% in the budget for this staff group equating to 14WTE more posts.
- Turnover for AHPs is elevated.

Key Actions & Progress

- AHP vacancy levels overall are now meeting the Trust target over the last four months, the first time since April 2020.
- Radiology has seen significant improvements in vacancy rates. International recruitment continues to be a success in radiology with a further six staff due to join the department in February.
- There has been a notable improvement in the vacancy rate in Chiropody/ Podiatry since the last report reducing from 14% to 5%.
- Targeted and international recruitment continues in these areas as part of the work to identify and pro-actively recruit to hard to fill areas as outlined on the previous page.







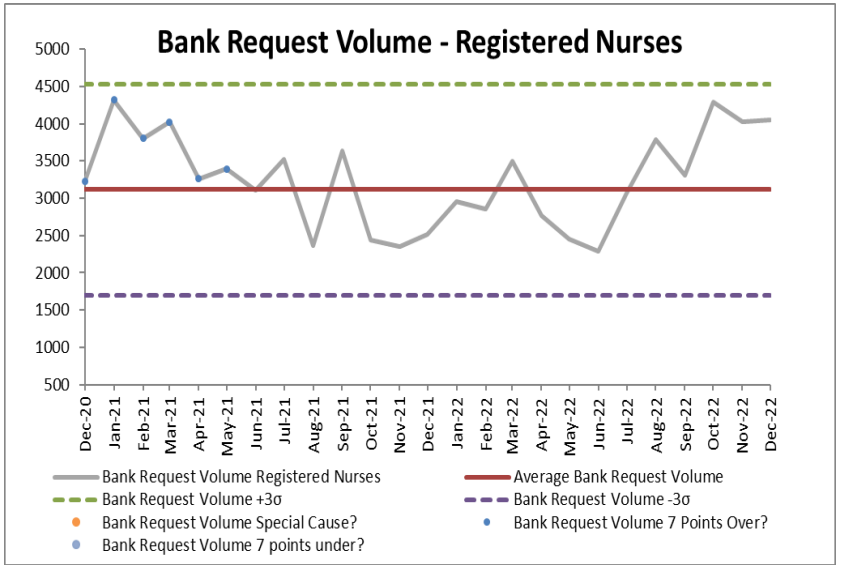
Key Issues & Challenges

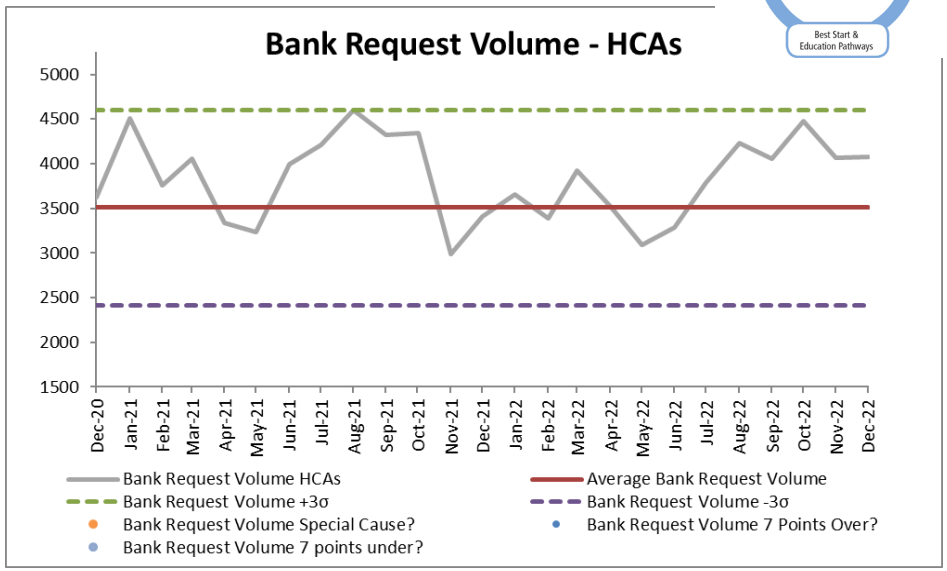
- Bank fill rates for HCSWs fell to approximately 74% in December. In month registered nursing fill rate remains below the lower control limit and Trust target at 55%.
- The number of workers joining Trust bank has reduced over the last month.

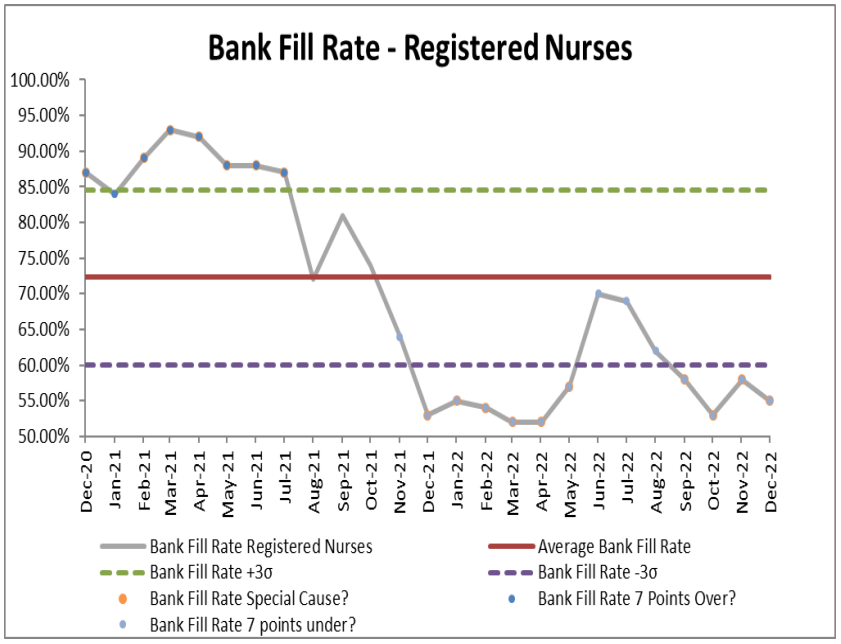
Key Actions & Progress

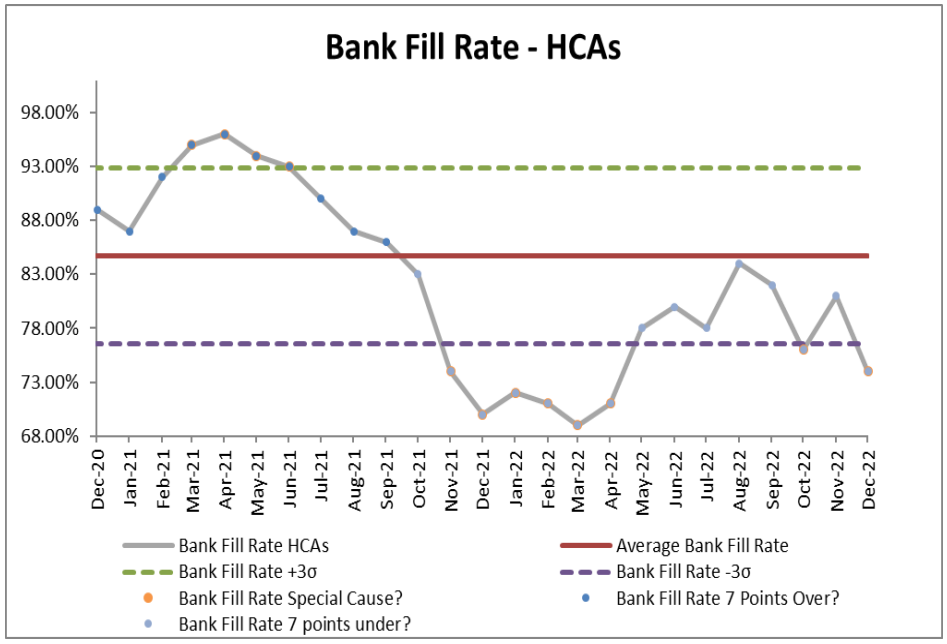
- The number of bank workers joining continues to exceed those leaving the Trust on a month by month basis. December saw an approximate net increase of 50 workers and there are now 1,919 'bank only' staff engaged by the Trust.
- Nursing Workforce Team have requested a pause in external HCSW recruitment; no new advert to be published until April.
- Bank request levels for HCSW and registered nurses both remained stable over December.
- A weekly system data cleanse exercise continues to remove inactive bank workers from the system.


Employer Branding, Attraction, Recruitment & Retention
Career Pathways & Succession Planning
Best Start & Education Pathways
Apprentices & Graduates


Bank Request Volume - Registered Nurses
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Bank Request Volume Registered Nurses
Average Bank Request Volume
Bank Request Volume +3σ
Bank Request Volume -3σ
Bank Request Volume Special Cause?
Bank Request Volume 7 Points Over?
Bank Request Volume 7 points under?


Bank Request Volume - HCAs
5000
4500
4000
3500
3000
2500
2000
1500
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Bank Request Volume HCAs
Average Bank Request Volume
Bank Request Volume +3σ
Bank Request Volume -3σ
Bank Request Volume Special Cause?
Bank Request Volume 7 Points Over?
Bank Request Volume 7 points under?


Bank Fill Rate - Registered Nurses
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
55.00%
50.00%
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Bank Fill Rate Registered Nurses
Average Bank Fill Rate
Bank Fill Rate +3σ
Bank Fill Rate -3σ
Bank Fill Rate Special Cause?
Bank Fill Rate 7 Points Over?
Bank Fill Rate 7 points under?


Bank Fill Rate - HCAs
98.00%
93.00%
88.00%
83.00%
78.00%
73.00%
68.00%
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
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Aug-22
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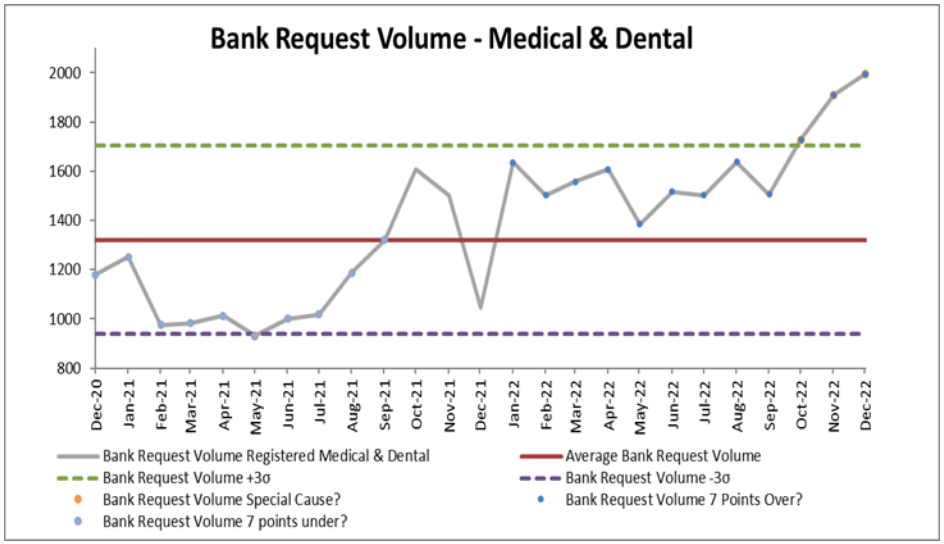
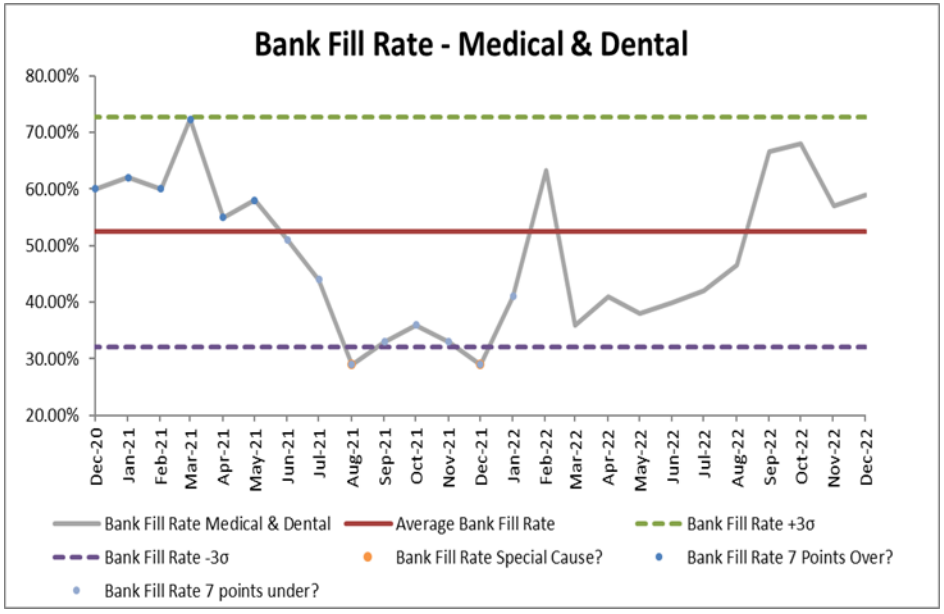
Oct-22
Nov-22
Dec-22
Bank Fill Rate HCAs
Average Bank Fill Rate
Bank Fill Rate +3σ
Bank Fill Rate -3σ
Bank Fill Rate Special Cause?
Bank Fill Rate 7 Points Over?
Bank Fill Rate 7 points under?





Key Issues & Challenges

Bank fill rates are as follows:

- 59% for medical staff in month, slight decrease from 68% last month
- 55% for registered nursing
- 74% fill rate for HCSW staff in month

Fill rates for nursing and HCSW staff are below target and there was a reduction in the medical bank fill rate, which remains above target. This reduction in the fill rate for medical staff was driven by the increased numbers of short notice requests attributable to unplanned absence.

Similar impacts are noted in nursing.

Key Actions & Progress

- Work continues to embed the use of the collaborative medical bank between RWT and WHT, including wider publication to medical staff.
- The number of medical staff on the bank continues to increase.
- Incentive schemes have been put in place to support increased fill in Nursing areas where demand requires.

Education / Organisational Development	BCPS	Corporate	Division 1	Division 2	Division 3	Division 4	Estates	Grand Total
Mandatory Training - Statutory Topics	90.6%	95.7%	94.1%	94.2%	95.6%	91.8%	96.3%	94.5%
Mandatory Training - Policy Required	93.9%	97.0%	92.1%	92.1%	95.5%	95.1%	97.3%	93.6%
Appraisal	81.8%	80.3%	74.2%	80.7%	82.1%	75.4%	87.5%	79.7%

Mandatory Training - Statutory Topics	Oct-22	Nov-22	Dec-22
225 Black Country Pathology Service	88.90	89.50	90.60
225 Corporate Division	96.50	96.20	95.70
225 Division 1	94.40	94.20	94.10
225 Division 2	94.60	94.80	94.20
225 Division 3	95.50	95.90	95.60
225 Division 4	93.90	93.30	91.80
225 Estates & Facilities Division	96.20	96.00	96.30
Grand Total	94.60	94.70	94.50

Appraisals	Oct-22	Nov-22	Dec-22
225 Black Country Pathology Service	69.90	77.60	81.80
225 Corporate Division	81.20	80.60	80.30
225 Division 1	75.30	75.40	74.20
225 Division 2	79.40	80.20	80.70
225 Division 3	80.70	84.50	82.10
225 Division 4	81.90	77.80	75.40
225 Estates & Facilities Division	87.60	86.80	87.50
Grand Total	78.80	80.10	79.70

Mandatory Training - Policy Required	Oct-22	Nov-22	Dec-22
225 Black Country Pathology Service	93.20	93.70	93.90
225 Corporate Division	97.20	97.20	97.00
225 Division 1	93.30	93.20	92.10
225 Division 2	93.10	93.50	92.10
225 Division 3	96.20	96.80	95.50
225 Division 4	96.50	95.70	95.10
225 Estates & Facilities Division	96.90	97.40	97.30
Grand Total	94.40	94.60	93.60

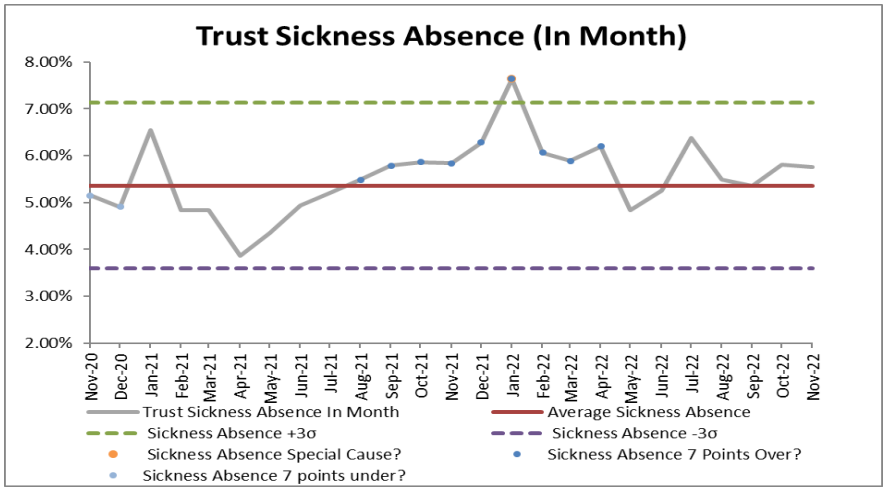
Key Issues & Challenges

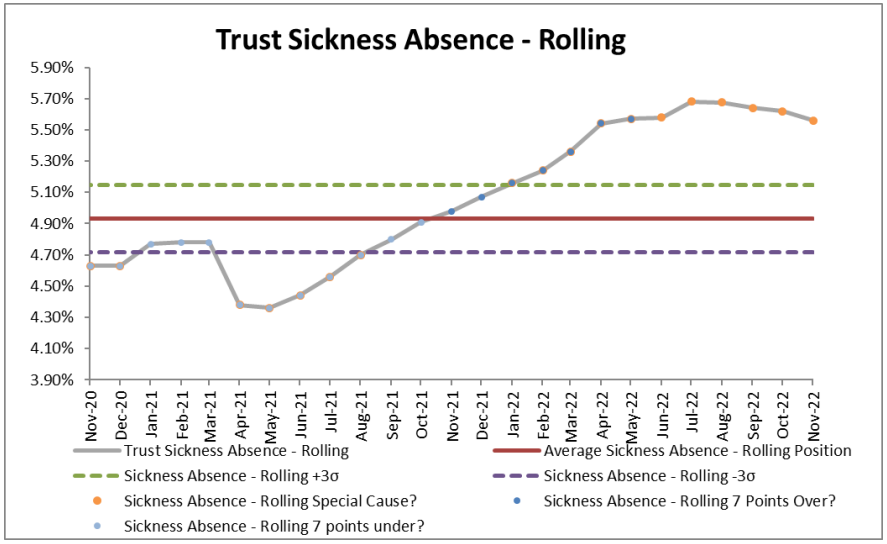
- Appraisal compliance is not meeting the target across the board and the last time this target was met was in December 2019.
- Particular focus is needed in Division 1 and 4 where performance is most challenged.
- Service pressures have had and continue to have a profound effect on the ability to undertake timely appraisals

Key Actions & Progress

- This matter has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.
- Improvements have been seen in BCPS over the last 2 months, with further work required, as in other areas.
- Mandatory training, both Tier 1 and Tier 2 continues to meet the Trust target.

Health & Wellbeing





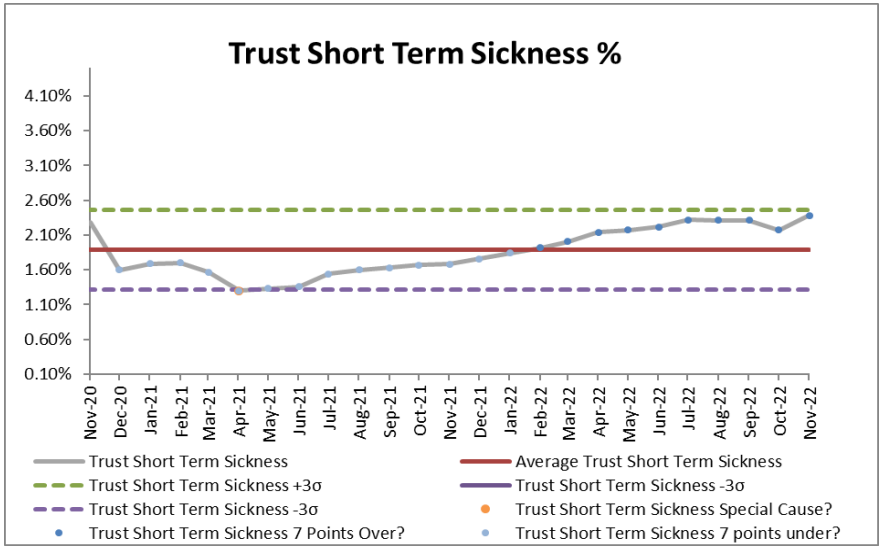
Key Issues & Challenges

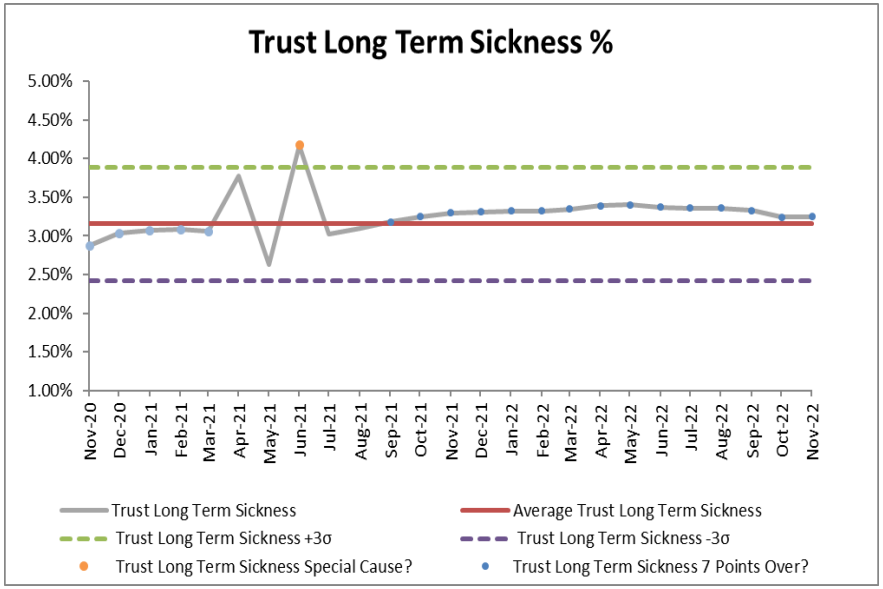
- The rolling 12 month absence rate remains above the Trust target at 5.56% as a result of elevated absence due to COVID-19 being represented across the full year in the figure.
- In month sickness absence has reduced to 5.75% in November 2022.
- Occupational Health referrals reduced to 206 (average) in December. There is a general trend of increased referrals to this service which is expected to continue.

Key Actions & Progress

- HR colleagues have been reviewing COVID related sickness absence returns to ensure that in cases where the absence (or household isolation) is seen as an outlier it is followed up and support offered to the manager/ staff member as necessary.
- HR teams continue to sensitively support the management of long and short term sickness absence cases as appropriate in the current circumstances.
- Considerable work has been done to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.
- The flu and COVID-19 vaccination campaigns commenced in September.
- Occupational Health appointments with nurses have been made within the required timeline in 100% of cases despite the increase in activity as have 100% of referrals requiring a doctor were seen on the required timeline for the last three months.

Health & Wellbeing





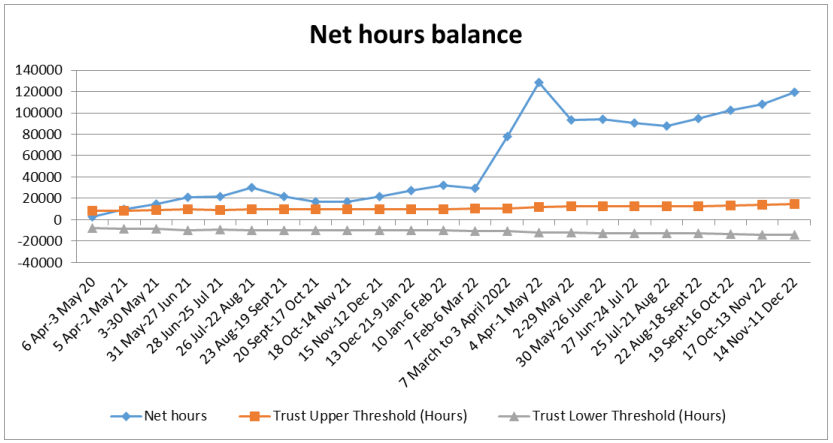
Key Issues & Challenges

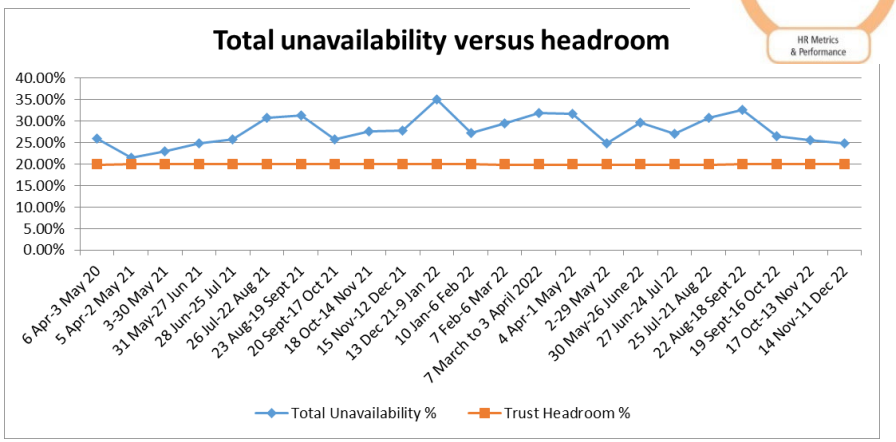
- Of the 4.25% target for sickness absence, it is typical for around 60% of the threshold (2.55%) to be attributable to long-term sickness absence and the remaining 40% (1.80%) to short term absence.
- Both short and long term absence are above these 'targets' in November 2022, with long term sickness absence further away from the target than short term. A detailed review has been undertaken by the Head of HR Advisory, which found the majority of cases were being appropriately managed in accordance with the policy.

Key Actions & Progress

- The attendance management structures will need to be revisited as part of the post COVID-19 recovery with the re-establishment of sickness absence workshops within the Divisions.
- Divisions shall need to focus particularly on long term absence.
- A case by case review has been undertaken by the Head of HR Advisory with HRMs for all long term sickness absence cases which has been reported to the People and OD Committee. It found that in the large majority of cases of long term sickness the process had been followed appropriately.
- The HR Advisory Team are working through the recently launched NHS England's Improving Attendance Toolkit, further updates will be provided through regular updates to the People and OD Committee.

Productivity – e-Rostering Metrics





Definition: Net hours are the planned versus delivered contracted hours
Trust threshold: Within 2% (over or under) total contracted hours

Definition: Any period of absence from core service delivery
Trust threshold: 20% total headroom allowance

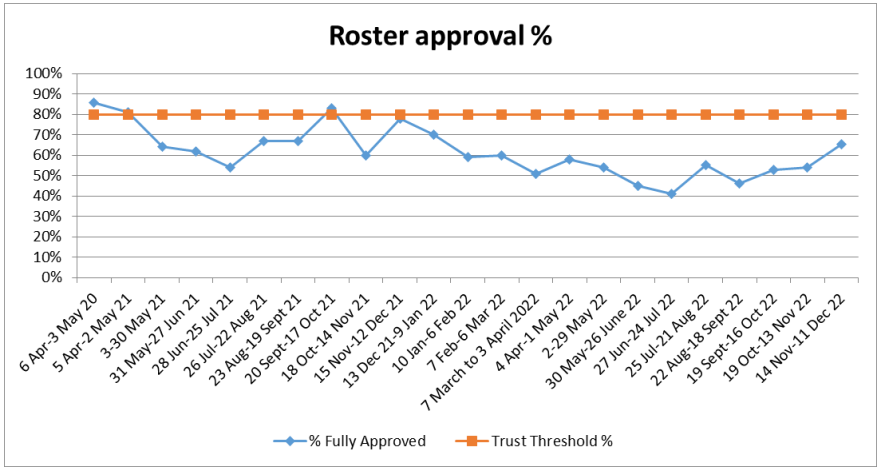
Key Issues & Challenges

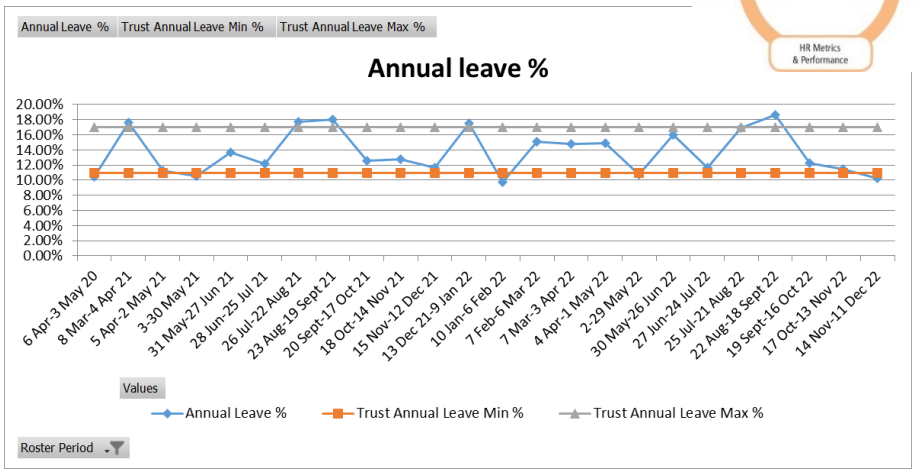
- The Trust's net hours balance remains outside of agreed thresholds (2% total contracted hours). For the current reporting period, this equated to just under 119.5K of unused contracted hours.
- Total unavailability remains outside of the Trust headroom percentage (20%) at 24.85%, this continues to be a positive trend with consistent minor improvements month by month (although still outside of required thresholds).
- Sickness, parenting (maternity, paternity, adoption leave), and other leave (authorised leave in line with policy) remain contributory factors, the latter two reasons for which are both excluded from headroom percentages:
    - Annual leave, 10.2% - outside policy thresholds (11-17%)
    - Sickness, 7.37% - outside of policy thresholds (3.24%)
    - Study, 2.28% - outside policy thresholds (2%)
    - Other leave, 1.21% - not factored into headroom allowance
    - Working day, 0.96% - not factored into headroom allowance
    - Parenting, 2.82% - not factored into headroom allowance

Key Actions & Progress

- Regular meetings and support sessions continue to be held with managers to address net hours concerns and identify and resolve historic balances. These meetings identify if balances are due to historic episodes of sickness/annual leave or recoverable missing duties. Work is also being planned to address the net hours issues contributed to by new project areas using activity manager. Managers are directed to Heads of Nursing/Midwifery/Department to escalate and obtain approval for resetting any net hour balances.
- During regular meetings the unavailability and reasons for it are challenged and discussed with areas and where possible actions put in place to address.

Productivity – e-Rostering Metrics





Definition: Rosters fully approved 6-weeks in advance of roster start date
Trust threshold: 80% of rosters fully approved

Definition: Absence from core service delivery due to annual leave
Trust threshold: Ideal is 15% but within 11-17%

Key Issues & Challenges

The number of rosters fully approved six weeks in advance of the roster start date remains below the agreed threshold (80%) at 65%.

Roster approval delays are partially attributed to changes in management, most in some of the larger corporate areas that had some major changes affecting multiple rosters. Another common issue is cover not being in place during the absence of the approvers, which also caused delays. Whilst still outside of the 80% threshold, some positive improvement is evident with the highest approval % since December last year.

Annual leave dipped below policy thresholds (11-17%) at 10.2%.
The entry and calculation of leave entitlements remain a key issue from a systems and policy perspective.

Key Actions & Progress

- Non-adherence continues to be escalated.
- Ongoing promotion of good rostering practice
- Nursing Workforce continues to address compliance at the confirm, challenge and support meetings.
- Progress continues to be made toward the development of e-roster training videos on My Academy
- Work commencing to update leave entitlements in HealthRoster for the new financial year
- Continued net hours management support meetings
- New process commenced in nursing areas for staffing updates.

Total % of system generated rosters
36.1% ↑

E-Rostering level of attainment	
Nursing & Midwifery	1
Healthcare Scientists	0
Pharmacy	0
Allied Health Professionals	0
Additional Clinical Services	0

Productivity – e-Job Plan, e-Rostering (Medics)

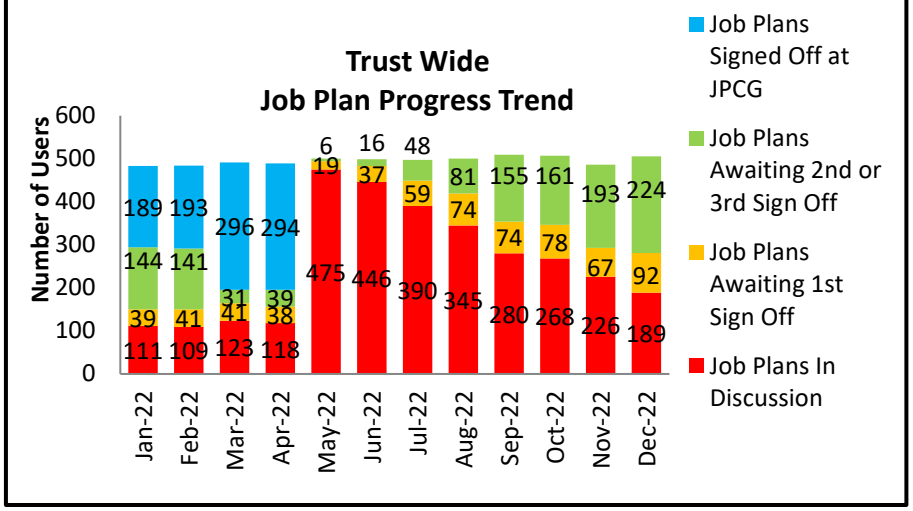
e-Job Plan Divisional Update

The Trust wide progress graph details that 37% of job plans are now in discussion stage, with 44% of job plans within 3rd stage sign off.

The movement at discussion stage, from the last reporting period is 16%, where job plans have moved into 1st, 2nd or 3rd stage sign off. The movements between the individual stages since the last reporting period have also increased, with job plans moving on to the next stage of the process.

There are currently 7 directorates where JPCG reports are being reviewed by the Deputy CMO in the first instance – these directorates have 75% or more of their job plans in 3rd stage sign off. Directorates included are Emergency Medicine, ENT, Neonates, Neurology, Orthodontics, Radiology and Sexual Health.

The official JPCG reviews of the above-mentioned directorates will take place throughout February - April 2023.



e-Rostering Update

Medicine SpR's – Following a meeting with the GIM leads, the on-call rota is complete within Health Roster and is now live. Agreement to trial the electronic roster alongside the current excel rota will take place until the end of February – feedback from GIM leads and doctors will be reviewed to incorporate any amendments necessary to ensure the electronic rota is workable (combination of x3 rotas in one).

Cardiothoracic Surgery – Remaining individual rota pattern to be completed within Health Roster. Meeting arranged with CD to review rota moving forward within Health Roster.

Fully Live

General Medicine, ED, Cannock, Clinical Haem, Neurology, O&G, Neonates, Ophthalmology, Paediatrics, ENT, Gen Surgery, T&O, Oral Surgery, Cardiology, Radiology and Urology.

Changes/Issues with Rota's

Cardiothoracic Surgery

Activity Manager Update

Activity manager was placed on hold, owing to the further extension of the job planning round. Since the round has ended, JPCG reports are under review where more than 75% of a directorate's plans are in 3rd stage sign off. JPCG meetings are due to take place throughout February - April 2023.

Workforce Metrics - Trust Board
M7: Data Effective 31 Dec 2022
Full Trust

The Royal Wolverhampton NHS Trust

B01	Workforce Profile	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Change Out-turn	Comments
B01.1	Substantive Staff WTE	9267.28		9279.83	9305.68	9347.89	9373.55	9455.96	9557.02	9689.19	9772.48	9809.06				541.78	Inc Permanent, Fixed Term, & Locums with WTE on Payroll
B01.2	Substantive Staff WTE (Exc Rotational Doctors)	8959.00		8976.31	9001.78	9047.82	9071.45	9125.21	9232.51	9360.58	9446.31	9487.43				528.43	Inc Permanent, Fixed Term, & Locums; Exc Rotational Drs
B01.3	Substantive Staff Headcount	10609		10631	10655.00	10700.00	10722.00	10813.00	10916.00	11062.00	11145.00	11180.00				571	Inc Permanent, Fixed Term, & Locums with WTE on Payroll
B01.4	Bank Staff Only Headcount	1805		1659	1542.00	1562.00	1628.00	1704.00	1773.00	1830.00	1849.00	1919.00				114	
B01.5	Agency LMS Headcount	150		156	160.00	167.00	171.00	168.00	168.00	163.00	163.00	165.00				15	
B01.6	% Staff from a BME background	31.98%		0.32	32.43	0.32	32.90	0.35	0.34	0.34	0.35	0.35				2.98%	
B01.7	TUPE In WTE	0.00		17.30	0.00	1.05	0.00	0.00	0.00	0.00						17.30	
B01.8	TUPE Out WTE	26.52		3.63	10.47	7.99	1.50	7.98	5.33	5.33						57.19	
	Data Owner: Workforce Planning & Business Intelligence																

B02	Changes to Workforce Profile	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Change Out-turn	Comments
B02.1	Change in Workforce Profile WTE (Exc Rotational Doctors)			-58.75	18.70	20.46	21.38	47.56	28.33	9.69	31.86	41.58				41.58	Leavers current month target calculated as 1/12th of 10.5% of in-month Staff in Post
B02.2	Starters WTE (Exc Rotational Doctors)			131.62	103.06	103.11	110.02	144.12	162.81	208.17	116.15	78.74				1,157.81	
B02.3	Leavers WTE (Exc Rotational Doctors)			46.76	95.93	80.36	104.73	109.27	95.10	86.28	63.73	82.74				764.90	
	Data Owner: Workforce Planning & Business Intelligence																

B03	Workforce Profile by Staff Group	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Change Out-turn	Comments
B03.1	Add Prof Scientific and Technic WTE	253.03		245.76	249.70	249.20	251.43	251.75	255.86	261.79	270.04	268.30				15.27	
B03.2	Additional Clinical Services WTE	1708.91		1,731.73	1,738.11	1,770.39	1,777.88	1,801.23	1,820.88	1,877.52	1,877.19	1,892.49				183.58	
B03.3	*Add Clin Serv: Newly Qualified / Overseas Nurses Awaiting PIN*	20.60		*41.00*	*57.00*	*65.00*	*59.84*	*103.63*	*97.23*	*129.83*	*121.83*	*126.47*				105.87	
B03.4	Administrative and Clerical WTE	2036.53		2,058.99	2,067.26	2,066.95	2,061.69	2,089.62	2,106.02	2,110.04	2,129.14	2,131.78				95.25	
B03.5	Allied Health Professionals WTE	513.08		515.11	509.36	503.03	504.51	513.29	524.94	540.19	544.66	545.02				31.94	
B03.6	Estates and Ancillary WTE	591.88		591.96	590.42	593.80	592.35	586.03	599.41	599.69	595.58	597.90				6.02	
B03.7	Healthcare Scientists WTE	482.54		481.86	480.76	485.87	488.83	491.84	502.24	496.28	503.13	501.76				19.22	
B03.8	Medical and Dental WTE (Exc Rotational Doctors)	737.00		728.47	732.97	741.84	747.78	737.31	751.68	753.79	768.12	772.38				35.38	
B03.9	Medical and Dental WTE (Rotational Doctors)	308.28		303.52	303.91	300.07	302.10	330.75	324.51	328.61	326.17	321.63				13.35	
B03.10	Nursing and Midwifery Registered WTE	2628.10		2,614.50	2,625.25	2,630.80	2,642.05	2,649.22	2,661.55	2,710.74	2,748.91	2,769.27				141.17	
B03.11	Students WTE	7.93		7.93	7.93	5.93	4.93	4.93	9.93	10.55	9.55	8.55				0.62	
	Data Owner: Workforce Planning & Business Intelligence																

B04	Vacancy Rate by NHSI Staff Group	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B04.1	Total	6.37%	6.00%	6.25%	5.22%	5.38%	7.34%	6.79%	5.90%	5.37%	2.95%	3.79%				5.44%	Staff in Post WTE vs Budgeted WTE in ESR
B04.2	Allied Health Professionals	7.16%	6.00%	5.72%	6.91%	5.35%	5.98%	5.09%	3.70%	0.74%	0.45%	3.58%				4.17%	Refined calculation 2019/20: removal of recharges and reserves from
B04.3	Healthcare Scientists	13.78%	6.00%	14.14%	12.84%	14.62%	14.64%	14.12%	6.74%	8.47%	7.58%	7.15%				11.14%	Budgeted WTE therefore not directly comparable to previous figures
B04.4	Medical & Dental	2.88%	6.00%	4.20%	3.07%	6.80%	6.79%	5.08%	4.46%	5.85%	4.90%	5.28%				5.16%	Staff Group definitions determined by NHS Improvement
B04.5	NHS Infrastructure Support	11.57%	6.00%	10.52%	9.86%	11.10%	14.13%	14.01%	12.78%	12.67%	4.43%	6.13%				10.63%	Staff in Post ajusted for St Helen's employed Rotational Doctors and
B04.6	Other ST&T	-3.29%	6.00%	-3.43%	-11.39%	-44.80%	-3.27%	-4.59%	-0.07%	-7.47%	-10.73%	-10.76%				-10.72%	removal of Chair / NEDs
B04.7	Registered Nursing, Midwifery and Health Visiting Staff	4.49%	6.00%	5.18%	4.49%	3.89%	7.33%	7.80%	6.69%	6.58%	3.85%	4.88%				5.63%	
B04.8	Support to Clinical Staff	5.95%	6.00%	5.20%	3.82%	-0.18%	3.93%	2.81%	3.18%	1.83%	1.27%	1.64%				2.61%	RAG ratings updated effective May 21
	Data Owners: Finance & Workforce Planning & Business Intelligence																

B05	Vacancies by NHSI Staff Group	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B05.1	Total	626.42		618.21	510.76	530.97	744.24	689.54	600.99	551.93	298.02	386.68				547.93	
B05.2	Allied Health Professionals	36.47		31.40	37.83	28.50	32.27	27.68	20.21	4.02	2.45	20.32				22.74	Staff in Post WTE vs Budgeted WTE in ESR
B05.3	Healthcare Scientists	78.91		81.17	72.46	85.30	85.97	82.89	37.19	46.97	42.32	39.69				63.77	Refined calculation 2019/20: removal of recharges and reserves from
B05.4	Medical & Dental	31.96		45.24	32.83	75.79	78.48	59.07	52.10	69.82	58.58	62.46				59.37	Budgeted WTE
B05.5	NHS Infrastructure Support	169.06		153.44	141.71	164.12	216.04	213.02	194.64	193.98	62.64	88.54				158.68	Staff Group definitions determined by NHS Improvement
B05.6	Other ST&T	-6.34		-6.53	-20.83	-63.57	-6.49	-9.08	-0.15	-15.01	-21.28	-21.74				-18.30	Staff in Post ajusted for St Helen's employed Rotational Doctors and
B05.7	Registered Nursing, Midwifery and Health Visiting Staff	128.10		143.40	123.87	106.51	209.45	224.07	191.47	191.01	110.02	142.58				160.26	removal of Chair / NEDs
B05.8	Support to Clinical Staff	188.27		170.09	122.91	-5.50	128.53	91.90	105.54	61.14	42.36	54.83				85.76	
	Data Owners: Finance & Workforce Planning & Business Intelligence																

B06	Turnover	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B06.1	% Total Workforce Turnover (Rolling previous 12 months)	12.43%		12.83%	12.76%	12.71%	13.13%	13.22%	13.14%	13.39%	13.15%	13.24%				13.06%	Exc Rotational Drs (reflects NHS Digital Benchmarked data)
B06.2	% Normalised Workforce Turnover (Rolling previous 12 months)	10.66%	9.00%	10.86%	10.61%	11.66%	11.44%	11.57%	11.43%	11.63%	12.41%	11.49%				11.46%	
B06.3	% Normalised: Additional Professional, Scientific, and Technical	13.20%	9.00%	14.20%	14.16%	13.80%	13.55%	13.56%	14.18%	13.20%	12.41%	11.30%				13.37%	
B06.4	% Normalised: Additional Clinical Services	11.03%	9.00%	11.73%	12.34%	11.63%	11.62%	11.87%	11.98%	12.07%	11.74%	11.94%				11.88%	
B06.5	% Normalised: Administrative and Clerical	8.87%	9.00%	8.87%	9.23%	10.19%	10.60%	10.76%	10.57%	10.60%	10.56%	10.86%				10.25%	Exc Rotational Drs, Students, TUPE Transfers, End of Fixed Term
B06.6	% Normalised: Allied Health Professionals	12.72%	9.00%	13.18%	13.68%	14.35%	14.82%	15.40%	13.68%	13.94%	14.26%	14.59%				14.21%	
B06.7	% Normalised: Estates and Ancillary	10.80%	9.00%	10.77%	11.20%	10.16%	11.16%	11.56%	10.70%	11.10%	10.55%	10.39%				10.84%	RAG ratings updated effective May 21
B06.8	% Normalised: Healthcare Scientists	13.22%	9.00%	13.52%	14.13%	14.05%	14.77%	14.52%	14.34%	16.15%	15.14%	15.05%				14.63%	
B06.9	% Normalised: Medical and Dental (Exc Rotation Drs & Clinical Fellows)	6.49%	9.00%	7.22%	7.21%	8.01%	8.15%	7.45%	7.33%	8.10%	7.52%	8.04%				7.67%	
B06.10	% Normalised: Nursing and Midwifery Registered	11.48%	9.00%	11.39%	11.31%	11.09%	11.22%	11.38%	11.44%	11.50%	11.22%	11.38%				11.32%	
	Data Owner: Workforce Planning & Business Intelligence																

B07	Retention Rate	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B07.1	Retention Rate (12 months)	89.55%		88.74%	85.92%	88.40%	88.93%	88.10%	89.01%	88.02%	87.95%	88.12%				88.13%	No. Employees with 1 or more years service now / No. Employees employed
B07.2	Retention Rate (18 months)	94.58%		85.34%	91.99%	84.76%	85.73%	84.23%	84.99%	83.70%	83.69%	83.63%				85.34%	one year ago x 100. Exc Rotational Drs, Students, TUPE Transfers, Clinical
B07.3	Retention Rate (24 months)	83.87%	85.00%	82.92%	78.69%	82.09%	82.76%	81.09%	82.30%	80.64%	80.60%	80.45%				81.70%	Fellows, & Fixed Term
	Data Owner: Workforce Planning & Business Intelligence																

B08	Sickness Absence (1 month in arrears)	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B08.1	% Sickness Absence (In Month)	5.89%	4.25%	6.20%	4.84%	5.26%	Avail Sept	5.50%	5.36%	5.81%	5.75%	Avail Feb				5.64%	
B08.2	% Sickness Absence (Rolling previous 12 months)	5.36%	4.25%	5.54%	5.57%	5.58%	Avail Sept	5.68%	5.64%	5.62%	5.56%	Avail Feb				5.61%	
B08.3	WTE Days lost to Sickness	16,871.93		17,200.94	13,941.64	14,716.78	Avail Sept	16,053.06	15,255.96	17,230.22	16,825.96	Avail Feb				16217.96	
B08.4	% Short Term Sickness	2.01%		13.79%	2.17%	2.22%	Avail Sept	2.31%	2.31%	2.17%	2.38%	Avail Feb				2.25%	
B08.5	% Long Term Sickness	3.35%		23.77%	3.40%	3.37%	Avail Sept	3.36%	3.33%	3.24%	3.25%	Avail Feb				3.34%	
B08.6	Estimated Cost of Sickness (£)	£1,589,320		£1,648,020	£1,279,320	£1,357,468	Avail Sept	£1,544,644	£1,500,675	£1,670,477	£1,635,428	Avail Feb				£1,549,193	
	Data Owner: Workforce Planning & Business Intelligence																

B09	Flu Campaign	2021-22 Season Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Cumulative	Comments
B09.1	Front Line Staff Vaccinated (Cumulative)	3828								4322	3414	3601				3601	Seasonal reporting only. Figures reported here those submitted to Public Health England for month-end periods.
B09.2	Non Front Line Staff Vaccinated (Cumulative)	1619								1228	1314	1363				1363	
B09.3	Total (Cumulative)	5051								4,322	4728	4964				4964	
B09.4	% Front Line Staff Vaccinated (Cumulative)	61.73%	TBC							35.20%	37.95%	40.52%					
	Data Owner: Workforce Planning & Business Intelligence																

B10	Open Employee Relations Cases - Number of Cases	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B10.1	Open Formal Grievances Cases + Open Bullying & Harassment Cases	22		25	26	24	19	15	18	16	18	16				35	
B10.2	Open Capability Cases	1										1				0	
B1103	Open Disciplinary Cases	28		22	19	19	22	25	29	28	24	27				43	
	Data Owner: HR Employee Relations																

B11	Freedom to Speak Up	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Cumulative	Comments
B11.1	New Genuine Whistleblowing Cases Raised	0														0	Cases reviewed and confirmed as Whistleblowing by FtSU Guardian. Discussions taking place around reporting this measure.
B11.2	Number of Concerns Raised through FTSU Guardian In Month	17		61	27	22	26	11	15	15	24	13				214	
	Data Owner: Freedom to Speak Up Guardian																

B12	Apprenticeships	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Cumulative	Comments
B12.1	Number of New Apprentices Started in Month	3		3	2	2	8	6	3	1	5	1				31	
B12.2	Number of Existing Staff Converted to Apprentices in Month	11		3	2		2	5	56	11	2	1				82	
	Data Owner: Education & Training																

B13	Education / Organisational Development	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B13.1	Trust Induction	85.00%	0.00%	84.60%	85.20%	86.10%	85.70%	85.30%	87.40%	86.50%	87.10%	86.80%				86.08%	
B13.2	Local Induction	68.30%	0.00%	67.70%	71.20%	76.50%	79.70%	84.80%	87.70%	88.90%	90.50%	90.20%				81.91%	
B13.3	Mandatory Training - Tier 1 - Statutory Topics (Formerly "Generic")	94.20%	85.00%	95.40%	95.70%	95.60%	96.50%	94.60%	94.60%	94.60%	94.70%	94.50%				95.13%	
B13.4	Mandatory Training - Tier 2 - Policy Required (Formerly "Specific")	89.90%	85.00%	90.40%	91.10%	91.60%	92.00%	94.20%	94.30%	94.40%	94.60%	93.60%				92.91%	
B13.5	Appraisal	80.10%	90.00%	79.20%	80.10%	79.70%	79.80%	80.20%	79.00%	78.80%	80.10%	79.70%				79.62%	
	Data Owner: Education & Training																

B14	Temporary Staffing Spend - Agency	2021-22 Total	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Cumulative	Comments
B14.1	Agency Spend - Total	£762,164		£708,868	£684,225	£828,894	£554,518	£639,840	£594,240	£598,781	£671,392	£770,972				£6,051,729	
B14.2	Agency Spend - Nursing & Midwifery	£0														£0	
B14.3	Agency Spend - Medical Staff	£650,338		£614,774	£603,477	£741,601	£490,365	£513,375	£470,340	£504,955	£554,402	£652,019				£5,145,308	
B14.4	Agency Spend - Other	£111,825		£94,094	£80,748	£87,293	£64,153	£126,464	£123,900	£93,826	£116,991	£118,952				£906,421	
	Data Owner: Finance																

B15	Temporary Staffing Spend - Bank	2021-22 Total	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Cumulative	Comments
B15.1	Bank Spend - Total	£2,162,905		£2,626,927	£2,862,552	£2,352,028	£3,058,086	£3,781,399	£3,716,828	£3,258,752	£2,930,613	£3,064,659				£27,651,846	
B15.2	Bank Spend - Nursing & Midwifery	£29,214		£358,288	£367,609	£376,097	£465,675	£775,426	£572,275	£677,781	£701,570	£729,221				£5,023,941	
B15.3	Bank Spend - Medical Staff	£1,550,677		£1,106,696	£1,448,247	£917,104	£1,264,147	£1,390,015	£1,268,301	£1,181,238	£936,556	£1,053,301				£10,565,605	
B15.4	Bank Spend - Other	£583,014		£1,161,944	£1,046,696	£1,058,827	£1,328,264	£1,615,959	£1,872,584	£1,399,765	£1,292,486	£1,282,137				£12,058,664	
	Data Owner: Finance																

B16	Bank Fill Rate	31st Mar 2022 Out-turn	Target	2022-2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2022-23 Average	Comments
B16.1	Registered Nursing Shifts Filled	52.00%	85.00%	52.00%	57.00%	70.00%	69.00%	62.00%	58.00%	53.00%	58.00%	55.00%				59.33%	Previously reported as number of shifts, now reporting fill rate
B16.2	Unregistered Nursing Shifts Filled	69.00%	90.00%	71.00%	78.00%	80.00%	78.00%	84.00%	82.00%	76.00%	81.00%	74.00%				78.22%	
B16.3	Medical Staff Shifts Filled	36.00%	50.00%	41.00%	38.00%	40.00%	42.00%	46.64%	66.67%	68.00%	57.00%	59.00%				50.92%	RAG ratings updated effective Jan 21
	Data Owner: Resourcing and LMS																

B17	e-Rostering	6th Mar 2022 Out-turn	Target	2022-2023 07 Mar 22 - 03 Apr 22	04 Apr 22 - 01 May 22	02 May 22 - 29 May 22	30 May 22 - 26 Jun 22	27 Jun 2022 - 24 Jul 2022	25 July 22 - 21 Aug 22	22 Aug 22 - 18 Sep 22	29 Sep 22 - 16 Oct 22	17 Oct 22 - 13 Nov 22	14 Nov 22 - 11 Dec 22	12 Dec 22 - 8 Jan 23	TBC TBC	TBC TBC	2022-23 Average	Comments
B17.1	% Rotas Set 6 Weeks in Advance (42 Days)	60.00%	80.00%	51.00%	58.00%	54.00%	45.00%	41.00%	55.00%	46.00%	53.00%	54.00%	65.00%	68.00%			53.64%	Reporting periods 4 weeks (28 days)
B17.2	Unused Hours	29579.00	e-Roster WTE * 6hrs	76961.00	128675.00	93517.00	93941.00	90284.00	87552.00	95075.00	102515.00	107987.00	119545.00	141055.00			103,373.36	RAG ratings updated effective Jan 21
B17.3	% Staff on Annual Leave	15.09%	14.00%	14.83%	14.85%	10.78%	16.02%	11.63%	16.87%	18.62%	26.56%	11.47%	10.20%	21.73%			15.78%	Jump in Net Hours explained in relevant PPT slide
	Data Owner: e-Rostering																	

The Royal Wolverhampton NHS Trust	
Trust Board	
Meeting Date:	7 February 2023
Title:	**The Royal Wolverhampton NHS Trust Equality Objectives 2023 - 2027**
Executive Summary:	The Trust Equality Objectives expired in April 2022 and in order to ensure continued compliance with the Equality Act 2010 and Public Sector Equality Duty the Royal Wolverhampton NHS Trust has reviewed a range of equality data and feedback to inform the review and development of its new Equality Objectives 2023 - 2024: **The proposed Equality Objectives 2023 – 2027 are:** 1. We will continue to review and improve accessibility to services for those whose first language is not English – to understand the changes in demographics for our patient population and the subsequent provision of interpreting. 2. Patients (service users) report positive experiences of the service. 3. We support the health and wellbeing of our staff through the promotion of initiatives and services that support staff to lead healthy lifestyles. 4. Our People Practices are inclusive, promote belonging, and are supported by actions that address inequitable outcomes for protected groups. 5. Our Board, leaders, and those with line management responsibilities lead with compassion and inclusion and routinely demonstrate their understanding of and commitment to equality and diversity. The proposed Equality Objectives are underpinned by supporting principles and actions which are detailed within the report, and have been subject to engagement with internal and external stakeholders. The engagement findings are detailed within the report.
Action Requested:	**It is recommended that the Trust Board:** • Approve the new Equality Objectives 2023 – 2027 for publication on the Trust Web Pages
Report of:	**Alan Duffell, Chief People Officer**

Author: **Contact Details:**	Alison Dowling, Head of Patient Experience Alison.dowling1@nhs.net Balvinder Everitt Email: Balvinder.everitt@nhs.net
Resource Implications:	None
References: **(eg from/to other committees)**	People and Organisational Development Committee
Appendices/ **References/** **Background Reading**	**Appendix 1: RWT Expired Equality Objectives 2018 – 2022**
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: **Equality of treatment and access to services** High standards of excellence and professionalism **Service user preferences** Cross community working Best Value Accountability through local influence and scrutiny

The Royal Wolverhampton NHS Trust Equality Objectives 2023 – 2027

1. Background and Context

The Trust Equality Objectives expired in April 2022 and in order to ensure continued compliance with the Equality Act 2010 and Public Sector Equality Duty the Royal Wolverhampton NHS Trust has reviewed a range of equality data and feedback to inform the review and development of its new draft equality objectives, including:

- Trust Equality Objectives and EDI Delivery Plan
- Trust Strategy
- Trust Annual Equality Report
- NHS People Plan and Model Employer
- The People Promise
- The RACE Code
- NHSEI Workforce Race Equality Standard
- NHSEI Midlands Race and Inclusion Strategy: 6 High Impact Actions
- NHSEI Workforce Disability Equality Standard
- Equality Delivery System 2023 – available on the NHSE Futures Platform
- Equality Delivery System 2
- Reducing Workforce Health Inequalities
- NEW Black Country Integrated Care System Equality Diversity Inclusion Strategy, due to be published in March 2023.

As public bodies, all NHS organisations are bound by the Equality Act 2010. The Act places a general overarching equality duty called the Public sector Duty (PSED) supported by four specific duties, one of them being a requirement to develop and publish Equality Objectives.

Five **NEW Equality Objectives** have been designed to cover patients and staff and will run from **April 2023 to March 2027.** The objectives are framed around the new Equality Delivery System domains. The objectives have thus far been shared with the Equality Diversity and Inclusion Steering Group, Health Inequalities Steering Group, Operational Workforce Group and People and Organisational Development Committee.

The Trust has undertaken an engagement exercise on the new equality objectives with internal and external stakeholders from 14 November to 5 December 2022. The engagement findings are summarised in section 3.0 of the report.

The Trust expired equality objectives 2018 - 2022, can be found in Appendix 1. These objectives have served the Trust well as guiding principles to progress the overall Equality, Diversity and Inclusion agenda. More specifically, they have set out how the Trust has met its duties under the Equality Act. Progress against the above objectives has been reported regularly through various reporting mechanisms such as People and Organisation Development Committee, QSAG, CQRM and Trust Board.

In line with legal requirements, the objectives have been reviewed with engagement from the Trust Employee Voice Groups, and Patient Council.

The new Equality Delivery System (EDS)
The new Equality Objectives 2023 – 2027 are aligned with the new Equality Delivery System domains and will consider any significant factors arising from the EDS framework. The EDS now comprises eleven outcomes spread across three domains, which are:

1. Commissioned or provided services
2. Workforce health and wellbeing
3. Inclusive leadership.

2. New Equality Objectives

The following new Equality Objectives 2023 -2027 are proposed. Objectives 1 and 2 refer to patients and Objectives 3 to 5 are workforce related.

Equality Objective 1:

Patients (service users) have required levels of access to the service

- We will continue to review and improve accessibility to services for those whose first language is not English – to understand the changes in demographics for our patient population and the subsequent provision of interpreting:
  (a) People who have left the UK due to Brexit. It is believed that this largely affects people from Eastern European countries. This is evidenced in the shortage of interpreters available as reported by the Trust Interpreting and translation provider. Any gap of provision identified will need to be addressed.
  (b) The likely increase in people from BAME communities in the local population because of (a) new arrivals, mainly as refuges and asylum seekers from countries such as Afghanistan and Ukraine (b) growth in the longstanding BAME communities in Wolverhampton
- We will engage with patient groups to understand barriers for effective communication

Equality Objective 2:

Patients (service users) report positive experiences of the service

- We will ensure compliance against the Parliamentary Health Service Ombudsman complaint handling framework
- We will deliver inclusive engagement opportunities across the diversity of our patient groups including acute and community settings.
- We will deliver a program of outreach across all hospital sites to better understand the feedback from patients and their loved ones.

Equality Objective 3:

We support the health and wellbeing of our staff through the promotion of initiatives and services that support staff to lead healthy lifestyles.

- We continue to build on our mental health first aiders programme and health and wellbeing champions.
- We will continue to deliver Respond training to all staff to encourage a caring and compassionate workplace.
- We will promote the Employee Assistance Programme to staff.
- We will monitor participation in health and wellbeing services by protected characteristic and promote ease of access to services.
- We will raise awareness of mental health and tackle stigma.

Equality Objective 4:

Our People Practices are inclusive, promote belonging, and are supported by actions that address inequitable outcomes for protected groups.

- We will deliver year on year improvements against our Workforce Race Equality Standard and Workforce Disability Equality Standard Metrics.
- We will support staff experiencing incivility, bullying or harassment, and provide access to advice, support and opportunities for reporting.
- We will deliver inclusive engagement opportunities across the diversity of our workforce.
- We will improve our equality data and reporting.
- We will grow and develop the Cultural Ambassador Programme.

Equality Objective 5

Our Board, leaders, and those with line management responsibilities lead with compassion and inclusion and routinely demonstrate their understanding of and commitment to equality and diversity.

- We will create a workforce that reflects the communities we serve across all levels of the organisation.
- We will provide inclusive leadership development opportunities for our leaders and managers including Reverse Mentoring
- We will grow our talent pool of under-represented groups through opportunities such as career conversations, coaching, and sponsorship.
- We will progress the Trusts performance through the Race Code Charter Mark and will identify other relevant charter marks where improvement needs are identified.

3. Engagement Findings

The Trust undertook an engagement on the draft Equality Objectives with both internal and external stakeholders:

The consultation included:

- Engagement with Council of Members. This involved questionnaire responses as well as meetings with individual members.
- Sending out the survey questionnaires to community organisations.
- Health Inequalities Steering Group
- Equality Diversity Inclusion Steering Group
- Operational Workforce Group
- Engagement with the Trust Employee Voice Groups
- Open engagement with all staff through Trust Brief

The qualitative feedback from all sources indicated strong support and agreement for the objectives. They were deemed to be pitched at the right level, were sufficiently specific and reflected the highest priorities for patient care. Some of the other themes that emerged from the feedback were:

- How can we communicate with people who cannot share their views due to lack of capacity and what about the views of their careers and relatives?
- Do we need to go beyond language and ethnicity to cover deprivation indicators and health inequalities?
- Should our objectives be about equal access in general?
- How will health and wellbeing offer will be evaluated / monitored by staff group and band to ensure equitable access?
- Importance of creating safe spaces for staff to report bullying and harassment
- Importance of challenging indifference to mental health conditions and disabilities

We believe these issues have been considered and reflected in the Equality Objectives 2023 – 2027 or are being taken forward through some of the existing EDI workstreams. For example, the area of health inequalities is subject of a Trust working group and the issue of feedback from patients with learning disabilities is being looked at by the Learning Disability and the Patient Experience Teams.

If endorsed by the Trust Board, the Equality Objectives and supporting actions will be integrated into relevant Trust Plans including the Workforce Equality Diversity Inclusion Delivery Plan, and Trust Patient Equalities Action Plan.

4. Recommendations

It is recommended that the Trust Board

- Approve the new Equality Objectives 2023 – 2027 for publication on the Trust Web Pages

Appendix 1: Expired Equality Objectives 2018 – 2022

The RWT Equality Objectives 2018 – 2022
Workforce
1. To ensure our people policies and strategies promote good practice in diversity and to work towards best practice
2. To further progress our response to the analysis from the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES)
Patient Experience
3. Improve how we monitor, use and report complaints from people in connection to an individual's protected characteristic
4. To aim to provide a positive patient experience for all patients regardless of their identity
5. Improve access to services, focusing on improved information and communication, and recognise that the Trust needs fair access to all.

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	7th February 2023
Title:	Health Inequalities (HI) Steering Group Update
Executive Summary:	The Health Inequalities Steering Group update provides a background on the Health Inequalities agenda and provides detail on the rationale of RWTs initial approach to Health Inequalities. RWT are currently focusing on Health Inequalities within the following areas: • Access and Quality of Care • Workforce Appendix 1 provides detail of work undertaken and workstreams developed in line with the 5 national priorities for tackling health inequalities which are summarised below: *1. Restoring NHS services inclusively, breaking down performance reports by patient ethnicity and indices of multiple deprivation (IMD) quintile.* Maternity and 0-19 service are both high impact areas for addressing root causes of inequalities. The workstreams currently being worked on include the creation of 'dashboards' to breaking down indicators by equalities characteristics and deprivation. The maternity team are leading on maternity care of women residing in city hotels (housing refugees/asylum seekers) and working closely with primary care and children's services. An EDI Midwife has also been recruited. Regional and Black Country level reports have highlighted disparities in waiting times and receipt of treatment in access to elective treatment within secondary care. DNAs, decisions to treat and waiting list prioritisation are being flagged as potential sources of inequalities. Local analysis from our Population Health Unit have studied Ophthalmology, General Surgery and Trauma and Orthopaedics as high volume specialities. The analysis indicated that there are clear inequalities of access to elective treatment, reflected in certain groups being more likely to be discharged due to DNA before the stage of treatment or decision not to treat. This is consistent with findings in other Trusts, which adds weight to the assertion that DNAs are a key driver of inequalities in access. The groups at increased risk of discharge due to DNA in Wolverhampton are men, socioeconomically more deprived, all ethnic minorities except Asian, and younger age groups. An analysis has been undertaken by the Wolverhampton Public Health team and the findings have been presented to the Health Inequalities Steering Group in August 2022 which outlines those who do reach the point of treatment or decision, the waiting time to receive this treatment or decision seems to be primarily driven by clinical urgency and demographics do not play a strong role in determining waiting times Further work has been undertaken including process mapping and reviewing and updating the patient access policy to include a Health Inequalities section. There is further work on-going to restore NHS service inclusively including: • An Equitable Recovery Programme pilot being undertaken within Ophthalmology from January 2023 to proactively contact patients

before their appointments to reduce DNAs and establish any inequalities which may be preventing patients from attending their appointments.

- A business case being developed across Wolverhampton and Walsall to review all patient literature to ensure that patient information is available in different formats and languages.

2. Mitigating against digital exclusion, identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile.

The group have supported primary care and the outpatients department to assess the impact of digital innovation using equity audits for Babylon Service and Healthy Ageing Coordinator. Further the WODEN study published in November 2022 identifies links between poor broadband provision and ill health and has been published in the BMJ Open. The WODEN project is a multi-agency project in Wolverhampton that is looking to better understand the risk of digitial exclusion and strive to prevent it. Further the Digital Innovation Unit in November 2022 have issued a survey to understand how comfortable staff feel with technology and any anxieties / concerns which are felt among staff groups.

3. Ensuring datasets are complete and timely, improving data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning.

Datasets have been reviewed and the ethnicity data completion meets the target of 95% in all areas excluding outpatients at 94%, and this is likely to be due to a reduction in face-to-face appointments following Covid-19 which is where reception staff would ask patients to populate this data. A quality improvement project has been undertaken within primary care also with 95% complete.

4. Accelerating preventative programmes: flu and COVID-19 vaccinations, annual health checks for those with severe mental illness and learning disabilities, continuity of carers for maternity services, targeting long-term condition diagnosis and management.

There are a number of workstreams across primary and secondary care which focus on engaging people with greater risk in prevention. Appendix A provides further detail regarding the work currently being undertaken.

5. Strengthening leadership and accountability, which is the bedrock underpinning the four priorities above, with system and provider health inequality leads having access to Health Equity Partnership Programme training, as well as the wider support offer, including utilising the new Health Inequalities Leadership Framework.

A variety of changes have been implemented to strengthen leadership and accountability. A health inequalities section has been included in the Business Case template with an audit due to take place on this in January/February 2023.

Education is a key priority, and a survey has been undertaken to gauge the current understanding of health inequalities within senior medical staff. A bid was submitted to HEE by Public Health which has been successfully approved. The funding from this bid will develop brief and engaging media content aimed at equipping senior medical workforce with the information necessary to address social determinants of health. Clinical engagement and

	patient voice insight will be gathered to develop and deliver the content and will be shared on various internal media channels with a communication campaign. Further the e-Learning for Health module on Health Inequalities will be made available on My Academy shortly as well as publicising the HEAT Tool. The annual EDI report has been completed and been presented to the group and the Workforce EDI Delivery Plan is currently in development by the HR Team. The Trust Equality Analysis Policy has been updated and has included a new dimension on assessment of health inequalities. A strategy across RWT and WHT is currently being developed by the Deputy Director of Strategy and a further update on this will be provided within the next report once approved. The RWT Health Inequalities Steering Group has developed a rolling plan of workstreams to review progress on and will continue to identify any other projects or workstreams being developed that support to address inequalities.
Action Requested:	Receive and note
For the attention of the Board	To provide an update on the work being undertaken surrounding the Trust's Health Inequalities Agenda.
Assure	The Health Inequalities Steering Group is a Trust wide committee which oversees the programme of work to address health inequalities. The group will assure the Trust Board that the Trust is meeting its strategic objectives with regards to health inequalities.
Advise	Not Applicable
Alert	The Health Inequalities Steering Group will alert the Trust Board on any potential workstreams or programmes that will adversely impact on Health Inequalities for its population or staffing groups.
Author + Contact Details:	Karenjit Sahota - Head of Chief Medical Officer Portfolios Email: Karenjit.Sahota@nhs.net on behalf of Dr Jonathan Odum Chief Medical Officer
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 6. Be in the top 25% of all key performance indicators
Resource Implications:	Revenue: Capital: Workforce: Funding Source: N/A
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	N/A
Risks: BAF/ TRR	None

Public or Private:	Public
Other formal bodies involved:	Health Inequalities Steering Group / Quality Governance Assurance Committee
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Health Inequalities - Trust Board Report – February 2023

This is the first paper being presented to Trust Board regarding the Health Inequalities (HI) Steering Group following the presentation at the Board Development Session in July 2022. The report aims to provide an overview of the current workstreams being discussed at the HI steering group.

Background

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

The Royal Wolverhampton Trust (RWT) established a steering group in January 2022 chaired by Dr Odum to oversee the programme of work to address health inequalities. This steering group has representation from community, primary care, secondary care, and public health.

In addition to the RWT HI steering group, there are also several non-RWT forums to address Health Inequalities:

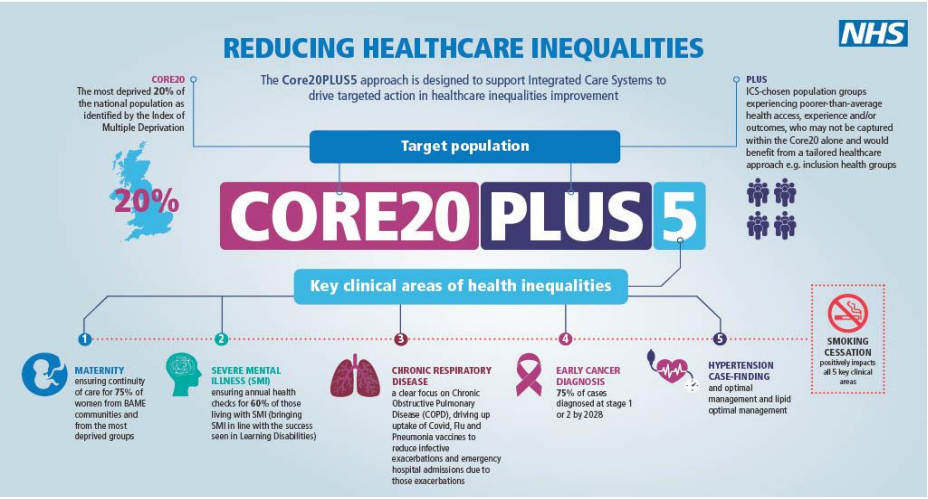
1. Health Inequalities and Prevention board (Black Country)
2. ICB Local Commissioning Board (Health Inequalities delivery plan implementation group)
3. Health and Wellbeing Together board HI strategy implementation and monitoring meeting

The RWT HI group has regular communication with the leads from these forums to ensure alignment.

CORE20PLUS5

Core20PLUS5 is a NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level.

The approach defines a target population being the most deprived 20% of the national population as the 'CORE20' and 'PLUS' includes population groups such as ethnic minority communities; inclusion health groups; people with a learning disability etc. The '5' refers to the focus on five clinical areas requiring accelerated improvement as listed below:



Rationale for RWTs initial approach to HI

To navigate where to focus initial efforts a mapping exercise has been completed to view current HI priorities across National, System and Place level. The group agreed to align objectives with wider Health and Wellbeing agenda and as a result RWT agreed to focus initially on HI within:

- Access and Quality of Care
- Workforce

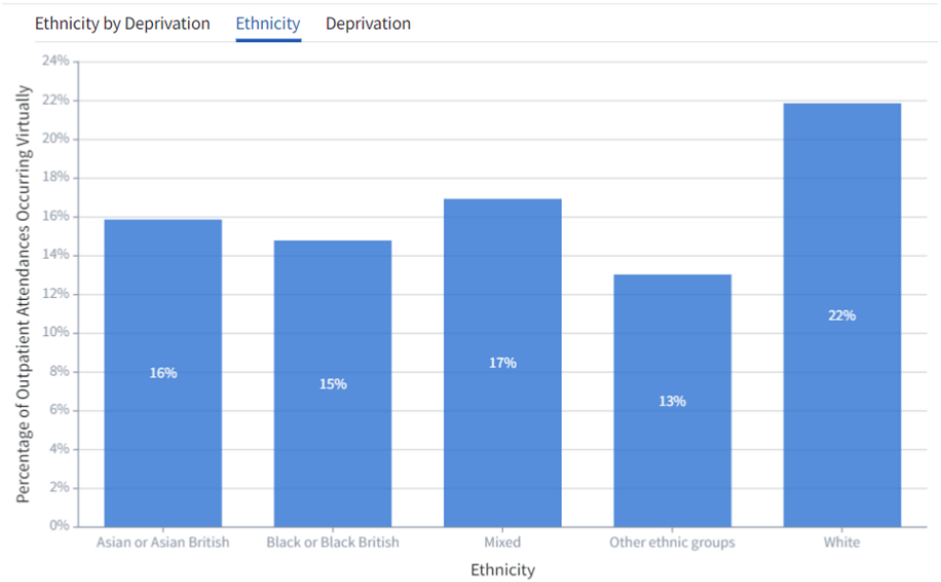
The Health Inequalities work currently being undertaken by RWT is being aligned to the Health Inequalities Leadership Framework Board Assurance Tool which is built on the Care Quality Commission's (CQC) well led domain and taken from the NHS planning guidance. It details 5 national priorities for tackling Health Inequalities:

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

RWT are undertaking work on a number of key workstreams which link directly to the 5 national priorities for tackling health inequalities and further detail has been provided in the table overleaf.

National Priorities for tackling health inequalities	Detail regarding workstreams being undertaken to support the national priorities
Priority 1: Restore NHS services inclusively	<u>Maternity</u> Maternity services in conjunction with the Information Department have developed a dashboard breaking down indicators reflective of National Saving Babies' Lives Care bundle by equalities characteristics and deprivation. This will complement the plans of the Midwifery Continuity of Care Model to focus within the most deprived locations within the city, the July 2022 figures showed 45% of women were booked onto this pathway of which majority were from BAME and the most deprived backgrounds. This is in addition to the work being undertaken by the established Vulnerable Womens Midwifery team which provides continuity of carer throughout ante-natal and post-natal pathways. The RWT midwifery team currently leads on maternity care of women residing in city hotels (housing refugees/asylum seekers) and working closely with primary care and children's services. An Equity, Diversity and Inclusivity (EDI) Band 7 Midwife has now been recruited to caseload and continue the engagement work within refugee and migrant centres. NHSE provided recommendations to provide face-to-face antenatal clinics in languages other than English and provide education for community providers to promote what the maternity services offer. An EDI strategic lead post will also be advertised to take this agenda forward. <u>0-19 Services</u> The 0-19 service has been targeted as a high impact area for addressing root causes of inequalities. This also links with Health and Wellbeing board strategy and priority areas to focus on 'Growing Well' and 'Early Years'. There is ongoing work being undertaken by the Information Department to allow the current data captured within 0-19 services to be stored in a more useable format. Once data is available, the group will work with the team to understand inequalities and develop indicators and monitor key outcomes across different patient demographics similar to the Maternity dashboard which is being developed. A draft dashboard has been presented to the HI Steering Group in January 2023 with a finalised version to be presented in April/May 2023.Once the dashboard has been developed the team will review the data to establish inequalities and develop key areas of focus. <u>Elective Recovery</u> Regional and Black Country level reports have highlighted disparities in waiting times and receipt of treatment in access to elective treatment within secondary care. DNAs, decisions to treat and waiting list prioritisation being flagged as potential sources of inequalities. Locally there has been a focus on the following areas:

	• Understanding disparities in DNAs (Did Not Attend) and discharges due to DNAs – quantitative and qualitative • Mapping out current processes, soft intelligence, and oversight mechanisms • Deep dive into high volume specialties to untangle the role of clinical priority and demographics. Local analysis from our Population Health Unit have studied Ophthalmology, General Surgery and Trauma and Orthopaedics as high-volume specialities. The analysis indicated that there are clear inequalities of access to elective treatment, reflected in certain groups being more likely to be discharged due to DNA before the stage of treatment or decision not to treat. This is consistent with findings in other Trusts, which adds weight to the assertion that DNAs are a key driver of inequalities in access. The groups at increased risk of discharge due to DNA in Wolverhampton are men, socioeconomically more deprived, all ethnic minorities except Asian, and younger age groups. An analysis has been undertaken by the Wolverhampton Public Health team and the findings have been presented to the Health Inequalities Steering Group in August 2022 which outlines those who do reach the point of treatment or decision, the waiting time to receive this treatment or decision seems to be primarily driven by clinical urgency and demographics do not play a strong role in determining waiting times Following this analysis further actions have been undertaken including: • Process mapping and qualitative insight gathering of the appointment letters which established that a further action was required to update the patient access policy. • The patient access policy has been reviewed and updated to include a Health Inequalities section. This is currently being finalised alongside other Trusts in the ICB. The new policy makes refences to ensuring services are available to all patients, easily accessible and that efforts are made so communication is clear and easy to understand. The policy is currently going through the final approval process. Further work is being undertaken looking at DNAs including: • Establishing oversight processes via the outpatient transformation group • A pilot undertaken by the Royal Free London (RFL) is being replicated at the Royal Wolverhampton NHS Trust. The pilot undertaken at RFL was an Equitable Recovery Programme (ERP) pilot in key specialties where a ‘Access Support Team’ was created to call patients one week before their appointments. The aim of the team was to identify and reduce health inequalities in patients on the RFL waiting list. A full evaluation is being completed but their preliminary results appear to show a reduction in DNAs (cost saving) and positive feedback from patient/staff. RWT are undertaking a similar pilot project which is due to commence in January 2023 and will take place over two to three months within Ophthalmology. • University Hospitals of Coventry and Warwick are working on a framework for prioritisation using social value judgements e.g. employment in addition to clinical prioritisation and the RWT steering group is monitoring their progress and results closely.

	Patient Information A business case is being developed across Wolverhampton and Walsall to review all patient literature across both organisations and ensure that information is available in different formats and languages. The business case is due to be presented to the relevant forums in February 2023.
Priority 2: Develop digitally enabled pathways inclusively	RWT have observed differences in usage of digital innovations such as video consultation and the use of 'apps' as seen below. Several factors are important, including privacy and data protection concerns, equipment and data availability and digital skills. The group are supporting primary care and the Outpatient Department to assess the impact of digital innovation, using equity audits for the Babylon and Healthy Ageing Coordinator Service and linking into wider initiatives. **Figure 1: Percentage Outpatient Attendances Occurring Virtually at RWT.**  WODEN The Wolverhampton Digital Enablement (WODEN) study has been published and identifies links between poor broadband provision and ill health. The study undertaken by the Trust was published on 02.11.22 and found a connection between poor broadband provision and health outcomes for Wolverhampton residents. This whole local population level observational study is the first to link data on broadband provision with health data at a defined health economy population

<table>
<tr><td></td><td>level. It used data for all residents of the city of Wolverhampton – 269,785 people. The study was conducted as part of the Wolverhampton Digital Enablement (WODEN) Programme – a multi-agency collaborative approach – to determine and address digital factors that may impact on health and social care in a deprived, multi-ethnic health economy. The WODEN project is a multi-agency project in Wolverhampton that will work to better understand the risk of digital exclusion and strive to prevent it.

A further survey has been issued by the Digital Innovation Unit in November 2022 to understand how comfortable staff feel with technology and any anxieties / concerns felt among staff groups.</td></tr>
<tr><td>Priority 3: Ensure datasets are complete and timely</td><td>The table below demonstrates that ethnicity data completion meets the target of 95% in all areas excluding outpatients at 94%. A likely reason for this is due to a reduction in face-to-face appointments following Covid-19 which is where reception staff would ask patients to populate this data.

<table>
<tr><th colspan="2">Ethnicity Data Completion (July 2022) target 95%</th></tr>
<tr><td>Acute Data (PAS) Outpatients</td><td>94%</td></tr>
<tr><td>Acute Data (PAS) Inpatients</td><td>97%</td></tr>
<tr><td>Acute Data (PAS) A&E</td><td>98%</td></tr>
<tr><td>Community (PAS) OPD</td><td>99%</td></tr>
<tr><td>Community (System One)</td><td>99%</td></tr>
<tr><td>Maternity Services Dashboard</td><td>98%</td></tr>
</table>

A quality improvement project has been completed, using an information sharing agreement to improve completeness of primary care ethnicity coding, reducing the number of patients who had no ethnicity coding from 5394 down to 2787 across the PCN (95% complete, individual practices saw up to a 28% increase).</td></tr>
<tr><td>Priority 4: Proactively engage people at greatest risk in prevention</td><td><u>Primary Care</u>
Across RWT PCN practices there are several schemes which focus on reducing health inequalities and reaching vulnerable groups, these include:

• Liaising with the Refugee and Migrant Centre and hotel settings</td></tr>
</table>

	• Use of interpreters (with set clinics) • Proactive Serious Mental Illness (SMI) and Learning Disability recalls • Improving cervical screening recalls (in particular for women with HIV/those that don't speak English) • Piloting outreach primary care sessions for hostel accommodation • Working with Covid Immunisation satellite clinics • Funding secured for diabetes health coaching • Re-launch of NHS Health Checks with outreach There is some overlap with the ICB Local Commissioning Board (Health Inequalities delivery plan implementation group) for the governance of the primary care HI agenda, however, the Local Commissioning Board are due to present at the Health Inequalities Steering Group in February or March 2023 to provide an overview of the work being delivered and the plans for integration into One Wolverhampton. <u>Secondary Care</u> An NHS Long Term Plan objective is by 2023/24, all people admitted to hospital will be screened for their smoking status and offered NHS-funded tobacco treatment services if required (this includes having access to appropriate pharmacotherapy). A Maternity Smoking Cessation service has been in place since 2019 and the team have seen a reduction for smoking rates in pregnant women from 16.6% in 2020 to 11.5% in Spring 2022. A Tobacco Dependency Treatment Service has been set up and the Tobacco Dependency Treatment Lead and Advisors have all been recruited. A pilot to implement the NHS Long Term Plan ambition for provision of inpatient tobacco dependency treatment services is due to commence in January 2023 before wide scale roll out across the organisation. This progress of this project is being reported to the HI Steering Group. A long-term conditions prevention pilot project is underway across the ICS with six primary care networks and three secondary care providers focusing on chronic kidney disease (CKD). The aim of the pilot is to proactively identify patients with early indications or progression of CKD with the use of case-finding. The pilot outcomes have been gathered and presented to the ICB Clinical Leadership Group in December 2022 with agreement to roll this pilot out wider across the ICS. The pilot identified 1306 new patients that have now been coded with CKD. The benefits of this project include preventative disease management as patients can be managed with medication and monitoring rather than specialist treatments such as dialysis and transplant which place a significant pressure financially and operationally with increases in demand. Further this project will provide care closer to home and improve patient experience and outcomes. The Alcohol Care Team service has been introduced; the in-hospital team works in conjunction with the public health funded community alcohol care team. The team works within inpatient and outpatient settings increasing provision for treating patients with alcohol related problems which are disproportionately increased in lower socio-economic groups. The in-

<table>
<tr><td></td><td>hospital team aims to provide seamless care to patients who are treated by the community team.

The TB Team screen new entrants to the UK for TB via the Refugee and Migrant centre and from data gathered from GPs and the local authority. It has been recognised that new entrants to the UK are at higher risk of TB but are less likely to know how to engage with health services. Interpreters are used and the team are working on sending letters in different languages to engage these groups since English may not be the first language for many of these patients. The team also screen for BBV and proactively contact patients before clinic visits to increase attendance.</td></tr>
<tr><td>Priority 5: Strengthen leadership and accountability</td><td>A change implemented at present is to the business case template to include a section of how each case will address health inequalities. An audit of the business cases will be undertaken at the end of January 2023 to review this change.

Education is a key priority and work has been undertaken to establish the level of understanding of health inequalities within the organisation. A staff survey was issued to clinical groups to gauge their understanding and the outcome outlined that further education is required. A bid has been submitted by the Public Health team to HEE, which the team have successfully won to support delivering the health inequalities education project. The aim, objectives and expected outcomes of this project are as follows:
Aim:
- to upskill the RWT senior medical workforce with the competencies, knowledge and skills necessary to address health inequalities in the patient population it serves
- to provide an innovative, “bottom-up” approach to reducing the impact of health inequalities in our local population, which draws from the insight we have already gathered from those who face these challenges in their current frontline service.
<table>
<tr><th>Objectives</th><th>Expected outcomes</th></tr>
<tr><td>To develop brief and engaging media content aimed at equipping senior medical workforce with the information necessary to address social determinants of health inequalities in their local context.</td><td>Development of 6-8 short videos outlining the impact of a social determinant on health, visually demonstrating the local referral pathway/s and what happens in the patient journey once the referral is made.</td></tr>
<tr><td>To include clinical engagement of senior medical staff in the development and delivery of the project, so that content is relevant and appropriate to the audience, taking a “bottom-up” approach.</td><td>Local clinicians featured in the media content, locally relevant and memorable content.</td></tr>
<tr><td>To improve patients’ experience by including the patient voice and insight in developing and delivering the content.</td><td>Local patients/volunteers featured in the media content, locally relevant and culturally sensitive content.</td></tr>
<tr><td>To maximise awareness of the media content and retention of the messages by sharing it on various internal media</td><td>Visibility of videos developed, and social media/communications items produced, measured by</td></tr>
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</td></tr>
</table>

channels during a communications campaign.	number of views/click-throughs.
To provide an easily accessible reference point for the ongoing hosting of the media.	Development of webpages and an e-learning module.
To increase the awareness of relevant local public and third sector referral pathways for the most common and high impact social determinants of health inequalities.	Increase in the number of patients referred into these services.

Further the e-Learning for Health module on Health Inequalities is to be added onto My Academy and the Health Equity Assessment Tool (HEAT) is being published across the organisation via the Equalities Impact Assessment work.

RWT HI Steering Group has representation from HR and it has been agreed the group will not duplicate work being completed in other forums but will instead support ongoing work for assurance that there is strategic alignment between workforce EDI and RWTs approach to tackling inequalities. There is recognition of the impact that recruitment practice can have on the local population by providing good quality employment and there is commitment to monitor and improve. The Annual Equality, Diversity and Inclusion report has been completed and has been presented to the Health Inequalities Steering Group. The Workforce Equality Diversity Inclusion Delivery Plan is currently in development. The Trust Equality Analysis Policy has been updated and has included a new dimension on assessment of health inequalities. Staff carrying out policy review will now need to consider what impact such policies will have on health inequalities amongst outpatients and staff. The toolkit for policy development has been amended accordingly and has been communicated across the organisation in November 2022 via the Trust newsletter.

The group is exploring options for disseminating leadership and accountability throughout the organisation in relation to Health Inequalities and agreeing a reporting structure into the Health Inequalities Steering Group to review progress on health inequalities related workstreams within the meetings.

There has been initial collaboration between Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust on their approaches to health inequalities. Walsall have made progress under ‘The Walsall Together Partnership’ and have strategic alignment to local, system and national health inequalities priorities.

WHT are taking a similar approach and are initially focusing on ‘Access & Quality of Care’ which includes:

- Maternity
- 0-19 years
- Elective Recovery

	• Digital Exclusion There will be continued collaboration and shared learning as both organisations progress with the HI programmes of work. A joint strategy is currently being developed by the Deputy Director of Strategy and will be shared once agreed across both organisations.

The Royal Wolverhampton NHS
NHS Trust

Minutes of the Audit Committee

DATE Tuesday, 6 September 2022
VENUE MS Teams Virtual Meeting
TIME 10.00 am

PRESENT

Ms Julie Jones	Non-Executive Director (Chair)
Mr John Dunn	Non-Executive Director
Professor Louise Toner	Non-Executive Director
Mr Junior Hemans	Non-Executive Director

IN ATTENDANCE

Mr Kevin Stringer	Chief Financial Officer and Deputy Chief Executive
Mr Mark Greene	Deputy Chief Financial Officer
Mr Paul Smith (part)	Head of Security and Car Parking
Mr Asam Hussain	RSM – Internal Audit
Mr Kashif Azeem	RSM – Internal Audit
Ms Erin Sims	RSM – LCFS
Ms Sarah Brown	KPMG – External Audit
Mr Keith Wilshere	Company Secretary
Mr Simon Evans (part)	Chief Strategy Officer
Mr Nick Bruce (part)	Associate Chief Technology Officer/Chief Information Officer – BCPS
Ms Jo Watts (part)	IT Cyber Security Manager
Ms Anne-Louise Stirling	Personal Assistant - Chief Financial Officer and Deputy Chief Executive (Administrator for the Committee)

Item No		Action
48/2022	**Apologies for Absence** James Green – Interim Director of Finance	
49/2022	**Minutes of the Previous Meeting** The minutes of the Audit Committee meeting held on the 27 May 2022, were reviewed, and approved by the committee.	
50/2022	**Matters Arising - Internal Audit Report - Waiting List Initiative (WLI) Policy, Management and Equity (9.21/22)** The Chair advised that the planned representation from the Divisional Team on the 'Waiting List audit' had been postponed and asked K Stringer to explain the background for the deferral to the committee.	

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	K Stringer advised that this was an outstanding follow up with the Divisional Team on the WLI audit and following discussion with the Chief Operating Officer and the Division it was clear that things had moved on. He explained that one of the elements was some confusion about the registering of interests and medical staff having to complete the paperwork that would link between that and internal WLIs and the relevance of the exercise. He advised that there was a need to do both, but the register of interest was of importance for insourcing work and whether any of the Consultants were doing work for insourcing or outsourcing departments. It had therefore, been agreed that there were elements of the waiting list audit report that needed to be reframed and some of the actions needed to be changed. It was noted that a meeting would be scheduled with Internal Audit who had agreed to hold a reframing meeting. The Chair thanked K Stringer for the update and acknowledged that the committee would receive an update on progress at the December meeting.	
51/2022	**Audit Committee Action Points Log** The committee reviewed the list of Action Points and agreed upon, which items had been actioned and could be closed.	
52/2022	**Declarations of Interest** No interests were declared.	
53/2022	**Quality Governance Assurance Committee (QGAC)** L Toner updated members of the committee on areas of interest following the last QGAC meeting advising that the key themes on the QGAC agenda remained as discussed previously 'Cancer and the Trust's Recovery Plan'. She advised the committee that mutual aid had been set up for some cancer sites, but it remained a challenge to secure mutual aid on a local or regional basis and therefore, it was necessary to look nationally particularly for kidney disease. It was of note that chemotherapy services had now moved from Cannock to New Cross Hospital which would have a significant impact on nursing capacity. The other major delay to the Cancer recovery plan was Histopathology with service demand high resulting in delayed reporting of results, however, work had commenced to improve this across the system. L Toner reported the other area of concern to bring to members attention was the A&E waits and the ambulance breaches. She advised that a new 'holding area' had been developed to enable patients to be cared for rather than waiting on the ambulance, but it was noted that this would not have a huge impact in decreasing waiting times. The final area of note was the clinical area of Stroke and Stroke metrics. L Toner reported that whilst the Stroke metrics had improved in the last month, they had been very much up and down over the last few months and that a lot of changes within the Stroke Ward and Stroke Services had taken place. It was noted that a report would be going to QGAC and Trust Board later this year.	

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	J Hemans advised that the retention and turnover of staff remained a challenge for the Trust. He reported that some of the staff turnover related to retired staff who returned during Covid and who were now leaving the service again, but with Winter approaching and the potential for flu it remained a concern for the Trust. Members noted that this risk had been escalated and was now on the BAF register to be closely monitored. The Chair thanked L Toner for the update on issues of note arising from the business of QGAC.	
54/2022	**Performance and Finance Committee (P&FC)** J Dunn updated members of the committee on areas of interest following the last P&FC meeting. He reported that budgetary positions for the financial year were going to be very challenging and that a deep dive investigation to understand the detail and level of risk would be undertaken to enable mitigation plans to be put in place. It was noted by the committee that more detail would be available at the December meeting on the size of the challenge and the risks associated with the Trust's Cost Improvement Plan (CIP) along with the risks associated with the run rate reduction plans from each of the Divisions. The Chair thanked J Dunn for a very helpful update and advised that at the December meeting a longer time slot would be allotted, in order that any risks that had been highlighted and any extra control assurances that had been enacted were working. It was also agreed that the Chair and J Dunn would discuss outside of the meeting as to how this would be presented to the meeting to ensure that any input from the committee would be passed on to the P&FC. The Chair thanked J Dunn for the update on issues of note arising from the business of the P&FC meeting.	**Chair/J Dunn**
55/2022	**Trust Management Committee (TMC)** K Stringer updated members of the committee on areas of interest following the last meeting of TMC. He advised that there was nothing of risk to raise to the committee and that discussion at the meeting had focused on restoration and recovery plans and preparation for Winter planning. The remainder of the agenda had been standard items of business and nothing of note to escalate to the committee. The Chair thanked K Stringer for the update on issues of note arising from the business of the TMC meeting.	
56/2022	**Board Assurance Framework (BAF) plus Collaborative Work with Walsall and BAF Risks** K Wilshere presented the BAF report to members of the committee.	

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	He advised that BAF risks SR15 and SR16 were currently being edited and were therefore, not available in an updated format for the committee meeting, but would be presented at the next Board meeting for review. Regarding the format specifically around Section 9, K Wilshere addressed J Hemans referencing a new BAF risk being drafted arising from the last meeting of PODC. J Hemans advised that this should remain on the 'watch list' for the time being and he would speak with the Interim Director of Human Resources and Organisational Development - A Race. K Wilshere reported that work had started on revising the format of the BAF to align it with Walsall Healthcare. The proposed revised BAF template would be considered by both Walsall and Wolverhampton Audit Committee Chairs with a final template being presented to both Trust Boards at the start of October. The Chair thanked K Wilshere for the helpful update to the committee. Addressing the last discussion point she advised members that although the meeting of the two Chairs would take place outside of committee meetings, she welcomed members thoughts or suggestions on the revised format of the BAF prior to the meeting taking place. **RESOLVED:** The committee noted the detail of the BAF**.**	**J Hemans**
57/2022	**Security Report** P Smith presented the quarterly progress report on security issues within the Trust to members of the committee. The Chair referred to 'incidents of violence and abuse' and asked for P Smith's perspective on how the Trust's incidents were increasing compared with other neighbouring hospitals. P Smith advised that the Trust was on par with incidents being reported at Walsall Healthcare, but added that there was an increase post COVID as this reflected the return of visitors and patient to the site. J Hemans referred to the number of threats against staff and asked what the Trust's approach was to these incidents in relation to taking action against the perpetrators and reporting to the Police. P Smith responded that joint working with the Health and Safety team had commenced, and a weekly report was now being produced. This new reporting arrangement facilitated Security being able to visit and check in on staff members effected and quantify with ward management what action would be taken for example, the issuing of a yellow card advising that behaviour was unacceptable or following on from that warning the issuing of a red card. It was noted that a similar process had commenced at Walsall Healthcare where every incident of violence and aggression was being investigated to ensure that any punitive action was taken and any learning from potential incidents taken on board. Members noted that going forward future reports would take on a slightly different structure if action against individuals was taken and the issuing of a yellow or red card was undertaken then this detail would be available to report to the committee. P Smith advised that this new reporting very much depended on Ward staff notifying Security that action had been taken as per Trust policy and this was currently being reinforced by the Health and Safety Team.	

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	J Hemans advised that this was an important piece of work as concerns by staff had been flagged in the Trust's Staff Survey results and therefore it was important that incidents were recorded, and managers were encouraged to follow Trust procedures. **RESOLVED:** The committee thanked P Smith for the progress report on security issues within the Trust. The Chair asked that going forward that a report summary sheet be completed to accompany the Security Report.	
58/2022	**Cyber Risk Management** N Bruce and J Watts presented the Cyber Risk Management report to members of the committee. N Bruce informed members of the detail of the recent national cyber incident and summarised the actions taken to protect the Trust from a similar incident occurring again whilst demonstrating compliance towards the National Cyber Security Centre's: 10 Steps to Cyber Security and Data Protection Security Toolkit (DSPT) assertions. He assured members that robust processes had been put in place with daily checks, daily risk assessments and enhanced monitoring. Referring to Section 4 of the report N Bruce detailed the joint IT Cyber Service with Walsall Healthcare and described the structure of how this would be enabled. He reported that J Watts, Head of Cyber Security would lead on the project as she was the accredited Cyber Security expert, and that future compliance and assurance reports would be presented to the committee. K Wilshere advised that following the last two external reviews the advice coming forward was that Cyber Risk should be formalised as a BAF risk and asked N Bruce for his thoughts in view of the pending review that was planned for the end of the year. N Bruce advised that in view of the number of cyber attacks increasing it was evident that this did now need to be formalised on the BAF register. J Dunn advised the committee that he was very much in favour that this was recorded as a BAF risk moving forward and suggested that a Board committee was appointed to oversee the risk to ensure that regular and in-depth reviews were carried out. J Watts reported that in relation to phishing attacks an increase against the NHS was being reported. The threat was now being targeted at individual user accounts with links appended in the email sent. She advised that NHS Digital were offering a free phishing simulation tests and training service that would be beneficial for the Trust and asked for the committee's approval to proceed. She advised the committee on the work undertaken on password reuse within the Trust and reported that the introduction of the new password control software SpecOps would encourage service users to set strong passwords. It was noted that in line with this software installation, 'OP12 IT Security Policy' had been updated and was currently going through the ratification process. N Bruce reported to the committee that multi factor authentication for elevated accounts and accounts with privileged access as well as some senior roles within the organization had been established. K Wilshere asked the Chair if a BAF strategic risk on Cyber Security could now be initiated. The Chair acknowledged that this was an area that required further discussion based on the evidence presented at the meeting by N Bruce. K Wilshere advised that he would address this matter with K Stringer as the responsible Executive Director in the first instance.	**K Wilshere/ K Stringer**

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	The Chair thanked on behalf of the committee both N Bruce and J Watts for their attendance and very informative update on Cyber Security. **RESOLVED:** The committee approved the phishing simulation testing to be commissioned, subject to Executive Directors agreement at their weekly meeting being held on the 7 September 2022.	
59/2022 59.1	**Internal Audit and Counter Fraud - RSM** Internal Audit Progress Report (including Recommendation Tracking progress update) A Hussain presented the Progress Report to members of the committee. It was noted that since the last meeting of the committee one Internal Audit report had been finalised along with two draft reports: - • Bank and Agency - 3.22/23 - partial assurance – final report • Clinical Services – Ophthalmology Follow Up 1.22/23 draft report • Business Case Process 2.22/23 – draft report Referring to page 58 of the report, A Hussain advised that the two draft reports had been issued, but due to leave commitments it had not been possible to finalise them in time for today's meeting. He assured members that once responses had been received from the responsible managers the reports would be issued to members of the committee before the next meeting in December. A Hussain advised that in terms of the Audit Plan members should note that the days allocated for the 'Income Management and Budgetary Control' had been repurposed to undertake an audit of the Trust's self-assessment around financial sustainability. He advised that this was a requirement for all NHS organisations to undertake as part of their internal audit work this year. The other area of note was the timing of the audit for the 'Place, Project Management Framework', which had been deferred until March 2023. Referring to Appendix B – 'Management Action Tracking', A Hussain advised that several actions had been closed since the last meeting of the committee, however, 14 actions remained overdue. He reassured the committee that a stringent process was in place and that work would continue to get these actions completed and closed. **RESOLVED:** The committee noted the detail of the Internal Audit Progress Report.	
59.2	Internal Audit report: 3.22/23 - Bank and Agency A Hussain presented the findings of the Bank and Agency review audit. It was noted that the audit had provided a *'partial assurance'* opinion and there were seven 'medium' priority management actions that had been raised as part of the Internal Audit review. A Hussain concluded that wherever the health roster automated system was used within the Trust there was compliance to support the bank and agency control framework and the audit trail was good.	

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	However, it was noted that there were still some departments where the rollout of the system had not yet happened and they were reliant on manual systems and, therefore, it had been evidenced that their audit trail was not as strong. Members noted that there was a planned rollout for health roster across the Trust, but this transition was being carried out in stages. The Chair thanked A Hussain for the update on the Bank and Agency report. She advised that it was disappointing to get a '*partial assurance'*, but it was reassuring to note that once the health roster was fully implemented it would deal with a lot of the issues that had been raised. She queried that in view of some departments not already using the software was this due to the software not being fit for purpose and was there a preferred alternative. A Hussain responded that the rollout of the system had been prioritized by the major staff groups and it was now to be rolled out to other areas within the Trust. He assured the committee that there was no reluctance to use the system. K Azeem added that one of the complexities was that some of the departments shift patterns did not match the templates in the health roster so were having to be built into the system. The Chair concurred that it was evident that the audit opinion could not be favourable as the system had yet to be rolled out across the Trust and in hindsight it may have been more appropriate to deal with the implementation of the system instead. **RESOLVED:** The committee noted the detail of the Bank and Agency Internal Audit Report and advised that it was essential that management actions were dealt with swiftly.	
59.3	<u>Local Counter Fraud Specialist (LCFS) Progress Report</u> E Sims presented the LCFS progress report to members of the committee. E Sims reported that the Counter Fraud Functional Standard return had been submitted ahead of the submission deadline and that the overall rating of Green (positive) had been obtained. She referred members to page 11 of the report which detailed the action plan. It was noted that LCFS were now attending the Trust's Policy Review Group, which facilitated the opportunity to be sighted on Trust policies and provide any comments for areas for improvement from a counter fraud, bribery perspective. It was noted that awareness sessions continued for Trust staff with bespoke sessions for Finance, Procurement, HR and budget holders being delivered. E Sims advised that three cases had been brought forward from 2021/22; four new referrals had been received since April 2022 and four cases had been closed since the last reporting period. She informed members that one case had resulted in a final written warning being issued and accepted by the member of staff concerned. It was noted by the committee that one new referral that had not been captured on the LCFS report, but was in relation to a member of staff with overlapping substantive and bank timesheets. The Chair enquired if the four new cases had been reported by staff members or whether it was the Trust's owned systems and controls picking up the irregularity. E Sims confirmed that the referrals mainly came via members of staff, which from a LCFS point of view was encouraging in knowing that staff were aware of how to identify fraud, and how to report it. She advised that there was a good working relationship both with the HR Department and the Freedom to Speak up Guardian within the Trust.	

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	Members were reassured that regular staff awareness sessions were being held to ensure that staff were aware of how to report potential fraud along with checking staff were aware of the understanding of gifts and hospitality. She confirmed that the number of responses were positive and that there was a good culture of reporting Fraud within the Trust. K Stringer concurred that the Trust circulated regular messages to staff that any fraudulent behaviour would not be tolerated, and action would be taken if appropriate. K Stringer referred to an old outstanding fraud case involving a Trust member of staff and advised members that this case was still under investigation with the previous Counter Fraud providers to the Trust. He advised the committee that the Trust continued to pursue this potential fraud from a Practice Manager that used to be employed by the Trust and that the case was currently sitting with the Crown Prosecution Service. It was noted that this case would be brought to future committee meetings as an update to members and that Grant Thornton would provide a progress update, which would then be presented alongside RSM's LCFS report. K Wilshere referred to the awareness around gifts and hospitality and asked E Sims for a form of counter fraud information/words that could be used in reminder letters to staff who had not made declarations or checked their declarations recently. E Sims agreed that she would assist K Wilshere with the drafting of the letter. **RESOLVED:** The committee noted the detail of the Counter Fraud Progress Report and noted that going forward a report from Grant Thornton would also be provided on the outstanding LCFS case.	**K Stringer** **E Sims/** **K Wilshere**
60/2022 60.1	**External Audit – KPMG** External Audit Progress Report S Brown presented the External Audit Progress report to members of the committee. She advised that there was not a significant update to bring to the committee, as the 2022 audit had only recently been signed off and planning for the 2023 audit had just commenced. Referring to Appendix A – Health Sector Update, S Brown advised members this detail was provided for information purposes. **RESOLVED:** The committee noted the detail of the Progress Report.	
61/2022	**Governance Arrangements for ICS and ICB** S Evans presented to the committee on the progress made to date on the Integrated Care System (ICS) and Integrated Care Board (ICB) Governance Arrangements. He advised members that the presentation would be available on IBABs after the meeting for future reference. S Evans reported that the ICB and the governance arrangement were currently in a state of change and in view of this could not give any formal assurances at this stage what the governance arrangements were going to be across the whole of the ICS. Members noted that the ICS was made up of two components the ICB and the ICP (Integrated Care Partnership). The Chair thanked S Evans for a very in-depth presentation and advised that the only concern would be of duplicated governance arrangements that the difference organisations would	

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	require. She advised that as part of the committee's remit assurance over certain elements would be required for example, budgetary constraint and internal controls, to ensure that a good assurance structure was in place with dialogue between the Audit Committee Chairs of the other provider organisations. S Evans advised that he had been in discussion with the Chief Operating Officer - ICB, whose remit was to coordinate the governance arrangements for this and reported that there was a lot of discussion around potential delegations and trying to secure a dictionary definition between delegation and devolved governance. He confirmed that it was imperative that a solution on how responsibility was going to be delegated to individual organizations through to the collaborative through to the place-based partnerships was defined, to ensure there was no risk of duplication or loss of governance of the three individual component organisations. S Evans advised that as this was now a regular item on the agenda for the committee it would facilitate regular updates on progress and assurance. **RESOLVED:** Members noted the detail of the presentation and thanked S Evans for his attendance.	
62/2022	**Losses and Special Payments Report** K Stringer presented the Losses and Special Payments report for the period 1 April 2022 to 31 July 2022 with approval requested for losses outside Officers' delegated limits for the period 18 May 2022 to 26 August 2022. The Committee were asked to note: - 1. the total losses and special payments in the period of £36.297.69 (17 new cases plus 2 existing cases) (*net £34,247.69) including: - i. the losses and special payments authorised within Officers' delegated limits in the period by the Deputy Chief Financial Officer under delegated powers of £8,988.69 (11 new cases) (*net £6,938.69); ii. the personal injury claims of £27,309 (4 new cases plus 2 existing cases). 2. Approve the write-off of losses and special payments of £97,820 (2 new cases) outside the Officers' delegated limits in the period 18 May 2022 to 26 August 2022 (this will be reported within the audit committee paper to be presented at the next meeting for the period 1 August to 31 October 2022). 3. a losses and special payment case of £6,790 (1 new case) where the outstanding debt is currently going through the process of legal action. 4. Note the total for the 2022/23 year of £36,297.69 (17 new cases plus 2 existing cases) (*net £34,247.69). K Stringer referred to Section 2 of the report detailing a large debt relating to an overseas patient that had since died and asked if members of the committee were happy to write this debt off or continue to pursue the family for payment.	

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	He further advised that the other matter of note was the write off of Ophthalmic drugs due to the refrigeration unit suffering a power surge resulting in the stock being unusable. Following careful consideration of the detail committee members agreed to the two write offs as discussed. **RESOLVED:** Members of the Committee approved the detail in the Losses and Special Payments report and approved write off of debt and other loss, outside Officers' delegated limits. It was noted that this detail would now be presented to the October 2022 meeting of the Trust Board for final approval.	
63/2022	**Audit Committee Workplan 2022** The Chair advised the committee that the workplan presented for review was now aligned with Walsall Healthcare to ensure that there was a consistent pattern of work across both organisations. However, it was noted that should there be emerging issues, these would be addressed and the workplan modified accordingly. **RESOLVED:** Members of the committee noted the Audit Committee workplan for 2022.	
64/2022	**Audit Committee Dates 2023** The Chair presented the draft committee meeting dates for 2023 asking for members approval. It was noted that the February 2023 meeting would need to be held virtually due to Winter pressures, but the committee agreed that a face-to-face meeting in the near future would be beneficial. **RESOLVED:** Members approved the committee meeting dates for 2023.	
65/2022	**Matters for Escalation** The Chair explained to the committee that 'matters for escalation' was a new agenda item, to facilitate any important issues that required escalation to the Trust Board or to other Board committees being discussed. She advised that arising from today's discussion was the issue of 'cyber risk' and whether it should be included as a BAF item and dealt with at Trust Board level.	
66/2022	**Any Other Business** No additional business was raised by members of the committee.	
67/2022	**Review of the Meeting** The Chair advised that this was another new item on the agenda where members had the opportunity to reflect on the business of the committee and consider what as a committee had been done well; what could have been done better and finally if the business of the meeting had made a difference to patients. The overriding view of the committee was that the meeting had been focused and positive with good involvement and challenges from members, to ensure that the committee was functioning effectively.	

Item No		Action
	There had been detailed discussion on Cyber Security and protection of data and updates from other Board committees, which facilitated information sharing. There had been an overall review of BAF risks and managing risks for both patients and staff alike along with security issues to ensure that the Trust's hospital sites were secure and safe for staff and visitors. One area of note raised was the BAF and the undertaking of a deep dive by the committee to review the risks on the register in more detail. It was suggested that each committee meeting could focus on one particular risk with an update from the responsible owner of the risk. The Chair agreed to discuss this with K Wilshere to ascertain the feasibility of taking this forward.	**Chair/** **K Wilshere**
68/2022	**Date and Time of Next Meeting** 13 December 2022 at 1 pm – MST	

Minutes of the Performance & Finance Committee – Investment

Date	Thursday 24th November 2022
Venue	via MSTeams
Time	10.30am

Present:	
John Dunn	Non-Executive Director (Chair)
Gwen Nuttall	Chief Operating Officer
Simon Evans	Group Chief Strategy Officer
Martin Levermore	Non-Executive Director
Alan Duffell	Chief People Officer
Kevin Stringer	Chief Finance Officer & Deputy Chief Executive

In Attendance:	
James Green	Deputy Chief Finance Officer
Stew Watson	Director of Estates Development (Part Attendance)
Claire Richards	EPA to Chief Strategy Officer (Minutes)

01/2022	**Apologies for Absence** Apologies were received from Lisa Cowley, Adam Race, Keith Wilshere, Tim Shayes and Nathan Joy-Johnson.	
02/2022	**Declarations of Interest** There were no declarations of interest.	
03/2022	**Revised Performance & Finance Committee Terms of Reference**	
	The revised Performance & Finance Committee Terms of Reference were discussed. J Dunn stated that an additional risk was identified at the Performance & Finance Committee Meeting which took place on 23rd November 2022. The risk will be added to the Terms of Reference along with the allocated reference number once it has been agreed. Due to the additional risk K Stringer will submit a 6 monthly SIRO report to the Committee. The 'Attendance' section will be revised to reflect that attendance will be on an as required basis. The proposed changes were discussed and agreed by the Committee. The Terms of Reference were updated and submitted to Trust Board for formal approval.	
04/2022	**Business Cases**	
04.01	Medical Locum Temporary Staffing Contract (REAF 261) – The business case recommends the award of a contract for Medical Locum Temporary Staffing via HealthTrust Europe (HTE) for a 2-year period at an estimated value of £15.2 million. J Dunn expressed concerns regarding the business case as it was renewed on 1st November prior to Performance & Finance Committee and Trust Board approval. J Dunn asked for a formal response as to why the business case was not submitted to Performance & Finance Committee for formal approval before renewal. K Stringer to obtain a formal response and feedback to the Committee.	**KS**

	K Stringer stated that the Executive Team have sent a clear message that the procurement of contracts in all teams need to be completed within appropriate timescales and built into a plan for a forward date of approval and not retrospective. J Dunn asked that the report be changed to 'note' for Trust Board. K Stringer assured the Committee that the business case had been submitted via the appropriate framework and business processes but that approval had been submitted late. **The Committee discussed and noted the business case. The Committee noted that although the business case was not done in a timely manner it was submitted through effective financial controls.**	
04.02	Managed Print Additional Funds (REAF 392) – The business case recommends the award of additional funds for the Managed Print Service contract to Ricoh UK Ltd UK Ltd at an estimated value of £310,800. The Committee discussed the extension of the contract and agreed to the request. K Stringer stated that strategically the option to renew was appropriate. K Stringer assured the Committee that alternative options will be explored with alternative print providers in the future, however changes to provider could result in printer hardware and software renewal costs. **The Committee discussed the business case extension and endorsed it to go to Trust Board for final approval.**	
04.03	Medisight Electronic Patient Record Software-Maintenance Contract plus 1st Year Training Costs (REAF 448) – The business case recommends the award of a contract for the supply of an Ophthalmology Electronic Patient Record system to Medisoft Limited for a total value of £491,612 (£174,900 capital and £316,712 revenue). The capital cost will be split equally across the 2022/23 and 2023/24 financial years, whereas the revenue commitment will be split over a nine-year period from the first anniversary of go-live. The anticipated start date for the revenue contract will be in quarter two of 2024/25, with the exact date to be confirmed post-system implementation. K Stringer clarified that this was an appropriate strategic option for the Ophthalmology as they were currently working on a paper-based system. The business case would allow the department to provide patient care through an electronic system. G Nuttall stated that this was a key recommendation from the audit, is part of the overall strategy and will align the Ophthalmology Department across the ICS and also reduce clinical risk. J Dunn queried if this system would fit with the current/new PAS replacement. K Stringer confirmed that this was correct. J Dunn queried if this would be compatible with Walsall Healthcare NHS Trust (WHT). K Stringer stated that the project has not been extended into WHT but would be a consideration going forwards. M Levermore queried if additional costs were available to extend to WHT. K Stringer stated that additional costs would be required for licensing as a minimum but would need to be scoped. However, further work needed to take place to connect software between both Trusts. The Committee agreed to stage 1 of the request and that there would be further discussions as stage 2 if linking any further sites. **The Committee discussed the business case and endorsed it to go to Trust Board for final approval.**	
04.04	Contract Extension for Interpretation and Translation Services (REAF 434) – The business case recommended the award of an extension to the existing contract for the provision of face-to-face and telephone Interpreting and Document Translation to Word360. The current contract will expire on the 5th January 2023, and the extension is required to	

	continue the service for a further 12 months at an estimate value of £960,000 including reclaimable VAT. Competition will be undertaken for a new contract commencing the 6th January 2024 and discussions are taking place regarding alternative options going forwards. S Evans stated that this should be explored via the provider collaborative about the use and provision of the service within the ICB. M Levermore suggested exploring Home Office assistance with costs for interpretation services. K Stringer agreed that this could be explored at the next renewal. K Stringer asked J Green to liaise with the Local Authority to see if there was an opportunity to off-set some of the charges. **The Committee discussed the business case requesting the contract extension and endorsed it to go to Trust Board for final approval.**	**JG**
05/2022	**Contract Awards**	
05.01	<u>Wrekin House Re-development</u> – S Watson confirmed that he would invite Non-Executive Directors to visit the Wrekin House site in the near future. S Watson outlined the contents of the business case, which outlined a number of re-development works within and associated with the reintroduction of Wrekin House into the useable estate at New Cross Hospital. The report sought endorsement of contract awards for the following works: a) Further Enabling Works to be carried out in advance of the Radio-Pharmacy project to prepare the building for re-introduction to the Trust estate. b) Proposed construction works to provide a Replacement Radio-Pharmacy and Aseptic suite on the Ground Floor of Wrekin House together with additional Clinical Trials space; new External Staircase and ground level Plant Room housing enhanced/new services for the hospital site. c) The provision of New Specialist Clean Rooms in support of the radio-pharmacy and aseptic suite function. d) The total Replacement of the windows in Wrekin House via PSDS conditional funding. e) The erection of a New sub-station and associated switchgear which is required to accommodate the increased services intake to the site necessary to support the additional power supplies coming into the site via both the National Grid and the New Solar Farm. J Dunn challenged if the business case was the appropriate strategic decision given the financial climate. A discussion took place regarding the business case and whether it was an appropriate strategic decision. Executive Directors present confirmed that this was the case. S Watson clarified that the re-development was included within the 5 Year Estates Strategy, which is currently in year 3 of the plan. The plan has been built into strategic plans which have been shared with ICB and the Provider Collaborative. K Stringer clarified that the building would be utilised for back-office functions (apart from ground floor) to free up clinical space that is currently being use by back-office functions within the estate. G Nuttall stated that the current Radiopharmacy and Aseptic Suite are awaiting re-location on the back of the Re-development project and that there was an operational and reputational risk if the project did not go ahead as the Trust would likely lose accreditation. K Stringer stated that non-delivery would also impact on the year end capital resource limit. M Levermore queried if the contingency calculation was sufficient. S Watson stated that £2m contingency have been allocated against the £21m project and that inflation contingency was also allocated. The Committee felt that this was sufficient.	

	K Stringer queried the delay from the initial tender to the request for approval. S Watson clarified that initial scoping took place May/June 2022 and that the tender exercise failed as the industry couldn't deliver the project in the timeframe needed or against the cost allocated. The tender was re-visited, which had an impact on timings for approval. J Dunn clarified that there is an operational imperative, a clear strategic fit, the contingency funding had been checked and the re-development was part of the advanced 5 Year Plan. J Dunn asked that when submitting the paper to Trust Board for approval it notes that the Committee has tested the business case and includes a supplementary sheet showing the deep dive queries from the Performance & Finance Committee. J Dunn asked that the Trust Board be asked for a DFE allowance. M Levermore asked that the report also highlight the reputational risk. **The Committee discussed the business case and endorsed it to go to Trust Board for final approval, for the following areas, subject to the changes identified:** a) Enabling Works: Contract Award to William Gough Ltd in the sum of £1,047,510.53 (£1,257,012.64 inclusive of VAT) for the enabling works to be carried out in advance of the Radio-pharmacy project to prepare the building for re-introduction to the Trust estate and to commence the works in line with the programme requirements. b) Replacement Radio-Pharmacy and Aseptic Suite: Contract Award to Interclass in the sum of £17,465,377.29 (£20,702,972.55 inclusive of VAT) for the proposed construction works to provide a new radio-pharmacy and aseptic suite in Wrekin House and to commence the works in line with the programme requirements. c) New Specialist Clean Rooms Contract Award to Bassaire in the sum of £3,173,750.32 (£3,808,500.38 inclusive of VAT) for the proposed clean rooms in support of the radio-pharmacy and aseptic suite function and to commence the works in line with the programme requirements. d) Replacement windows: Contract Award to William Gough in the sum of £1,073,073.52 (£1,287,688.22 inclusive of VAT) for the replacement of the windows in Wrekin House which is PSDS funded and to commence the works in line with the programme requirements. e) New sub-station: Contract Award to William Gough in the sum of £1,828,028.21 (£2,193,633.85 inclusive of VAT) for the new sub-station which is required to accommodate the increased services intake to the site required for air source heat pumps and future demands on capacity and to commence the works in line with the programme requirements.	**SW/KS**

Minutes of the Performance & Finance Committee

Date	Wednesday 23rd November 2022
Venue	via MSTeams
Time	08.00am

Present:	
John Dunn	Non-Executive Director (Chair)
Gwen Nuttall	Chief Operating Officer
Simon Evans	Group Chief Strategy Officer
Martin Levermore	Non-Executive Director
Kevin Stringer	Chief Finance Officer & Deputy Chief Executive
Lisa Cowley	Non-Executive Director

In Attendance:	
Tim Shayes	Deputy Chief Strategy Officer – Planning, Performance & Contracting
Dean Gritton	Group Manager, Oncology, Haematology, Radiotherapy and Palliative Care (part attendance)
Adam Race	Deputy Director of Human Resources and Organisational Development
Keith Wilshere	Trust Secretary
James Green	Deputy Chief Finance Officer
Mark Greene	Deputy Chief Finance Officer
Alvina Nisbett	Associate Director of Digital Innovation
Sian Thomas	Deputy COO – Division 3 and Partnership Director OneWolverhampton
Claire Richards	EPA to Chief Strategy Officer (Minutes)

114/2022	**Apologies for Absence** Apologies were received from Alan Duffell. J Dunn clarified that the meeting has been split this month to allow more time for discussion regarding the Investment section of the meeting. The investment meeting will take place tomorrow, 24th November. Additional Investment Meetings have been scheduled in January and March 2023. However, the meetings may be stood down if the Investment section of the meeting reduces once the revised SFIs have been put into place. K Stringer will provide a monthly list of authorised business cases up to the new limits. The Committee will focus on post implementation reviews and high value orders of those orders/contracts. J Dunn thanked L Cowley for Chairing last month's meeting.	
115/2022	**Declarations of Interest** There were no declarations of interest.	
116/2022	**Minutes of Meeting Held on 26/10/22** The minutes of the meeting from 26th October 2022 were agreed.	
117/2022	**Action Points from the Previous Meetings**	
118.01 (893)	Cancer Referrals/Recovery Trajectories – G Nuttall updated that the Cancer trajectories, in particular the cancer 62 day treatment plan are currently under review following a request from NHSEI. Referrals continue to increase across tumour sites, most notably Gynae, Haematology, Breast and Colorectal. Breast and Colorectal as a result of national events (campaign and RIP of a famous person). The trajectory for the 62 treatment has	

	been revised across the ICS. The target for patients waiting for all patients remains the same for all Trusts, the trajectory has been back ended for achievement. Risk is amber/red across the ICS. **Action closed.**	
118.02 (894)	IQPR Board Development Session (BDS) – K Wilshere agreed to arrange a meeting with S Evans and J Dunn to discuss the requirements for the BDS. J Dunn felt that there was a need for the meeting to address connectivity and triangulation issues with the report. J Dunn stated that the summary of IQPR should be utilised to focus Board attention on critical issues across all parts of the scorecard.	**SE/KW/JD**
118.03 (895)	Year End Forecast – K Stringer reported that ongoing discussions within the system and other providers have been held at regular intervals as to the detail, format and content of the recovery reports. The recovery plan has been developed and shared with Directors and Divisions. In order to follow good governance the report will discussed as an item at today's meeting and will then be submitted to Trust Board on 6th December for agreement/approval. **Action closed.**	
118.04 (896)	Acuity of Movement – M Green informed the Committee that he will circulate the data regarding costs of acuity using tariff pricing to G Nuttall by the end of the week.	**MG**
118.05 (897)	Financial Progress Report to Trust Board in December – K Stringer and J Dunn to prepare the paper. A paper on the updated forecast outturn position and related recovery and control issues are being discussed in detail at today's Performance & Finance Committee Meeting.The paper will form the basis of the update to Trust Board on 6th December. **Action closed.**	
118.06 (968)	Wolverhampton Place Winter Plan – G Nuttall confirmed that wording regarding GP input had been updated within the plan. **Action closed.**	
118.07 (969)	Winter Plan Finances – G Nuttall stated that the finance table will be shared with the Committee following the meeting.	**GN**
118.08 (970)	Discretionary Spend Summary (Financial Recovery Plan) – L Cowley has asked if a summary can be included against slide 8 discretionary spend and the RAG rating against them for the November meeting. The balance sheet detail will also need to be updated for the November Performance & Finance Meeting to report to Board. This action has been added into the report. **Action closed.**	
118.09 (971)	RAG Rating (Financial Recovery Plan) – S Field asked if additional information could be included against the RAG rating to indicate the effect/impact. The information will be made available at the meeting. **Action closed.**	
118.10 (972)	Business Case Process – A discussion took place regarding the business case process. L Cowley stated that all of the business cases are retrospective that have been presented. The Committee are unable to provide retrospective approval and on examining the business cases on the agenda it was felt that there was opportunity for the business cases to come through the Committee. L Cowley and K Stringer had met and discussed the process. L Cowley and K Stringer agreed that the Committee should be informed earlier when there is a potential need for last minute approval ahead of the meeting, in those cases the Committee Chair can be asked to provide short notice pre-approval with the bids being an item for noting for due diligence at the Committee Meeting. S Rawlings seconded the proposal. **Update:** Discussions have taken place since the Performance & Finance Committee meeting. New requirement duly noted on advance notice of business cases wherever possible. **Action closed.**	

118.11 (973)	Rolling Respective Business Case Summary – N Joy-Johnson will be providing a summary from the December meeting onwards.	**NJJ**
118.12 (974)	Capital Review Group Terms of Reference – The Committee requested an amendment to the Capital Review Group Terms of Reference to add the responsibility of financial monitoring and governance ensuring that sufficient time is allocated for Committee and Board approval where required. S Watson reported that the Terms of Reference had been updated and re-presented to CRG for sign off. **Action closed.**	
118.13 (975)	November Agenda – Discussions had taken place regarding the reformatting of the agenda to allow for an in-depth discussion about the Proposed Financial Recovery Plan. **Action closed.**	
119/2022	**Financial Recovery Plan**	
	J Dunn asked K Stringer to provide and overview and G Nuttall to provide assurance on delivery. K Stringer stated that when setting the budget for the organisation at the beginning of the year the Trust was aware that it would be a challenging year. K Stringer stated that there was a financial gap at system level which had to be split across organisations that already had a challenging CIP requirement and cost pressures, which had added increasing stress and pressure on the budget. The Trust had submitted a side letter to the system leaders explaining the significant financial challenges. In addition throughout the year the Trust has had additional unavoidable costs which have added further challenges to the budget e.g. unfunded inflation pressures, covid costs that have incurred despite a planned assumption that they would be removed by the end of Quarter 1 and the increased number of delayed discharges. K Stringer informed the Committee that 4 Acute Community Integrated Organisations are likely to activate the protocol; this will prompt the system to activate the protocol for The Black Country ICS.	
119.01	J Green presented the Financial forecast 2022/23 to the Committee, outlining the key pressures against the aspiration to break-even.	
119.02	Forecast Position – The gross forecast position at month 5 was £33.3m expenditure above resources by the end of the financial year, however, a number of partial mitigations were identified in month 5, resulting in a net forecast deficit of £24.7m. The QIA process deemed that the majority of the identified amber schemes could not be supported resulting in £0.22m improvement being deliverable from the schemes identified which amounted to £1.58m. A full analysis of the Balance Sheet has resulted in £2.2m additional flexibility being identified to support the gap. From the current £14.9m deficit approx. £12.7m of pressure has been unavoidable.	
119.03	Efficiencies – The Trust set an ambitious target of £19m efficiencies during 22/23 (2.37% of turnover). Original plans amounted to approx £7.7m, with a forecast to over-achieve at £9.8m. Despite liaising with neighbouring Trusts to seek any potential schemes that could provide additional savings there remains a shortfall of £4.2m against the £19m (improved from £4.7m in month 6).	
119.04	Agency Costs – J Green stated that there is a target to reduce by 30% against last years outturn. The Trust is forecasting £7.6m (lower than £8.2m 2021/22). J Green stated that the Trust will fall £1.9m short of the target, but that this is substantially lower than other organisations.	
119.05	Developments & Discretionary Spend – J Green stated that following a review development and discretionary spend totalled £1.7m.	
119.06	Balance Sheet – During the escalation meeting with the ICS there was a focus on the level of balance sheet opportunities that may exist. The ICS has analysed Balance Sheet	

	movements across all organisations from 2019/20 through to 2022/23, including monthly values for 2022/23. The drive is to understand whether organisations have flexibility contained within the Balance Sheet which could be released to offset the significant deficits. The analysis shows that Liabilities for RWT have increased from £77m in 2019/20 to £135m at month 6 2022/23; a £58m increase. Within our forecast outturn, we have already assumed the release of £10.9m of flexibility, and the mitigations stretch this by a further £2.0m – the majority of which is contained within the £135m at month 6. Although still work in progress, a further review of the Balance Sheet has identified the possibility to release an additional £6.8m to improve the forecast deficit. Following the challenge from the ICS to all providers regarding the increases in liabilities contained within Balance Sheets, the Trust has have undertaken an analysis of the movements since 31st March 2020. Whilst the movement does look significant (£58m) there are specific reasons in some cases for this (e.g. Payroll, Capital, Technical issues, etc.) which amount to £22.3m. The Trust Financial Plan anticipated releasing £10.9m from the outset and following reviews during months 5-7 the Trust has assessed that approx. £10m additional will now be released. In addition, £11.5m of specific balances are related to timing and will not be evident at the end of the financial year.	
119.06	<u>Recovery Plan</u> – J Green outlined the content of the Recovery Plan. The breakdown is as follows: Gross FoT Deficit at M6 (inc pay award £1.1m) £34.4m *Revised Deficit after Green and supported mitigations £14.9m Revised Deficit after Amber mitigations £13.6m QIA not supported Revised Deficit after Red mitigations £12.9m QIA not supported *This includes QIA supported Amber Scheme £221k	
119.07	<u>NHSE Deficit De-escalation Protocol</u> – J Green outlined the Formal Escalation Process timetable and the NHSE Deficit De-escalation Protocol to the Committee and the consequences and implications of the official process. J Dunn asked G Nuttall to confirm if there was operational sign off for the plan. G Nuttall stressed that there are risks and sensitivities to the plan. G Nuttall stated that there were challenges around Nurse staffing, inflation and non-pay which are unknown. G Nuttall stated that the despite covid levels remaining low the Trust was still incurring expenditure against this and that the Trust was not currently seeing significant outbreaks of influenza and RSV in children, which would result in increased costs if the admissions changed. G Nuttall felt that there were opportunities surrounding GIRFT and Model Hospital, however, impact this financial year would be limited. G Nuttall informed the Committee that the Divisional and Directorate Management Teams were engaged and that there was a desire to manage within their budget, however, the focus is on ensuring that the organisation is safe and is providing timely and quality care. J Dunn stated that there is a need to inform Trust Board what the key risks and sensitivities are and that some sensitivity testing needs to take place to identify the range and degree of risk faced. There is a need to inform Trust Board what protocols are being put into place for monitoring and control. J Dunn also asked for a clear Communication campaign be put into place for this: • Monitoring Control/Protocol • Comms Plan • Risks & Sensitivities L Cowley asked that PODC review agency and workforce pressures to provide a formal response around the achievability and what the Committee can do to address workforce risks. L Cowley agreed that there was a need for a clear Comms approach. L Cowley sought further assurance that all internal and external funding sources had been explored. J Dunn agreed and asked that PODC look at the key dependency of workforce and to look	

	into further revenue sources that can be fed into the plan. G Nuttall informed the Committee that there are a high level of regional and national revenue possibilities that are being conveyed to Trusts at short notice and assured the Committee that the Trust did submit bids for anything that could assist with capital and revenue costs. G Nuttall stated that there is also a need to consider any that would have ongoing long term revenue consequence before submitting bids. L Cowley suggested noting where potential funding had been explored to demonstrate the work that has taken place. M Levermore sought clarification regarding the schemes not supported by the QIA process. J Green stated that the Director of Nursing and Medical Director had undertook a detailed review and they did not feel able to support the amber and red items (with the exception of £221k Gynae SDEC) due to the impact on patients, safety and quality. A Race stated that PODC would be discussing staffing issues on Friday 25th November. Since the end of the financial year the Trust has increased the number of qualified Nurses by 82 and that a further 130 are at various stages within the recruitment process. A Race stressed that there have been a number of challenges around international staffing and that the first time pass rate for OSCI has dropped. The 4 – 6 week training period is now being extended to allow Nurses to re-take the test, which has a knock on effect to the Nurses being fully operational. G Nuttall stated that training is now taking 3 – 4 months and that the Divisions are currently reporting a gap of nearly 200 Band 5s which is a significant risk. J Dunn requested the following updates to the paper prior to submission to Trust Board: • Pre-covid run rate v run rate should be included within the report. • Include Percentage drop in productivity (Pre-Covid to post Covid). • To complete sensitivity testing around volume of covid, influenza and child respiratory illness. • To show Board, ICB and region what the Trust is doing differently with monitoring/control. • Show that the Trust is looking towards Model Hospital and GIRFT to examine opportunity values. • There is a need to tighten up revenue charges. • Identify if there are any further sources of funding – i.e mutual aid funding • Need to examine opportunity for payment flex. • There is a need to clearly identify the key risks to Trust Board and what is being done to mitigate those risks i.e. Recruitment • There is a need to demonstrate new controls to ICB and region. • There is a need for a full Communications campaign – highlighting the overspend, actions taken and also positive achievements. J Dunn stated that the revised paper should be signed off by the Performance & Finance Committee Executives and the Chair to show full support. The Committee agreed with the summary. J Dunn expressed concerns regarding the option of increasing car parking charges given the current economic crisis. S Evans agreed that a clear communications campaign would be required to convey changes to sub-groups which would be impacted by the changes to contracting and investment going forwards. J Dunn asked that as part of monitoring and control that a GIRFT/Model Hospital workplan be generated with start dates, end dates and review times.	**JG/KS**
120/2022	**Performance**	

120.01.01	RWT Winter Plan – G Nuttall presented the report, which provided a progress update on the Trust's plan for managing winter, focusing on the priority areas within NHS England's overarching plan. The plan aligns with the wider plans within OneWolverhampton and the ICS in recognition of the responsibility that needs to be taken across the Health and Care System. Structures are in place and are working well to maintain involvement and engagement with partners in the coming weeks/months at Executive, clinical and operational levels. The combined pressure of delivering elective recovery targets whilst simultaneously managing unprecedented non-elective demand, is putting significant strain on the Trust and wider system. These challenges are expected to increase during the winter months. Usual pressures are expected to be exacerbated this winter, because of: • The potential unpredictability of any emerging Covid variants, • Potential surge in Respiratory Syncytial Virus (RSV) in children, • Winter influenza and noroviruses at higher levels than normal, • High general non-elective demand, • Challenges in the social care market to assist with discharges. There are financial risks associated with the delivery of the plan. Additional cost may be incurred as a result of an increase in staff sickness or as a result of inflationary pressures in pay and non-pay elements involved in the delivery of non-urgent emergency care. Divisional plans are in place for delivery. The report detailed the progress on the delivery of initiatives, the planned impact, associated measures and risks.	
120.01.02	Wolverhampton Place – A summary of the Wolverhampton Place plan was presented to the ICS Urgent and Emergency Care Board on the 7 October 2022. The plan was given partial assurance, mainly as a result of potential workforce challenges, particularly around the staffing of the Ambulance Receiving Centre (ARC). Funding allocation for Wolverhampton Place schemes took place as planned on 25 October 2022. The Wolverhampton Place funded initiatives were included in the aligned progress summary of the report.	
120.01.03	Black Country ICB – The NHSE requirement for 7/7 day support across ICB systems is in place to support urgent care over the winter months. Daily sitreps are being submitted to the 'ICB Winter Room' each morning with escalation calls currently being held three times a week with all providers and ICB colleagues.	
120.01.04	G Nuttall highlighted two new initiatives; a national push model which is being piloted by the Trust. G Nuttall stated that the pilot had been implemented and the Trust has agreed to only move patients onto wards where there are confirmed beds. The Trust has also implemented a criteria led handover. G Nuttall stated that transfer team hours have been extended to reduce delays after 4pm. G Nuttall informed the Committee that organisations had received a letter regarding the Social Care Discharge Fund on 18th November which indicated £500m funding is available. The Black Country has been allocated £6.5m as part of the Fund. £300m has been allocated and nominated for additional bed capacity which will flow through ICBs. G Nuttall stated that the Trust has taken the decision to not open the 27 bed ward due to staffing challenges. G Nuttall stated that any additional funding for capacity would need to include staffing. £200m has been allocated to Social Care to reduce Medically Fit for Discharge/Stable in Hospital. G Nuttall stated that further work needs to be included within the Winter Plan around the Social Care Schemes. Funding will be made available throughout December, January and February. G Nuttall stated that she has attached a pack on Emergency Department performance for information for all Board members. J Dunn stated that the Committee are re-assured that a comprehensive winter plan is in place. The Committee have received assurance from the data pack, however, G Nuttall	**GN**

	was asked to report back with a monitor/control system and KPIs for the Committee to monitor. The Committee noted that ambulance handover is still an issue at RWT and that ARC will be opening shortly. The Trust will monitor how successful ARC will be. The Winter Plan is a work in progress. **Alert to Board:** Re-assurance that a winter plan is in place, working on assurance issues moving forward. L Cowley asked for the metrics to be included within the report going forwards. L Cowley stated that there was mention of rapid access to social care within the plan and queried the difference it would make and the challenges surrounding this as performance was not at a high level. L Cowley expressed concerns around the push model due to increased requests for late discharges. G Nuttall stated that any issues surrounding the discharge process is being picked up via the Director of Nursing. G Nuttall stated that there is a comprehensive list of measures which are being developed by the Urgent Care Place Group. J Dunn queried if the £4m for medically fit for discharge patients can be claimed back via the Social Care funding. J Green stated that can be claimed back from the additional funding being made available. J Green stated that he has spoken to ICB colleagues and that some potential funding may be available via the Better Care Fund, it is unlikely to that the Trust would see a financial benefit. J Dunn queried if there were other opportunities that could be explored for funding medically fit for discharge patients. G Nuttall confirmed that Wolverhampton pay the lowest rate for Social Care within the Black Country. G Nuttall stated that further discussions need to take place with Wolverhampton Local Authority regarding social care costs. T Shayes stated that the Trust has now agreed that we will no longer incur the cost from next year. S Evans informed the Committee that planning guidance is likely to be delayed until January 2023.	
120.01.02	<u>Recovery Trajectory (inc Elective Recovery Programme)</u> – T Shayes presented the report to the Committee, highlights are as follows: • The Trust missed the H2 ERF threshold of 110% for clock stops with achievement of 101%. • The Trusts waiting list continues to grow and at a quicker rate to that expected. • The Trust achieved the national planning ambition to clear 104 week waits by the end of June 2022. • The Trust is meeting its trajectory for 78 week waits although the achievement of the year end ambition is still high risk. • The Trust is not currently meeting the trajectories for outpatient transformation. • Cancer waits are not expected to return to February 2020 position by the end of this financial year due to the combined effect of, an increase in referrals, diagnostic delays and specialty specific constraints. • Good progress has been made in diagnostics in CT and MRI as a result of CDC plans and are back within the national standard. Overall diagnostic performance is being impacted with challenges in ultrasound. J Dunn asked that the following lowlights be raised to the attention of Trust Board: • Concern that with the continually increasing waiting list there will be an increased negative impact on 52 day, 78 day and 104 day patients. • The cancer target is not being met and there is a need to seek mutual aid. J Dunn requested that a forward projection of the RTT waiting list be included within the report and that the report become more future focused.	**TS**

	L Cowley queried why activity has dropped for outpatients and day cases in October and asked that it be included within the narrative in the report in future. L Cowley queried why there was an ongoing issue around diagnostics and what the cause was for it. L Cowley also queried why outpatient transformation was stalling, why and what is being done to resolve this. T Shayes stated that the Elective Care Strategy are not focussing on patients sitting between 0 – 40 weeks at present. The Trust has cleared the 104 week back log and is supporting other Trusts who haven't yet done so. T Shayes agreed to discuss modelling with J Dunn outside of the meeting. In response to L Cowley's queries T Shayes stated that there has been good improvement in CT and MRI diagnostics and in Endoscopy where additional funding has been obtained. Endoscopy activity has been sustained through the independent use of the independent sector and CDC funds. T Shayes stated that plans had been put into place to address workforce within Ultrasound and ECG, however, Trust staff have then left to explore opportunities with agencies and other Trusts. T Shayes stated that outpatient transformation performance is reflecting the cultural changes involved with the piece of work. G Nuttall clarified that pockets of transformation are taking place as opposed to a full scale outpatient transformation project. J Dunn stated that he would like to highlight the achievements to Trust Board which could be conveyed to team meetings and asked that this information be included within future reports. G Nuttall provided an alert to the Committee that the Consultants National Union is promoting a BMA rate card. The card tries to set rates for completing additional work as a Consultant that they are paid at a substantially increased rate. G Nuttall stated that the Trust had informed the Local Negotiating Committee (LNC) that they had rejected the card but that the Trust has received formal notification from all Anaesthetists that they will not undertake WLIs unless they are paid at the BMA card rate. G Nuttall stated that the Trust could potentially see a reduction in elective activity by the cancellations of these WLIs. G Nuttall stated that the work is being quantified at present and that this will have minimal impact in November. **Alert:** J Dunn to alert Trust Board that the BMA scorecard has been rejected by the Trust and it will have potential impact on elective activity through WLIs. J Dunn asked that A Race raise this as an item at PODC also. The Committee see a continuing pressure on the 78 week and want to do further investigation work in this area. Capacity issues in some areas which are impacting on diagnostic performance for cancer. What actions can be taken on the national issues around Renal/Urology. PODC is being asked to review the workforce issues surrounding this. **Highlight:** Good consistent progress month on month. M Levermore queried if there was a cultural problem with productivity in certain areas when activity had increased but productivity had dropped. A Race stated that there was no evidence of this but agreed that there was evidence of staff tiredness. M Levermore asked for a strong narrative as to why the issues are there. J Dunn stated that the acuity of some patients has also changed following delays caused by covid, which could be clarified once the pre-covid/post-covid data is available.	
120.01.03	Monthly Performance and Forecast (inc IQPR National & Contractual Standards) – As per 118.02 a meeting will take place with S Evans, K Wilshere and J Dunn to discuss the requirements for the BDS for the development of the triangulation of the IQPR.	
120.02.94	Sustainability Update – J Smith presented the report to the Committee. Highlights are as follows:	

- The Trust has delivered all the required deliverables except for reducing the use of Nitrous Oxide and Entonox. Reducing Nitrous Oxide and particularly Entonox which is used by Maternity Services will require substantial capital input.
- NHS England and NHS Improvement published the Technical Annex to the Estates Net Zero Plan 26 October 2022. The Technical Annex details the interventions, activities and target dates required to achieve the 11 strategic actions within the Estates Delivery Plan, the Trust has delivered 9 to date. There was a need to apply 10% social value rating in all construction and capital spend, this is not yet fully implemented (was due April 22).
- The walking aids reuse scheme was successfully launched on 17th October. 507 walking aids were collected with over 50% assessed to be suitable for reuse by the Trust. The scheme will deliver cost savings and carbon emissions reduction. A promotional video was produced to inform staff and the public of the scheme.
- Finance has reported a projected 4tCO2e carbon emissions reduction from business travel from 2020/21 baseline.
- Desflurane use as of October 2022 is 0.6% which is 88% lower than the 5% Greener NHS target.

A full report on cost improvement and carbon emissions reduction outcomes of sustainability initiatives will be available February 2023. Requests have been received from Black Country Healthcare NHS Trust and Shrewsbury and Telford Hospital Trust to mentor their sustainability leads.

Revenue funding is required for Trust-wide sustainability initiatives that do not qualify for capital funding. The implementation of the mixed recycling scheme for New Cross Hospital and the community sites has been delayed due to funding issues. The scheme does not qualify for capital funding because the cost per item is less than £5k. There is no budget line within the waste and recycling services to cover the implementation cost. The same issue has arisen with the Metered Dose Inhaler Recovery and Recycling Scheme which is intended to deliver the required national carbon emissions reduction.

The report outlined the action priorities for the next 6 months, initiatives that required capital funding and funding opportunities.

S Evans stated that a lot of the work that RWT is completing is leading into the ICB and are being introduced across other Trusts. S Evans stated that there is a need to consider some of the national profile changes such as costing of PPE. S Evans thanked J Smith for her hard work.

G Nuttall thanked J Smith for the report and stated that there was a good opportunity in terms of sustainability improvement/efficiencies as staff engagement within the area was of high interest and wanted this to be recognized.

K Stringer thanked J Smith for the report and was in full support in principle but cautioned that some of the initiatives and replacement running costs were very expensive and would be challenging to some Trusts going forwards given the future financial difficulties.

M Levermore queried if the Trust was engaging the local private sector with innovative ideas. J Smith confirmed that a lot of the carbon reduction was achieved via business as usual, where staff were reducing their carbon footprints on scope 3 which was not achieved by other Trusts. J Smith confirmed that the Trust's green plan is focusing on 'business as usual' initiatives to reduce carbon intensive areas. J Smith confirmed that the Trust was liaising with local companies, international companies and the local council to meet recycling requirements.

J Dunn thanked J Smith for the report.

Highlight to Trust Board: J Dunn to highlight the achievements within the Board report.

121/2022 **Financial Performance for Period**

121.01 Monthly Financial Report – K Stringer provided an overview. The Trust is reporting an in month adjusted deficit of £293k, £2.0m adverse to plan. The year to date deficit of £12.8m is £6.8m adverse to plan. £3.6m of the year to date deficit relates to budget reduction CIP that was planned to be delivered by this point in the year, whereas much of the CIP performance has been around cost avoidance efficiencies. There is also an overspend of £7.1m on pay (year to date), which is temporarily offset by £6m of unspent reserves, and a £1.7m overspend on drugs due to activity and the application of block contract arrangements to costs previously passed through to CCGs. Significant run rate improvements and CIP delivery are needed later in the year to achieve the planned break-even position.

121.01.02 Trust Income & Expenditure Position (within the report) –

	In Month Actual	YTD
Income	£'m	£'m
Block Payment	56.79	389.97
Other Income	18.61	95.39
Top-up Payment	0.61	2.75
Total	**76.02**	**488.10**
Expenditure	**76.31**	**500.89**
Surplus/(Deficit)	**(0.29)**	**(12.79)**
Planned Surplus/(Deficit)	**1.75**	**(6.00)**
Variance to Plan	**(2.04)**	**(6.79)**

121.01.03 System Updates – The latest ICB position was unavailable at the time of reporting, at M06 the YTD deficit was £42m, with most organisations running deficits (especially the combined acute/community), and this being £34.6m adverse to plan. The ICB along with its members are still forecasting break-even for the year but the system recognises the significant inherent risks in delivering the break-even position by the end of 22/23 and we are working collectively to review these risks in order to manage and mitigate these as comprehensively as possible. This process has included a Q1 stocktake review with NHSE regional team and individual escalation meetings with the ICB team. Current guidance is that ICBs should not forecast loss of funds for ERF underperformance and on that basis it is assumed that ERF will not be clawed back where planned activity is below plan. However, final guidance on this is yet to be issued. NHSE's review of the ICS position continues with a focus on the underlying ICS deficit moving into 2023/24.

121.01.04 Covid 19 Expenditure – In month 7 there was a total of £846k expenditure relating to Covid 19. Of this amount £779k is reimbursed for testing and vaccinations.

121.01.05 Capital – K Stinger stated that capital is also proving to be challenging due to the large amount of late capital opportunities being presented which need to be bid for and spent by the end of the financial year.

Alert to Board: J Dunn to highlight the £12m deficit and that the Trust is moving through the period to do a formal re-forecast for Public Board. Finance are pulling together a paper for Private Board which is being supported by the Committee.

121.02 Finance Supplementary Report – This report is read in conjunction with the Finance Report. M Greene stated that there has been an improvement in EREAF and that there is still much to be done.

121.03 Quarterly Cash Flow Report – M Greene presented the report to the Committee. The report indicated that cash is quite strong at the moment, however, there is risk to cash now that the Trust is in deficit. M Greene stated that he would complete a 2-year cash flow forecast in future. K Stringer queried if the cashflow was based on the forecast defict

	position as he would have expected the cash position to be lower than forecast. K Stringer and M Greene to discuss outside of the meeting.	
121.04	Financial Recovery Group Update – G Nuttall presented the report to the Committee. The 2022/23 CIP Target is £19.1m. The Trust has delivered £1,688,455.58 in month 7 which sees an achievement of 80% of the monthly target. This equates to 101% of the year to date phased target, and 45% against the full year delivery target. Against an in month target of £2.12m, the Trust has achieved £1.69m. YTD £8.58m achieved against a target of £8.49m. Within this, there has been a rebasing of CIP achievement to ensure reporting is consistent across the ICB although this does not impact the Trust's bottom line. Recurrent savings are forecast at £6.2m, of which £2.12m are from the revised reporting, with total savings currently forecast at £14.81m. There are approved PIDs of £8.183m, £2.12m recurrent and £6.06m non-recurrent with, £48.5k of schemes in progress. G Nuttall informed the Committee that the Pharmacy Department are completing a review of Medicines Management and an update will be provided next month. All Divisions have gone through model Hospital packs and are coming up with schemes they will focus on which will align against GIRFT, more detail will follow in next month's pack. L Cowley asked if Sensyne could contribute towards CIP. K Stringer stated that the shareholding value is now next to zero. A Nisbett is currently having discussions with Sensyne regarding a potential future commercial relationship. Discussions would need to take place at Board level regarding this. M Levermore queried if machine learning was included within Model Hospital. G Nuttall stated that machine learning is not included within Model Hospital as it provides comparison/benchmarking data. G Nuttall assured M Levermore that the Trust continues to undertake pilots with machine learning where possible. The Committee noted that the Model Hospital and GIRFT data will be examined in more depth. Work will also take place to examine the pre and post covid productivity lost which could also drive initiatives.	
121.05	Temporary Staffing Dashboard – A Race provided highlights as follows: • Recruitment continues to progress well; 7 Clinical Fellowship Programme Nurses (CFP) are due to arrive in December with a further 40 scheduled for January. Deployment to wards following arrival takes approximately 12 weeks • A third recruitment hub event held on 5th November at Cannock Hospital; targeting registered nurses, 4 conditional offers were made. • There has been continued successful doctor appointments via the Clinical Fellowship Programme The following risks were highlighted: • International nurse recruitment – flight availability and costs remain a significant challenge, as does delays in visas. • 24 out of 34 international nurses from CFP cohorts have failed their OSCE exam meaning they are unable to be deployed to wards as qualified nurses (but can work as non qualified nurses). Nurse Education and the CFP Team are reviewing pastoral support and OSCE programme to identify any root causes. • Of the 88 newly qualified nurses who received conditional offers; 24 are having to re-submit assignments from November through to Summer 2023, which will impact on start dates.	

	Alert to Board: J Dunn said one of the key risks for the financial plan and winter plan is the availability of Nurses. The Committee have asked PODC to look at how International Nurses training can be accelerated to expedite their operational readiness. L Cowley queried Primary Care agency costs and asked how it was comparable to privately operated practice and if there was any comparable data. A Race stated that comparable data was not available in relation to private Primary Care practices. G Nuttall stated that she would ask S Thomas to liaise with A Race to look into this query further.	**ST/AR**
121.06	SFI Threshold – J Green informed the Committee that a proposal is being developed to alter the SFI limits to bring them in line with limits of other similar sized organisations within the Country. The RWT levels are substantially lower than others. The draft proposal will be submitted to Trust Board for authorisation. J Dunn asked J Green to provide him with a copy of the paper before it is submitted. K Stringer clarified that the paper will be submitted to Trust Board with delegated authority to Audit Committee.	**JG**
121.07	Better Payment Practice Action Plan – There is a renewed focus by NHSE/I on those trusts that underperform against the better payments practice code standard of settling at least 95% of invoices (value) within 30 days. An action plan has been produced to enable the Trust to be able to endeavour to meet the 95% Better Practice Payment Code target. The Trust is falling short of the 95% requirement. L Cowley queried if the Trust had received any complaints regarding payment dates and if a risk analysis had been completed regarding any payments which could pose a risk to a Service. M Greene stated that there was nothing material to note at the present time. K Stringer asked that the team be challenged to ensure the 95% target is met.	**MG**
122/2022	**Governance**	
122.01 122.01.01 122.01.02 122.01.03 122.01.04 122.01.05	BAF Update – K Wilshere provided an update. The Committee discussed the following risks and accepted the proposed changes: Ref: SR15 – Strategic risk: Impact of future funding flows resulting in potential deficit position and financial challenge (Red). Strategic Objective: A discussion took place regarding the risk score given the pressures from the ICS budget settlement, inflation and other financial pressures. The risk level will be increased to 5 x 4. The Committee agreed the change. **Note to Board.** Ref: SR16 – Strategic risk: Restoration of services (including Cancer services) post pandemic (Red) **Review outcome:** A discussion took place and the Committee felt that the risk should remain the same at level 20. Future Risks – The emerging Wolverhampton ICP/Place collaboration formation may need to also be considered either as part of this emerging risk or as a separate risk by the Performance & Finance Committee Meeting, including better knowledge of the legislative changes when confirmed. **Review outcome:** The Committee agreed to continue to keep this as a watching brief. New Risk – A discussion took place regarding the impact of a potential risk of a successful cyber-attack which could compromise Trust IT systems, personal data and records access. The Committee agreed that this would become a new risk going forwards. **Alert to Board** Other Additional Risks – L Cowley queried if the potential instability in the broader provider network, specifically energy costs, should be a watching risk. J Dunn agreed that this item	

	should be held on a watching list. G Nuttall suggested that she would examine this risk to see if there was scope to include it within the existing risk SR16. K Wilshere informed the Committee that a Board Development Session will take place early new year to discuss the changes to the BAF.	
123/2022	**Tettenhall Road Practice Integration**	
	A Nisbett and S Thomas presented the report to the Committee. The report outlined the findings of the due diligence undertaken for the integration of Tettenhall Medical Practice and made a recommendation on how to proceed. The due diligence process demonstrated that the practice is generally well-run practice and is in a positive financial position. The report highlighted that there is room for generation of additional income through LES and DES participation bringing the practice in line with RWT practices activity. Whilst a financial deficit has been identified going forward this will only materialise if the current model remains and the practice is not relocated to West Park. It is not recommended that the Trust proceed with the integration of the practice if the practice was to remain at its current location. The proposed operating model (which is predicated on the practice relocating to West Park) makes the integration of the practice with the Trust a financially and operationally viable option. K Stringer raised the following queries: • The biggest risk from loss to surplus on the I&E statement is the GP TUPE model. *A Nisbet confirmed that the Partner costs were cheaper which is why the I&E went into surplus.* • Would the Trust ask the Primary Care Provider to pay rent for West Park? *Would ask for rental income.* • Are there any sickness/financial issues if the partner retired? *The Doctor will retire on ill health grounds on 31st March and there are no other employed GPs so the contract will transfer to RWT with no medical employees and RWT will have no liability.* • What are the capital costs of West Park – *Estates team are working on this as this would align with existing work. Waiting for further clarification but it is expected to be low cost.* J Dunn asked that the following updates be included within the paper before it is submitted to Trust Board. L Cowley asked if a plan is in place for patient engagement? S Thomas stated that the Trust is waiting to hear back from ICB as to what patient engagement needs to take place and timings. L Cowley queried if there was an assumption locum agency costs would not be required. S Thomas stated that a long-standing locum is in place due to the current Doctor's health. The Trust will continue to work with the locum for a short period until recruitment has taken place. L Cowley asked that locum costs be declared as a worst case scenario if agency was required. L Cowley queried what the dilapidation requirement is and whether the liability would sit with the current incumbent or the Trust. A Nisbett confirmed that the practice currently leases from the landlord, there is a break clause in the lease and the Landlord would be happy to release the lease early. K Stringer asked that S Lowndes look into this and feedback regarding the dilapidation queries. J Dunn stated that this would need to be completed before the paper goes forward. S Thomas stated that S Lowndes had not highlighted this as a concern but that the query will be checked.	**AN/ST/GN** **AN/ST**

	M Green queried if there was any risk associated with patients moving to another GP. S Thomas stated that there is no indication of footfall to other surgeries and that the risk is minimal. M Levermore queried how many practices were in site at West Park at the moment, if there would be capacity to accommodate the patients and if TUPE would apply. S Thomas stated that there is one practice currently at the West Park site and there are no risk of redundancies. The Committee agreed that the paper will need to be enhanced to incorporate the recommendations from the Committee before submitting to Private Trust Board.	
124/2022	**Reports to Note**	
124.01	NHSI Monthly Return – The return was noted.	
124.02	Annual Work Plan – The work plan was noted.	
124.03	Capital Plan Report – The report was noted.	
125/2022	**Any Other Business/Meeting Reflection**	
125.01	Any Other Business – No further business was discussed.	
125.02	Meeting Reflection/Chairs Report – The items to be included within the Chairs Report are highlighted within the minutes.	
125.03	Meeting Reflection/CEO Highlights – The Committee asked that the following items be raised for the attention of the CEO to be discussed at the CEO/NED Meeting. • Winter Plan – asking for further monitoring/assurance. • Criticality of Medically Fit – impact of funding from that.	
126/2022	**Date and Time of Next Meeting**	
	The next meeting is scheduled to take place on 21st December at 8.30am via MSTeams. The deadline for papers is 12 noon on 16th December.	

The Royal Wolverhampton NHS Trust

Minutes of the People and Organisational Development Committee

Date	**25th November 2022**
Venue	**Via MS Teams**
Time	**10:30am**

Present:	**Name**	**Role**
	Alan Duffell	Chief People officer
	Bal Everitt	Head of Equality, Diversity & Inclusion
	Junior Hemans (Chair)	Non-Executive Director
	Allison Heseltine	Associate Non-Executive Director
	Lyndsey Ibbs-George	Divisional Manager, Estates & Facilities
	Tracey King	Interim Head of Resourcing
	Ros Leslie	Chief AHP
	Zoe Marsh	Associate Director of People
	Mark Ondrak	Staffside Lead
	Adam Race	Interim Director of HR & OD
	Sue Rawlings	Associate Non-Executive Director
	Julie Shillingford	Head of HR Advisory
	Sian Thomas	Deputy COO, Division 3
	Ananth Viswanath	Deputy Medical Director
	Cath Wilson	Deputy Chief Nurse
In Attendance:	Maria Dent	PA to Chief People Officer
	Nick Price	HR Manager, Division 3
Apologies:	Kevin Bostock	Group Director of Assurance

Agenda Item No		Action
1.	**STANDING ITEMS**	
1.1	**Apologies for Absence and Welcome to the Meeting** The apologies were noted and recorded as above. J Hemans informed that A Duffell had been appointed as the Group Chief People Officer, covering Wolverhampton and Walsall, which would come into effect from the 1st December 2022 whilst still supporting Dudley Healthcare.	

Agenda Item No		Action
1.2	**Declarations of Interest** No declarations reported.	
1.3	**Confirmation of the Minutes from the Last Meeting, 28th October 2022** The minutes from the 28th October 2022 were reviewed and agreed as a true record of the meeting.	
1.4	**Review of Action Log and Matters Arising**	
1.4.1	**The Future of HR & OD in the NHS (Action 2022/013)** A Race reminded the committee that a national review had been undertaken approximately 18 months ago, following which, the Future of HR and OD in the NHS was published which provided best practice across the industry and professional bodies for HR & OD functions. He advised that the information presented had been taken from the national status report issued in November. A Race stated that the priorities were already included as part of the Trust's focus on the People agenda, there was regular engagement across the HR Director community and A Duffell was also part of the national workstream working on policies. The identified workstreams of the Future of HR and OD were: • Embedding digitally enabled solutions • Supporting the development of the people profession • Leading improvement change and innovation • Harnessing and developing the talents of our people • Prioritising the health and wellbeing of our people • Creating a great employee experience • Ensuring inclusion and belonging for all • Enabling new ways of working and planning for the future A Duffell reported that there had been some delay in progressing due to varying reasons over the last 12-18 months, but the digital agenda was a key area and a tender was due for a replacement to ESR (electronic staff record). It was expected that this would be implemented by 2024/25 and would link into workforce planning. In regards to the work around national policies, A Duffell reported it had been recognised that all NHS Trusts wrote and reviewed their own policies so it had been agreed for the national group to identify a bank of policies that would be available to all. The work had commenced with two policies completed, one on baby loss and the other on menopause. A Duffell reported that there was also a massive push to scale up services which the joint working with Walsall, and the acute collaborative work, supported. This was linked to the ICBs needing to work closer together with organisations. Guidance and tools to support this work were to be produced. He reported that further updates would be reported back to the Committee on this work. In response to a question raised by J Hemans as to whether any funding had been identified to support these initiatives, A Duffell commented that he was not aware of any funding identified for individual Trusts but informed that the Provider	

Agenda Item No		Action
	HR Directors and deputies would be meeting in the new year to start discussions around future projects and developments against this initiative. S Rawlings queried whether the Trust had already started working on the initiatives proposed, notwithstanding that no funding had been made available; A Duffell confirmed that these areas were a priority for the Trust however, the difference would be the wider focus across the region and on a larger scale	
1.4.2	**Retention Report (Action 2022/037)** T King, Acting Head of Resourcing, presented the report on the retention position, advising that there was limited data available on the reasons for leaving sourced from ESR therefore there were limitations in drilling down the information available to identify trends. She advised that there had been very little change to the data submitted to PODC previously, there had been a slight increase in the turnover rate, at 11.43%, against the target of 10%. The data showed a consistent position with no spikes and September was showing a reduction in leavers. From the data available from NHSI and Nuffield, in the Midlands the Trust was 5th in ranking, in terms of leavers, and was the best rated across the Black Country. She stated that although the current position was slightly over target, it was currently felt that this was not an exceptionally challenging position but the situation would be kept under review. J Hemans stated that there had been a continuous trend above mark on retention and therefore he was considering as to whether the Committee required a further meeting to focus on the specific areas affected. A Duffell commented that the Trust's position, although of some concern, was in a much better place than a number of other Trust's nationally, however, he stated the Committee might want to consider whether a dedicated BAF risk was required, especially if a particular service was struggling. A Race confirmed that there were fluctuations in turnover in different departments and the Divisions were sighted on this data. He stated that following the covid pandemic, it was expected that turnover would be elevated and retention reduced, as the data was affected by the number of people who had joined or re-joined the NHS temporarily to support during the crisis. However, the two main drivers for people leaving, identified in the 2019 retention programme review, were development and flexibility. Flexibility remained as one of the key issues, therefore, the Attract and Retain Group would focus on a number of actions to support flexible working over the next 12 months. J Hemans noted A Race's comments and acknowledged that RWT was in a reasonable position, however, the Committee needed to ensure that focus continued in this area. C Wilson advised that retention was discussed in a number of other meetings and not just at PODC, stating that Nursing and Midwifery had: • developed the Professional Nurse Advocate service who covered crisis management, career conversations and improvements at work. • employed a Chief Nurse Fellow to develop the internal transfer scheme. • held a 'stay' event where over 70 nurses attended, the data and outcomes would be pulled together and evaluated.	

Agenda Item No		Action
	• approved the commencement of legacy mentors to allow senior nurses to pass on their skills and provide mentoring for new nurses. After discussion by the Committee, it was agreed that at the present time the Committee was not fully assured of the retention position and it was agreed for a further report to be submitted to the January meeting which also included additional information such as identifiable data, ie age groups and ethnicity, identified the challenges and included action plans.	**Action 2022/047 T King**
1.4.3	**International Recruitment Update - The Clinical Fellowship Programme – Recruitment update (Action 2022/044)** Z Marsh provided an update on the report presented, key points to note : • The collaborative international recruitment programme supported the Black Country System and there had been an increase in numbers required and accelerated demand, but of the target of 504 nurses, 416 were in place to date. • On target for RWT appointments, with a further 48 due to commence in December 2022 and January 2023. • There had been a number of challenges, one of which was accommodation as mentioned previously by J Hemans but the team continued to manage the situation and were working with Estates and Facilities teams. • Changes to the OSCE assessment and examination by the NMC had seen a high reduction nationally in pass rates. Therefore, C Wilson and team were carrying out an in depth assessment to understand the themes and trends to assess the impact on timelines from arrival to working fully on the wards. • In regards to retention, the data on this was available and at the last view 98% of international nurses remained in employment. C Wilson advised that the NHS England had recognised the national problem with the OSCE pass rates and a national working group was being pulled together. She confirmed that the changes to introduce additional core skills were valid but the lead time had been very short. In response to a question raised by A Duffell, Z Marsh confirmed that all international nurses were recruited through the Clinical Fellowship programme which provided a complete package of pastoral support. A Duffell queried how far behind was the project trajectory in terms of arrival to working fully on the wards, given the delays in visa applications and the delays in passing the OSCE examination. Z Marsh advised that currently the programme was ahead of trajectory and was expected to be achieved by January 2023. A Viswanath acknowledged the impressive pass rate which was close to 100%, and queried whether this was due to the selection process or the additional support and training. He also noted the huge disappointment for those who fail after making such a commitment to travel to the UK. Z Marsh reported that this was predominately down to complete package of support in place for the international nurses or fellows, with the OSCE programme which expanded beyond the curriculum and also provided day to day support.	

Agenda Item No		Action
	A Race commented that the overall success of pass rates was hugely encouraging and an accolade for the programme. One observation, following conversations with colleagues in regards to the changes to the OSCE and the reduced pass rate, was the operational impact and this would be reviewed and an update included within the resourcing report due to PODC and OWG In response to a comment by A Heseltine regarding an academic paper on this initiative, Z Marsh advised that a research study was currently underway and there had been a publication in the British Journal of Nursing, which she agreed to share. J Hemans congratulated the team on the success of the programme and also offered his support in regards to speaking to some of the registered providers for accommodation across the Black Country; Z marsh agreed to follow up.	**Action: 2022/048 Z Marsh**
2.	**Key Updates and Workforce Performance s**	
2.1	**Key Updates**	
2.1.1	**Industrial Action** A Duffell reported that the RCN had voted to take strike action in two days during December, however at RWT, the RCN had not reached the mandate for strike action. The union could go out to ballot again although a number of nurses were Unison members and not RCN and a number of unions had informed that they would also be going out to ballot. He advised that the Trust would work alongside Staffside colleagues, both locally and regionally, regarding derogation of services and this was being led by Gwen Nuttall, Chief Operating Officer. In response to a query from J Hemans, M Ondrak advised that the UNISON balloted closed 25th November, with results due out nationally in the following week.	
2.1.2	**National Workforce Plan** A Duffell advised that the national workforce plan for the planning over 10-15 year period was due to be published end of the year to mid-January.	
2.2	**Executive Workforce Report** A Duffell provided key highlights from the Executive Workforce report, to note: • It was recognised that appraisals were not where they need to be. • There was still a higher number of starters than leavers to the Trust every month. In response to a question raised by S Rawling regarding the flu vaccination targets, A Duffell advised that RWT, as well as the majority of other NHS Trusts, were struggling to encourage staff to uptake, but work continued to re-engage with staff and enable easy access to both the flu and covid vaccinations.	
2.3	**Key Update from the Operational Workforce Group (OWG)** A Race reported that at the last OWG meeting, the group discussed the temporary staffing dashboard and the recruitment impact, and to triangulate and	

Agenda Item No		Action
	forecast temporary staffing spend, and high levels of agency spend, against high level vacancies, to ensure focus in those areas facing the biggest challenges.	
3.	**Formal Review / Sign Off** No items put forward this month.	
4.	**Strategic Focus Areas**	
4.1	**Deep Dive : Allied Health Professionals (AHPS)** R Leslie, Chief AHP, provided key highlights from the report submitted, to note: • There were over 600 AHPs within the organisation which included orthoptists, operating department practitioners, therapeutic radiographers, physiotherapist, occupational therapists, speech and language therapists, dieticians, podiatrist, orthotists and diagnostics therapists. There was also five paramedics working across emergency and critical care services. • The age profile position was in a positive place and succession planning was place where needed. The group was also looking to explore opportunities through legacy mentor roles to support the retainment of skilled staff. • The overall vacancy position was within the Trust target although there were a number of hot spot areas such as podiatry and dietetics. There had been some issues within diagnostic radiography but this had reduced due to the success in international recruitment and apprenticeships posts. • Turnover within the group was around 13-14% and the top reasons for leavers was work life balance, promotion and relocation. Following review, no trends were identified. • Sickness absence workshops were held with managers and teams and all were encouraged to support and promote the Trust's wellbeing initiatives for all staff. • Safe Staffing – risk assessments were in place for any areas of concern and business cases to support. • AHPs in several areas would be moving onto to E-roster which would make staff more visible, support rostering and monitoring leave. • 24% of the AHPs were from a BAME background which was higher than the national average of 12%. • Stay conversations were supported and ongoing. • The importance of leadership training had been recognised for AHPs going into leadership roles and following conversations with education leads, baseline assessments were due to commence to assess requirements. S Rawlings queried whether there would be any other best practice available at other Trusts in regards to leadership training for AHPs; R Leslie advised that the Black Country System worked closely together with the Black Country AHP's council meeting regularly. The group comprised all of the chief AHPs and this area had been discussed and identified across all Trusts, therefore, in order to provide something robust to support leaders going forward, the baseline assessment would look to identify any gaps in the training currently available, but agreed, she would raise at regional and national AHP meetings.	**Action: 2022/049 R Leslie**

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	In response to a question raised by A Heseltine regarding an issue raised by the sonographers on working conditions, N Price advised that the concerns had been followed up by the Group Manager and the Freedom to Speak Up Guardians. A wider working group had been established and he understood that the situation and the concerns had been addressed. J Hemans stated that he had met with AHPs at Walsall who had identified that their continuous professional training was an issue as they were unable to attend and queried whether there were any similar concerns at RWT. R Leslie stated that she was not aware of any similar issues and understood that the concerns raised by colleagues at Walsall had been addressed. In response to a question raised by J Hemans on the promotion of these roles as careers to younger people, R Leslie advised that recently a careers event had been held on the 4th November which had been attended by the schools where each professions gave an update on their specialty and provided hands on practical experience. This had been well received and these events were scheduled on a regular basis.	
4.2	**Equality, Diversity & Inclusion Update** B Everitt provided an update from the report presented on performance against the Workforce Disability Equality Standards (WDES) and the Workforce Race Equality Standards (WRES). Key points to note: • WRES action plan had been developed as a requirement of NHSEI. • Work was ongoing on the development of a joint anti-racism and culture statement with Walsall Healthcare NHS Trust which had included staff engagement via survey and staff workshops, with the final statement due to a joint board session in January for feedback and endorsement. • In terms of WRES recruitment it was recognised the need to reduce the gap in outcomes from black, asian and minority ethnic candidates and the Trust had launched the inclusion of the Cultural Ambassadors (CAs) on recruitment panels for band 7s and above. Monitoring and assessment by the Resourcing Team was in place and a range of resources had been development to support the recruitment mangers and an e-learning programme was in development. • Future programme of recruitment planned for early 2023 for additional Culture Ambassadors and further work planned to align to the Walsall Cultural Ambassador programme approach. • During the Black History month in October, the Lord Mayor of Wolverhampton visited RWT and the Trust held a racist policy showcase event. These provided the opportunity to celebrate our black nursing colleagues as well as to raise the profile of some of the race equality initiatives within the Trust. • Work continues on the WDES action plan and the team had worked closely with the Disability and Long Term Conditions Employee Voice Group in the development of the new health adjustments passport. There was also ongoing work with the Disability and Access Planning Group to look at some of the wider accessibility issues around the site. • Equality objectives had been developed jointly for workforce and patient experience and the teams were currently engaging with internal and external stakeholders prior to presenting these to Board for approval.	

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	S Rawling thanked B Everitt for the update report and requested additional comparator data to be included alongside the RWT metric for the race equality standards in future reports; B Everitt to follow up. In response to a question by S Rawlings on the utilisation of the Clinical Ambassadors for recruitment panels, B Everitt confirmed that the ideal plan was that the CAs would be fully integrated into all levels of recruitment panels, however, this was currently being managed by volume and availability. A Duffell commented that the plan was to expand and roll-out this practice once the initial practice was embedded. A Race advised that this was a data led approach and currently the CAs were supporting areas identified by the data.	**Action : 2022/050 B Everitt**
5.	**KEY RISKS**	
5.1	**New Risks** A Duffell stated that it was recognised that there may be a potential new risk around retention but the Committee would need to consider further following the agreed update report due to the next meeting. The Committee agreed and no other issues were identified.	
5.2	**Board Assurance Framework** A Race advised that SR17, the draft risk on EDI had been added to the new template and was due to the private Board for consideration.	
6.	**Committee's Objectives – Areas of Focus** • To examine the issues, data and impact in relation to staff turnover and retention • To monitor the ongoing sickness absence position and actions being taken to address • To monitor Equality, Diversity & Inclusion areas of concern It was agreed that all focus areas had been discussed during the meeting and the EDI would now be monitored via the agreed risk.	
7.	**Any Other Business**	
7.1	**BMA Rate Card** A Race reported that the Performance and Finance Committee had requested that the PODC were made aware of the discussions around the British Medical Association (BMA) rate card. He advised that the BMA had produced a rate card which recommended the rate for consultants to be paid for any work over and above contract, which would bring the RWT WLI session rate to approx. £600. The current offer by the Trust was a flat rate of £514. This had caused some contention and letters had been received to advise that some consultant anaesthetists would no longer be undertaking this additional work and this, would therefore, have an impact on elective activity. A Duffell advised that across the Black Country, RWT was not singled out and other Trust's had also received similar notification letters from consultants but all four acute Trusts had formerly rejected the BMA rate card.	

Agenda Item No		Action
8.	**Evaluation of Today's meeting** The Chairman thanked the group for their participation in the meeting.	
9.	**Items for Escalating in the Chair's Report to Trust Board** To note: • NHS HR OD Plan • Retention • Clinical Fellowship report • Industrial action – only RCN confirmed to date • National workforce plan • Metrics • Deep Dive update – AHPs • EDI report update • BMA rate card	
10.	**Date and time of Next Meeting** 10.30am-12.30pm, 27th January 2023 via MS Teams	

The Royal Wolverhampton NHS Trust

Minutes of the Trust Management Committee

Date	25/11/2022
Time	13:30 - 15:30
Location	MS Teams Virtual Meeting
Chair	Prof. Loughton
Attendees:	Kevin Stringer, Catherine Wilson, Suneta Banga, James Green, Louise Nickell, Mark Greene, Kate Shaw, Beverly Morgan, Rosalind Leslie, Ann-Marie Cannaby, Adam Race, Matthew Reid, Prof. Singh, Doreen Black, Charlotte Leo, Simon Evans, Lewis Grant, James Green, Lindsay Ibbs-George, Alison Dowling, Alan Duffell, Dr Macve, Andrew Morgan, Damian Murphy, Magdalena Zajac, Gwen Nuttall, Adam Race, Chipo Ndlovu, Stew Watson, Cathy Higgins, Helen Boyce, Keith Wilshere ,Kate Cheshire, Sally Evans

1 **Apologies for absence: Lewis Grant, Nicki Ballard, Dr Higgins, Dr Odum, Tracy Palmer, Sian Thomas, Prof. Cannaby, Nick Bruce, Kate Shaw, Kevin Bostock**

2 Declarations of interest

There were no new or changed Declarations of Interests to those published on the Trust Web Site.

3 Minutes of the meeting of the Trust Management Committee held on 28 October 2022

The minutes were approved unchanged.

4 Matters arising from the minutes

There were no matters arising from the minutes.

5 Action Points list from TMC meeting

1. **Patient Experience Report**

Action item: Ms Evans to prepare a press release on the report. Ms Hickman to discuss this with Ms Evans.
Ms Evans confirmed the action had been completed.
Resolved: action was closed

2. **Acute Care Collaboration**

Action item: 15 minutes to be allocated to the November TMC meeting for the Acute Care Collaboration item

Update: the item be added to the January TMC Agenda

Key Current Issues/Topic Areas – none this month

7 Elective Care Recovery

Ms Nuttall highlighted there was an increase in cancel referrals together with an increase in waiting lists. She said the Trust had no patients waiting over 104 weeks for any treatment. She said the national focus was there would be no patients waiting over 78 weeks by the end of March. She said there were challenges with General Surgery, Gynaecology and Urology. Prof Loughton asked if the Elective Recovery Plan took into account any strike action. Ms Nuttall said there would be no impact in terms of the Royal College of Nurses (RCN) and no forecast on impact on the Recovery Plan around strike action.

Resolved: the Report was received and noted.

8 By Exception Papers - there were none listed this month

9 Monthly Reports

9.1 Integrated Quality and Performance Report

Ms Nuttall highlighted the ongoing ambulance handover delays at the Trust. She said the Ambulance Receiving Centre (ARC) was scheduled to open on Monday 28 November. She said there would be a minimum of 11 cubicles and discussions were taking place as to staffing at the ARC. She also mentioned £500 million had been allocated nationally across the system for the Social Care Discharge fund. Ms Evans said comms would be circulated in respect of the ARC once she had received confirmation that the ARC had opened. Ms Nuttall said there had been an increase in the number of people waiting for discharge.

Prof. Loughton asked for clarification on what “Medically Optimised” meant. Ms Nuttall said this was the new phrase for patients who were medically fit for discharge, where patients were still waiting for a package of care to be put in place to be discharged and medically all work had been done for those patients.

Ms Hickman highlighted the challenges with staffing. She said work was in the pipeline however staffing was impacting on the skills mix and the requirement to support staff. She said there had been a deterioration in observations on time and work was underway She also mentioned there was an increase in *C-Difficule* cases. She made all aware that the ability to decant and deep clean was recommenced,

Mr Dowson asked if there had been any improvements of using the new IQPR, was it easy to identify the areas of concern and areas of where

there had been improvements. He said if staff needed assistance on Structured Conduct Performance (SCP) methodology he could arrange training with them. Mr Duffell said the SPC charts set limits and highlighted when the Trust had any concern which he felt was positive. Dr McKaig said he had positive feedback and asked whether it could be rolled out across all of the metrics for all meetings within the organisation to enable staff to understand how it worked. Mr Evans said if staff required assistance with SPC charts the Quality Improvement Team would also offer support and training. Ms Arthur said following the CQC Well Led Review in 2019 the CQC made a recommendation to ensure better understanding and use of information and felt if things could be done to increase this would be positive.

Resolved: the Report was received and noted.

9.2 Division 1 Quality, Governance and Nursing Report

Ms Black highlighted the harm rate per 500 occupied beds remained static over last 20 months. She said there were no new Never Events for and no new red concerns. She assured the Committee there had been a decrease in the number of Serious Untoward Incidents (SUI) actions. She said there had been no breaches in the submission of final Route Cause Analysis (RCAs). She said there was an increase in the number of falls but none of serious harm. She highlighted 8 NICE Guidance had not been assessed and were now overdue. She said staffing issues had been identified for all wards during October and there had been an increase in the number of reported Datix incidents.

Resolved: the Report was received and noted.

9.3 Division 2 Quality, Governance and Nursing Report

Ms Boyce assured the Committee that immunotherapies and targeted therapies continued to be delivered solely on the New Cross site. She said there were no death or severe harm incidents in month. She said there had been an increase in infection outbreaks which had been reported as Serious Incidents (SI). She said there were concerns on registered nurse vacancies. She also mentioned the pass rate on the Objective Structured Clinical Examination (OSCEs) had impacted on nurses in the pipeline.

Prof Loughton asked whether the poor pass rate on the OSCE was the same for every Trust. Ms Hickman said it was a national issue which had been affected by the change of standards.

Resolved: the Report was received and noted

9.4 Division 3 Quality, Governance and Nursing Report

Ms Ballard said there had been no serious incidents in month. She said the Division's audit completion rate had been 8% behind at the end of

quarter 2 and a plan was in place to improve by quarter 3. She said the number of nurse vacancies was 43.91 whole time equivalent with 70 adjusted with the business cases. She said there had been an increase in the use of Centre for Addiction and Mental Health (CAHM) beds. She mentioned the SPC showed an increase in medical incidents on the chart however Pharmacy is within Division 3 and was not of concern. She said there was low harm noted.

Resolved: the Report was received and noted

9.5 Executive Workforce Summary Report

Mr Duffell said there were more starters than leavers at the Trust. He said the Trust now employed over 11000 staff. He said nationally there was concern and focus on staff retention rates. He reminded all to complete appraisals with staff if not already done so. He said in relation to Industrial Action the Royal College of Nursing (RCN) had today announced strike action dates for December. He said as a Trust the threshold was not met to go on strike and technically staff could not strike. He asked all to have conversations with staff to understand their positions in relation to this.

Action: Prof Loughton said the Trust needed to have meetings with the Union particularly with the RCN.
Resolved: the Report was received and noted.

9.6 Chief Nurse (CNO) Nursing Report

Ms Hickman introduced the report and said half of the number of students had now completed the programme. She said Universities were working with the Trust to bring forward exam boards to sit pre-Christmas to enable the remaining students to move forward. She said a lot of experienced staff had been lost at the Trust and work needed to be done on how to bring those back in different roles to support junior staff and those new to the NHS. She also mentioned there was shortage of staff at the Trust due to long term sickness one area of concern being the Safeguarding Team.
Resolved: the Report was received and noted

9.7 Finance Position Report - Month 6

Mr Green said there was a £12.79 million deficit in year to date. He said a proposal had been taken to the Finance Committee which sets the forecast at £14.9 million which would be challenging particularly with the Integrated Care Service (ICS). He also mentioned NHS England had launched a deficit protocol with a number of actions and conditions which have to be undertaken. He said the Trust had recovery plan in place. Prof Loughton asked whether the position at the Trust was improving as the Trust was not deteriorating at the same rate.

Mr Green said pay spend during the last months was flat but it was expected that spend over the winter would slightly increase.
Prof Loughton asked how much the ICB owed the Trust
Mr Green believed it was less than a quarter of a million differences between the balance of the Trust and the ICBs but there were challenges to discuss with the Integrated Care Service (ICS) health inequalities, funding, and Community funding. Prof Loughton asked how much that was worth. Mr Green said approximately £1 million he said indicatively it had been allocated but the Trust needed to validate that it was allocated to the Trust.
Resolved: the Report was received and noted

9.8 Capital Programme Update

Mr Watson said the Trust was in line with the spend profiles and some funding was expected before the end of the year. He said the Trust was currently at £33 million Trust funded and £33 million from external funds which included decarbonisation program. He said the Trust had submitted ICS system bid for additional funding for more decarbonisation work for the next year financial year. Prof Loughton asked whether the Trust was still experiencing goods coming in over budget. Mr Watson said there were challenges particularly with steel and concrete where there had been a 100% to 120% increase in costs from last year.
Prof. Loughton asked whether it was being corresponded to the centre that inflation on construction costs were way above general inflation
Mr Green said not specifically on construction costs the Trust had received funding on energy bills. Mr Stringer said the estates professions and capital professionals were aware of the inflation impact on the capital schemes. He said at a national level Treasury were not funding anymore capital into the system.

Ms Boyle asked about the plans for the learning village in building 12.
Mr Watson said all plans and the 5 year capital spend were being reviewed. He said investment from the Trust next year would be on the Wrekin House redevelopment work. There was a discussion about building 12 and Mr Watson said he would speak to Ms Boyle after the meeting to discuss in more detail.
Resolved: the Report was received and noted

9.9 Operational Finance Group Minutes

Resolved: the Report was received and noted

9.10 Financial Recovery Group Update

Resolved: the Report was received and noted

9.11 Acute Care Collaboration

Mr Evans said work had commenced on the proposed scheme of delegation which was to commence with clinical work. He said this

would be discussed in more detail at the presentation for the next TMC. Prof. Loughton said Dr Odum needed to create a group to look at vascular.
Resolved: the Report was received and noted

10 Statutory or Mandated Reports (1/4, 6 monthly and Annual)

10.1 OneWolverhampton update paper and Developing the OneWolverhampton performance and outcomes framework

Mr Evans introduced the report and thanked Sian Thomas for collating the papers and work involved. He said the first report highlighted the new governance arrangements for Place which included the partnership alliance which was the legal entity which was being established for Place. He said the second report included the development of the outcomes framework together with the reporting matrix. He said Place was to undertake a population led approach which would be data driven by using digitally enabled information. He said included in the report was data from work being undertaken by the Trust for the virtual wards. He said the Trust had received positive feedback nationally for the work on the virtual wards.
Resolved: the Report was received and noted

ICS Development – Prof. Loughton asked Ms Nuttall to do a presentation at the next TMC on the benefits which had been seen since July since the formation of the ICS – is this required?

10.2 Research & Development report

Dr McKaig introduced Ms Boyle the Director of Research across both RWT and Walsall Healthcare NHS Trust (WHT). Ms Boyle said focus was on commercial research in terms of performance management. She said there was opportunity to bid for capital funding in the pathology departments. She highlighted the Trust currently hosted the Clinical Research Network (CRN). She said a bid had been submitted to host the CRN for 6 years commencing in 2024.
Resolved: the Report was received and noted

10.3 Patient Experience Report & Annual Complaints Report

Ms Dowling said there had been an increase in the number of complaints however positive outcomes were received from the complaints which were escalated to the Ombudsman. She said out of the 6 complaints escalated to the Ombudsman 4 were not upheld, one was partly upheld with no financial redress and another was referred back to the Trust for a local resolution. She mentioned the national inpatient survey results for 2021 had been released. She said the results were consistent with previous years with the most improved scores

relating to category of living hospital specifically of information giving, medication and self care on discharge. She said there were two areas of deterioration relating to waiting times of beds on arrival and also notice of period given upon discharge and clarity of answers given She reminded all to use none jargon and clear language for patients.

Resolved: the Report was received and noted

10.4 Infection Prevention & Control and Infection Prevention Board Assurance Framework (BAF) Report

Dr Macve said the Trust was below target of Polymerase Chain Reaction (PCR) and toxin testing. She said a new test in the Laboratory for *C-Difficile* had been introduced across the Black Country whereby a direct test could be undertaken for PCR rather than a different screening test first. She said the Trust was below external targets for E. coli, Klebsiella and Pseudomonas aeruginosa bacteraemia. She said the Trust was undertaking Carbapenemase-Producing Enterobacterales (CPE) screening which was positive in identifying patients for CPE. She said there had also been an increase in device related bacteraemias.
Mr Reid introduced the Board Assurance Framework (BAF) and said the National BAF was updated in September which had a reduction in key line enquiries from 124 to 97. He said the Trust currently had zero reds,7 ambers and 90 greens. He said 3 of the ambers related to single room provision in the organisation which was also on the Trust's Risk Register with 2 relating to ventilation.

Resolved: the Report was received and noted

10.5 Midwifery Services Report

Ms Cheshire said the Trust continued to work towards the National Maternity Transformation Program. She said the nationally target of achievement had been removed and the Trust was looking at the development of local plans. She said the Trust continued to make progress with the 7 immediate and essential actions from the Ockendon Report. She said a national team was reviewing the Ockendon Long Term Plan. She mentioned a CQC inspection took place at the end of October, a report had been received and work had commenced from feedback received. She said positive progress was being made with the Maternity Voice Partnership. She highlighted from the Clinical Negligence Scheme for Trusts (CNST) Team Maternity Incentive Scheme the Trust's compliance for Safety Action 8 on training was being monitored. She said due to staff shortages some training was cancelled.

Ms Hickman asked about the trajectory on training for midwifery.
Ms Cheshire said she would forward information to Ms Hickman.

Action Ms Cheshire to forward information to Ms Hickman

Resolved: the Report was received and noted

10.6 Winter Plan 2022/23 – Royal Wolverhampton and Wolverhampton Place

Ms Nuttall said the report was a highlight report which mentioned some additional schemes being incorporated particularly within Division 2. She said she would include in the next TMC report funding allocation which had been received. She mentioned there had been national allocation for additional beds. She said the Trust was to receive £570 thousand for the additional 10 beds which were opened at the Trust. She said Wolverhampton Place Winter Scheme had allocated over £1 million and the Trust had secured £7 thousand of that money predominantly for the Community Schemes with some funding towards the ARC. Ms Nuttall said she would keep the item on the agenda for TMC to advise of updates.

Resolved: the Report was received and noted

10.7 Contracting and Investment Group Terms of Reference

Mr Evans said the terms of reference had been amended to align with the same process with Walsall Healthcare NHS Trust (WHT)

Resolved: the Contracting and Investment Group Terms of Reference be approved

10.8 Sustainability Report

Mr Evans highlighted the Trust may have to submit bids to achieve some of the carbon solutions longer term due to some of the expectations that by 2035 would require National funding.

Resolved: the Report was received and noted

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11 Business Cases

11.1 Division 1 - none this month

11.2 Division 2 - none this month

11.3 Division 3 - none this month

11.4 Corporate - none this month

12 Outline/proposals for change

13 Policies/Strategies

13.1 Policies, Procedures, Guidelines and Strategies Update

13.1.1 OP111 De-identification and Pseudonymisation Policy

Resolved: OP111 De-identification and Pseudonymisation Policy was approved.

13.1.2 Guideline for the management of direct oral anticoagulant (DOAC) associated bleeding

Resolved: Guideline for the management of direct oral anticoagulant (DOAC) associated bleeding was approved.

13.1.3 OP09 Corporate Policy and Framework for the Governance of Partnership Agreements

Resolved: OP09 Corporate Policy and Framework for the Governance of Partnership Agreements was approved

13.1.4 GP02 Local Anti-Fraud, Bribery and Corruption Policy

Resolved: GP02 Local Anti-Fraud, Bribery and Corruption Policy was approved.

13.1.5 OP91, Data Quality Policy

Resolved: OP91, Data Quality Policy was approved

14 Any new Risks or changed risks as a result of the meeting - none

15 AOB

1. Prof Loughton highlighted all should discuss with staff any thoughts on and anticipated Industrial action. He said this should be undertaken in a friendly manner and he was supportive of staff getting a reasonable pay rise.
2. He asked all to be mindful on what could be offered to staff to try and assist with the current standard of living for example he mentioned the £1.50 meals which supported staff which was positive.

3. He also mentioned an email was circulated to staff on Group roles

16 Date and time of the next meeting Friday 27 January 2023 at 1:30pm

The Royal Wolverhampton NHS Trust

Minutes of the Quality Governance Assurance Committee:

Quorum: 4 members must be present consisting of 2 Executive Directors and 2 NED members. No tabled papers except with Chair's approval.

Date	**Thursday 24th November 2022**
Venue	**Virtual (via MS Teams due to COVID 19)**
Time	**9:00pm – 11:00pm**

	Name	**Role**
Present:	Louise Toner **(LT)** Chair	Non-Executive Director
	Maria Arthur **(MA)**	Group Deputy Director of Assurance
	Kate Cheshire **(KC)** Part	Head of Midwifery & Neonatal Services
	Allison Heseltine **(AH)** Part	Associate Non-Executive Director
	Debra Hickman **(DH)**	Director of Nursing
	Julie Jones **(JJ)**	Non-Executive Director
	Dr B McKaig **(BM)**	Chief Medical Officer
	Michelle Metcalfe **(MMe)**	Group Deputy Director of Assurance
	Martina Morris **(MMo)**	Deputy Director of Nursing
	Dr J Odum **(JO) -** Part	Chief Medical Officer
	Keith Wilshere **(KW)**	Group Company Secretary
Attending	Alison Dowling **(AD)**	Head of Patient Experience & Public Involvement
	Kate Cheshire **(KC)**	Head of Midwifery and Neonatal Services
	Matt Reid **(MR)**	Head of Nursing – Corporate Suport Services

Apologies:	Dr G Pickavance **(GP)**	Non-Executive Director
	Gwen Nuttall **(GN)**	Chief Operating Officer

Item No		Action
1	**Apologies for absence** Apologies were noted.	
1a	**Declarations of Interest** None declared	
2	**Minutes of the Previous Quality Governance Assurance Committee dated 26 October 2022** The minutes dated October 2022 were accepted as a true and accurate record.	
3	**Matters arising from the Minutes** Actions Page 2 – Corrections to September minutes have been completed. Page 2 - Circulation of the membership of LEG. – MA advised this has been completed and will send following this meeting. Page 4 – GN to obtain more details on ambulance wait times if the longest handover time could be incorporated into the report - to be picked up with GN on her attendance. DH added to recognise the IQPR, the matrix that is ongoing behind the screens. Page 5 – GN Appraisal of staff to be picked up at the People meeting on Friday 28th October- to be picked up by GN Page 6 – GN and NICE guidance – To be picked up in the QSAG report. Page 6 – Clarification on comments relating to Deteriorating Patient Group – BM advised the full DPG report that comes out in the minutes gives clarity around what the discussion was. BM to pick up in QSAG report. Page 6 – Perinatal Mortality – LT advised she has met with Tracey Palmer (TP) and all concerns have been addressed and maternity papers will be discussed later in the meeting.	
4	**Regular Reports**	
4.1	**Cancer Improvement Plan (for information only)** Paper was received and acknowledged by the group. Due to absence of GN the paper was not presented.	
4.2	**Trust Risk Register – M Arthur** MA advised the group that going forward although she would continue to be an attendee at this meeting the actual portfolio splitting Governance will mean that MM will take on the reporting of the Trust Risk Register (TRR) MA aid there were no new risks to escalate. Three are being downgraded from the TRR. All have got rationale. **Risk 5681** staff shortages within plan care team in Division Three is being managed at grade 9 amber. **Risk 5776** Lack of IT support. – There is now IT support and this has been downgraded to local management at Grade 8. **Risk 5785** Delay in patient information leaflets. – Some mitigations have been put in place to include a paper proposed to standardise information leaflet management across both trusts. This risk has been downgraded to a yellow.	

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	MA said most of the eight red risks have had a review. In terms of their positive/ negative assurances risk 5802, Division Two medically fit for discharge risk, November's positive assurance introduced that they are trailing a push model which is showing some improvements in some metrics around handover within 60 minutes length of stay in. LT asked BM what the push model was that she had seen mentioned in his report. BM answered it is a model developed within North Bristol NHS whereby when patients are ready to proceed from ED that they are on an hour by hour basis then moved to the ward basis. There is an element of boarding that is attached to the North Bristol Model which we as an organisation feel creates risk in other areas and it's about managing where the most appropriate places to have that risk. We do recognise there are some benefits to come from that in that if we are aware of planned discharges then that pressure is knowing that a patient is enroute as it may precipitate a move to the discharge lounge or to sitting out so that the patient coming in can be accommodated. What we do not feel is appropriate is to have patients boarding on wards and having excessive numbers of patients without the appropriate equipment on the wards in those areas. There are other elements in the North Bristol model that we are trying to embrace along with other things including criteria led discharge to try and improve the organisation. BM it is all about trying to improve the speed at which patients move from ED to base wards, from AMU to base wards and from base wards to discharge lounge or discharge. MA advised the discharge lounge arrivals is showing improvements within the hour and is showing in the positive assurance this month. Negative assurance for that risk around still having some short term increases in medical discharge patient numbers in November and still needing to use surgical beds for outlaying medical patients **Risk 5246** – Lack of consultant cover within cancer services. Positive for this month is unchanged. The negative assurance show there are some remaining vacances within the cancer team that being one medical oncologist, one clinical oncologist and confirmation of a replacement for a Melanoma consultant. **Risk 1984** – Backlog of Ophthalmology patients. Positive assurance are a glaucoma consultant has been recruited to start February 2023 and a proposal paper being put out for outsourcing approximately 5000 glaucoma patients which is awaiting an outcome. **Risk 4900** – Histology is reaching turnaround times again. There has been some positive assurance in terms of daily monitoring of the oldest outstanding cases in terms of the lab processes. There is negative assurance around vacancies across al three sites. Ten vacancies reported and they are looking to review their operating model to manage that in the interim. **Risk 5667** – Cancer backlog- There has not been any. It has been reviewed but there have not been any changes to the assurances this month. MA pointed out there were at least four of the red risks that have been longstanding ones with some going back to 2008. These are the ones we will see on our heat map that we have not been able to progress quickly. **Trust Risk Register Heat Maps. – M Arthur**	

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	MA said there are no new risks to update the ratings with nothing further to report on the heat maps. **Board Assurance Framework (BAF) – K Wilshere** KW said we are in transformation with the BAF going from the old template to the new template therefore the ones attached this month are a draft and there are areas to be completed. The two for the committee to look at are 15 and 16, these being the financial and recovery performance and the implications of that particularly around cancer. The new one is regarding equality, diversity and inclusion SR-70 for information. KW said the Performance and Finance committee agreed to increase the risk score of SR 15 to 20 given the increasing and potential declaration of an increased overspend this year. SR 16 remains at 20 due to no significant positive move with it at the moment. KW advised there will be a full development session in the new year around the new template. This committee said it would keep an eye under section nine of the cover report for any potential emerging risks regarding maternity or emergency CQC reviews unless LT thought there was any move on those or at the end of the meeting any potential risks you think might be emerging. LT said given things are getting better but not as well as it might be it would be best to continue keeping an eye on things and asked for members thoughts. DH agreed stating although there are comprehensive plans around both, they are very much staff dependant. KW agreed. MA mentioned there was an OP10 categorisation matrix document within the papers and she was not sure if that was an item or if that was just for reference. MA pointed out that the attached was dated 2018 whereby the latest one should be September 2020. MA advised the September 2020 is in the policy.	
4.3	**Integrated Quality & Performance Report November 2022 – DH** DH said there has been challenges in observations on time. There have been discussions with the teams. and quality away days with the band 7's and they were received extremely well noting there have been a number of new staff in post, some new to the NHS. DH said we have seen some performance improvements at Walsall where they have introduced certain things and these are being piloted across our areas. DH said there are a number of factors affecting this in terms of if we have a bay of patients that are due observations at 10am and they start at 10am then we are already on behind. In terms of the visualisation around the observations and the vitals and having that watching eye, this has not been achievable in all areas. We have some good performance and some individual pockets where we have significant under performance which is pulling down that overarching. The targets working with the senior nurses across the organisation in terms of focus has been happening over the last 4-6 weeks and we are seeing from November's data an upward trend in improved performance. The actions taken seem to be making a difference and this will continue to be monitored.	

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	DH advised page eight of the report shows from a CDif perspective there was a spike in October. A task & finish group was set up to look at the action plan to complete some analysis. Decamp facility is coming back now work has been completed on Wards 26 and 14. The challenge moving through winter will be how to facilitate that due to having to move areas taking a lot of resource. DH mentioned that the Trust have asked for a regional support visit with this being a national problem and not just a problem at RWT. DH stressed from an RWT perspective we are not an outlier although that's not to say we should not be learning the lessons. The Trust is awaiting feedback from NHSI as to when that can take place. DH stressed the positive to take from this is that of the nine cases there were only linkage between two cases demonstrating that we have not got that internal transmission which is positive. It is the understanding as to why we are getting these transient months where these spikes are seen. What we see is behind some of these cases there are complex patients in terms of their journey and their management. LT asked about the review that was mentioned. DH replied we have asked for NSH regional lead Kirsty Morgan if she could come and test out the action plan, review the output of the task and finish group, look at the ward environments and undertake some analysis. We are waiting on a date and time for this to be undertaken. DH said Infection Prevention are at a conference today looking at this and it will be interesting to see what comes from that. From a Performance perspective, recognising stranded patients is going down. Medically fit we are also seeing is going down and where we were above 100 we are now approximately 80 with some interesting conversation within ICB around place and local authorities role and remit. We know we have the additional monies allocated and understanding in terms of the winter plan how that expedites that work. LT asked if the money has come through. DH replied she was not aware although the letter of commitment had been received. LT said at the pre meet GP was talking about the vacancies in care homes, how They were having to decrease staffing in care homes due to not enough patients coming through whilst recognising that some of the care homes do not provide short term care. LT confirmed with JJ that they are undertaking a piece of work targeting this area. BM said it was part of the overall winter plan agreed by PLACE to look at how those monies will be looked at. There is some concern in Wolverhampton social care that the amount Wolverhampton Local Authority pay social care is less than other local authorities which causes issues with staffing. We are anticipating a plan coming through Local Authority on how those additional monies are going to be utilised for those sort of issues and what the rates of pay will be. We are primed to work with the authority and to challenge them to an extent to ensure that rates of pay are competitive to attract people into those roles. This will be seen as part of the winter plan. DH said there is a lot of focus and a lot of work going on around ambulance handovers with ARC due to open on November 28th. Staffing is precarious at best, although the plans have been appropriate, it is due to the ability to recruit locally. A large number are international recruits and the challenges around that pipeline and the ability to expedite it. The conversation had by Directorate to divisions are that we move towards that stance	

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	recognising the requirement of seventeen beds consistently 24 hrs seven days per week is not necessarily the need but the ability to be able to flex to meet demand as required. All of the work that is in place around the push pilot, criteria led handover, discharge, expansion of the virtual ward. All of these are winter plan as well all come together to support that movement and focus on ambulance handovers. We had the report from the regional peer visits which were not highlighting anything that we were already aware of. There will be a revisit proposed for early December with the focus being the North Bristol model. LT asked if the ARC will be open seven days a week. DH said at present due to staffing and challenges faced it would on a flex capacity with daily conversation taking place. LT noted, page 10 of the report refers to a shared professional decision-making council, if this was something we had set up. DH replied it was. They are forums run internally bringing stakeholders together to identify what reasonable solutions would be to an issue. Staff contribute well and they have been used for pressure injuries and falls in the past and output is seen by way of improvement. It is a positive improvement in terms of quality improvement. MMo said it is also about breaking the barriers and a non-hierarchy approach. Any staff members are involved in decision making councils empowering everybody to be part of the solution. **Cancer Improvement Metrix – BM** BM said the demand around fast track is still significantly above where it was pre covid. The month previously it was approximately145% and this month it is approximately 130% resulting in real challenges around 62 day targets and 28 day faster diagnosis. BM said In the numbers of patients coming through post 104 day harm we are not seeing significant numbers of physical harm and documented psychological harm although a discussion has been held previously as to how valid that metrix around psychological harm really is. It is recognised that patients are struggling as seen in social medial and newspapers. Urology and particularly renal cancers are difficult where there is a nation shortage of individuals who can do robotic nephrectomies. We have that facility here and that Consultant has been training someone from Dudley to try and increase that capacity. Unfortunately our Consultant will be taking compassionate leave affecting our capacity to undertake renal tumours. The intention when the consultant comes back is for the consultant from Dudley to run parallel theatres with two robots in the theatre side by side increasing our capacity. Waiting times are currently over a year although renal tumours are very slow growing and therefore you do not tend to see harm as a result of that. BM said in terms of the 104 day harm where DH chairs we have been having productive discussions on how we try and make that a sleeker meeting and how we pick up the themes and build them then into the cancer oversight group which is being restarted in order for less onus to be put on the clinicians. We are looking at how we can optimise the efficiency of MDT's recognising the vast amount of work and time they consume from the consulting body.	

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	LT said GP was very interested in urology and the renal tumours. LT spoke about the IQPR and asked regarding the hospital acquired VTE and dual prescribing. BM replied work is happening on how best to report it. Discussions have included reporting VTE as a thromboembolic event per thousand admissions to give an indication of levels of harm. The data is still visible at QSAG in terms of if there are specific services that are struggling with those compliance. In terms of dual prescribing this was a theme of work initiated by the previous Patient Safety Specialist. This was a case where there had been a significant harm death associated with somebody who had been described both Warfarin and Adoac. Whether or not it caused death was contentious however it was still picked up as a contributory factor. We had a look back exercise and recognised that there had been five or six episodes. We know that EPMA is not particularly well set up to alert people to this. There has been making it better alerts, work done by the VTE team and recurrent remainders going out around the importance identifying and preventing dual prescription. There has not been any in the last two quarters We are hopeful the information sharing has improved although this is not known as yet and the system making it impossible to do this. There is an alert that comes up that was identified nationally and it was agreed to put that alert on a national level from the work we had done. BM said it was very difficult as when you try and prescribe something through EPMA you will get around six alerts each time, LT said the maternity report also advised of 10% incidents of Perry Partum Hysterectomies and she will pick this up with KC outside of the meeting. At this time LT welcomed AH to the meeting. AH asked DH for an update with regards to the IQPR the continued deterioration of patient observations. DH advised this had been discussed in this meeting and DH and AH agreed to pick up outside of the meeting.	LT/ KC
5	**Subgroup Reports**	
5.1	**Quality & Safety Advisory Group Meeting – November 2022 – Chair's Report – Dr B McKaig** BM stated he had sent around a list of attachments of the various meetings that feed into QSAG to clear up any confusion as to how all the different groups that come through and that we are trying to align those groups, agendas and timing reports across both organisations. BM said he is aware the QSAG minutes follows the chair's report that comes here therefore in his Chair's report he tries to take the salient points of what the different groups are bringing to the meeting in terms of their assure, alert, advise criteria and then adding in any intelligence comments that come from that meeting. BM said if the group wanted the report to be completed differently he was happy to adapt it. BM said from the meeting held last week the 104 day harm shows there were no elements of physical or psychological harm identified. The EDI group reported and it was predominately around assurance they are acting within obligations and their draft five objectives for moving forward have been circulated. Once they	

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	are approved they will come back to the committee. The objectives were all appropriate and around staffing opportunities for staff and attracting and retaining people ensuring staff have got the same opportunities around progression, speaking out and also linking into the REST data. BM said Learning from Experience group (LEG) is going through a transitional phase with the development of the Patient Safety Incident Reporting Framework agenda (PSIRF). PSIRF will be developing over the next six to nine months and the work LEG currently do will feed into that. The idea is identifying themes which we can then triangulate with other bits of information and intelligence to then say what are the themes through PSIRF that we then want to work on as an organisation. BM said the report shows the key outcomes. These are taken from complaints from complaints and from RCA's predominately. At the present time due to no transition to PSIRF there is no specific work that LEG are doing around those at the moment as it is felt that may start something that may not necessarily lead into the old PSIRF agenda. MMe informed the group the ICB are now setting up their PSIRF implementation group. It is very much about having a system wide approach to PSIRF and to be able to share the learning Across the whole system which will benefit our patients. **Organ Donation** – BM said the Trust is deemed a level two in organ donation and we are Aspiring to become a level one. There are not many non-transplant organisations that are a level one and it is around the numbers and percentages of potential donors who go on to donate. Prior to Covid we had three years that put us at level one data. We were about to be called a level one Trust and then it was suspended due to Covid with organ donations dropping around the country. We are now back on track in terms of 100% referral rate. BM said he had discussion with the Clinical lead for the organ donation group and with one consultant stepping down they were keen to find a non-medic who has got an association or affiliation with organ donation to join the group, to drive it forward and give it a different profile. BM advised he is gathering that information and then it will be distributed via comms to find an appropriate chair whilst still having a clinical lead. **Patient Experience report** – BM said the report shows the number of complaints. Of those referred to the Ombudsman only was upheld which resulted in a letter of apology with no financial implications. The report shows details of the CQC inpatient survey showing where there has been improvement and where there has been deterioration relating to bed availability on arrival. BM acknowledged the amount of work AD and the patient experience team do around complaints and compliance with turn around times and responses statin we are well below the national average in terms of numbers of complaints upheld. **Safeguarding Report** – BM said the Safeguarding report focused mainly on training and compliance with training. Some areas require targeted interaction. There has been significant increase in the number of unaccompanied asylum seeking children referrals through the multi agency meetings. The alert is around young people in care and low in compliance. Currently working with the local authority and Division three with the community teams to try and address that. **Audit Plan** – BM said the audit plan report was very positive in terms of feeling assured that the number of audits are on track particularly all the NCAPOP and NICED related audits whilst remaining confident we will hit what we need to by the end of the year. The Assurance	

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	and Governance teams are working on how to structure our audit teams going forward across both organisations to provide equivalent levels of support. There was an issue around the difficulty in complying with one of the Ophthalmology audits due to the electronic note system not yet implemented within Opthalmology. The business case has been approved. The issues are around implementation of that through the supplier And it will take some time before we are able to comply with that audit. LT asked looking at what will be required mandatorily in the future will we be penalised if we cannot complete audits due to not having the electronic system. BM replied we do not get penalised although we should be contributing as it is a national audit. We need to be able to assure ourselves that we are not a significant outlier by triangulating other metrics through that. LT queried the number of audits stating of the 65 national audits we are doing 57 with another 3 coming on and was not sure of the numbers. BM advised only 60 of the 65 audits were relevant to us and we are contributing to them. Of the audits that have been completed, in 68% of them we are fully compliant and of the 32% we are not compliant with they are minor issues. **External reviews** – BM said there were 40 external reviews which we evaluated. The majority of which QSAG were happy to sign off. They were rated as green in terms of responses. There was one rated as a risk red around staffing of FY1's in general surgery. There had been an external review from HEE. Significant work has been completed here in terms of changes to job plans for consultants to ensure there is supervision time within that, additional staff being employed through the Fellowship programme. **Divisional Reports** – BM said the overarching theme coming through from all three divisions here was staffing. BM, DH and GN have had discussions with divisional teams, Kevin. Allen and David to explore and develop as many options to make it attractive for our staff to be able to undertake bank work and fill as many of the gaps as possible. There are some staff who are due to come on board. We do need to keep an onus on individual departments doing their own recruitment and retention exercises. BM said staffing across the organisation is challenging and this is reflected in the risk register. BM said the final pathology lab from City and Sandwell is due to come across by the end of November and therefore all of histopathology will be on site allowing some efficiency and improvements to the metrics particularly around histopathology turnaround times which we are aware is sitting as a red risk and impacting on cancer performance. AH asked if the delays on some of the NICE guidance and SI's are related to staffing as well. BM they probably are although some of the delays are historical particularly with Division one. This was picked up at QSAG and the Divisional Medical Director for Division One has had discussions with the areas responsible for those guidelines so we hope to see some movement. We have been assured these are not guidelines which are not deemed to be critical in terms of the NICE guidance changes and patient safety. DH supported what BM had said recognising that although staffing is a challenge not everything should be associated to staffing.	

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5.3	**Patient Experience Strategy Report – A Dowling** AD said the report is for members to have a vision of what is seen for the patient experience and patient experience enabling strategy for 2022 to 2025. This is the first strategy for patient experience in collaboration with Walsall Healthcare and it is hoped this will strengthen our approach towards patient experience, engagement and public involvement. The aim is to work more closely with local councils and partners on how we drive forward improvements in patient experience. It is based on three pillars of improvements – involvement, engagement and the experience. Some of this work has already begun. AD aid they are now an earlier adopter of the Ombudsman standard framework which is hoping to be rolled out nationally. Our approach to complaint handling has tightened over the last month in terms of complaint handling with the with the Directorates, establishing grounds for extensions, complaints and timescales. In terms of experience, we have completed an audit of the ward rounds. In the forthcoming weeks we will try to centralise some of the information and make sure it is clear and accessible for the patients. The patient experience agenda will be put back on the Preceptorship program. It is very important to work with newly qualified staff on what good patient experience looks like and the impact they can have on that both negatively and positively. We think the strategy will outline how the patient voice is so important in some of those key decisions. Some of the work that is already being done around coproduction will be expanded and a communication will be going out in the next few days. Update will be shared in due course. JJ said this was a great document and congratulated everyone that had helped in putting it together. JJ said she would like to see timescales added to this measure. This is a three year strategy and something will be done earlier than the three years to be able to have the effect wanted, JJ wanted to make sure that as a committee when we hear back from AD on the implementation of this is happening that we know the timescales you are working to and that if there are occasions when you need extra support to achieve by that you will get the support. JJ asked how often would the committee hear back for AD for updates. AD advised a new patient experience framework for reporting had been introduced underpinned by a feedback group where matrons and divisions represent and a lot of the actions for this strategy will go through those groups, AD advised she was happy to come back with quarterly updates. DH suggested to work up the timescales and then confirm the reporting back as to whether it is quarterly or biannually. MMe said one of the founding principles of the new PSIRF is to get families and patients more involved in reviews of incidents etc and felt it was important to have close liaison between each other to ensure we are looking at this from both the PSIRF patient safety angle and from the Patient Experience team. MMe added it would be good to make sure those links are really solid. AD agreed adding recruitment was taking place for the patient safety partners. LT reiterated it was a really good report and looked forward to hearing on the progress.	
6	**Assurance Reporting / Themed Reviews / Business**	

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6.1	**Infection Prevention – M Reid** MR said they are below or at external targets for Gram negative, bacteria (E-coli, Klebsiella and P. aeruginosa) CPE screening will continue to identify cases. In one of the alert boxes in the report there was a blood stream infection in October which was an unusual occurrence. A meeting was held to discuss this, 89 year old patient who had no identified risk factors for CPE colonisation and had no invasive devices. It was very difficult to ascertain where this may have come from. Blanket screening showed no other cases. A full RCA is awaited. There are still challenges around C. diff and we now have a C diff group that commenced in October. MR said IP were above their internal targets MSSA, blood streaming infections, MRSA acquisitions and device related bacteremia's. There were a couple of cases MSSA on the neonatal units that was reported as an SI that was subsequently downgraded to a period of increased instance (PII) because the typing showed no link between those two cases. MR advised yesterday indicated there were seven cases of flu in the organization, three in AMU and four on separate wards one of those being Pediatrics. Point of Care testing in ED – Staff will be able to test for Covid and flu point of care although it is a separate test they have to do. The IP BAF was revised nationally the end of September. The number of key lines of enquiry (KLOE's) reduced down to 97 from 124. The report shows no red. There were seven where we were assessed as amber, three of those around single room capacity which is something that sits on the risk register here and ventilation as well. There is a ventilation group in the organization and we are awaiting on a survey of the organization which an external contractor will do. Estates do not have a timescale for this at the moment. LT asked if there was anything that we could do to help to secure what needed to be secured. MR said there have been discussions previously in the organisation around PECC (Patient Equipment Cleaning Centre). This was a business case that has not approved two times. MR said he and DH would like to revisit this. DH said the work will be to get it through the channels. If it reaches a block then they will come back for support and escalate it and any additional support if required. DH said she would meet up with AH to talk through in detail which may be helpful in terms of support and awareness.	DH/ AH
6.2	**Litigation & Inquest Report – First Half Year report - K Wilshere** **Clinical Negligence** - KW said we continue to see an increase in the numbers and complexity some due to delayed treatment from Covid, some to do with Ophthalmology and Cytology. **Personal Injury cases**- We continue to try and manage down as far as possible bur we do have those within the theme stated. We continue to get needlestick injuries despite the amount of work done in the past to try and mange those. We have one PFD inquest.	

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	There are no new data breach claims. We have some pre claims around gynecology investigations. We are currently looking through our latest GIRFT analysis KW said he was happy to take any questions around individual details outside of the meeting LT stated at the September meeting, which she was not present at, there was some discussion about this report and how it relates to other reports. It was discussed that this report was just the factual information and things are picked up other groups. KW referred LT to page 26a where he had put a note in around the context of the report. AH referred to the coroner's inquest piece of the blood results, miss fractures and the deaths in ED. AH said there were no things there that we had gone through in any details in any of the other groups and asked where that learning is sitting, how are we informed at the time and how is that learning shared across the whole of the organisation particularly with the broader things as opposed to just a departmental thing. KW said in terms of any of the legal processes it is fed back both to the services and into the learning from experience structure. BM said those issues will come through in the SUI reports ad they are discussed at ESERG and QSAG and then escalated. BM gave an example of the coroners inquest blood results. This case was reviewed extensively and was felt not to be a SUI. However the impact, results and the actions have all been picked up and fed back. We know about and had sight of all the Ophthalmology incidents. In terms of the numbers of fractures and falls etc in ED this is a consistent theme. BM said he saw some of this triangulating potentially depending on where it sits is through some of the PSIRF work and themes. We know nationally, and this is where the GIRFT information comes in is how do we benchmark as an organisation around those metrics and where we are outliers is then those pieces of work. That will come through in different areas. It will come through with some of these reports and probably come back six months later after the clinical incident may have been discussed. The Ophthalmology were over a year old when they were discussed but they all do come through. MA said where incidents are either SUI's or RCA's there is the immediate learning through the action plans and we also extract from that items that might need to go into the Risky Business newsletter and making it better alerts for immediate learning and this is how it is shared across the Trust. We get the twelve month theme review at the LEG group. We compare that to claims to incidents to complains to safeguarding to mortality outcomes. That would be outlined in the report that M|A said she I share with members after the meeting along with the minutes when they are ready. MA mentioned within the Governance arrangement that's recently changed we have got portfolios for the three deputies, one of them is about testing and that is one thing we know we have not got greatly developed as the others so how do we go back to evaluate and measure that we made the improvement we had intended. This shows there is work that still needs developing.	
6.3	**Trust Clinical Audit annual report** Deferred	

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7	**Themed Review Items** No reports this month	
8	**Issues of Significance for audit committee** There were no issues to escalate. **Issues of Significance for the Trust Board** There were no issues to escalate.	
9	**Any Other Business** **Terms of Reference – L Toner** LT said TOR had not been discussed due to trying to align QGAC from RWT and Walsall. And there have been initial discussions between KW and KB with further discussions in the future. The reporting structure underneath quality and safety are separate in Walsall but together in RWT and that is why there is a significant difference in the papers that go to each committee. We decided we needed to sort out TOR for this group in the meantime. Items in red are the additions. MA confirmed those marked in red had been added confirming the rest of the TOR had not changed. IT was to canvas the members views in terms of areas that may require updating. Regarding point 8 MA said a once yearly joint audit committee and Governance and QCAG meeting is held and asked whether that should continue. KW said this needs to be changed and will feed back after the meeting. MA asked for comments/ updates by the end of next week. The document to be circulated as a word document in order to make changes. **Midwifery Services QGAC Report – K Cheshire** KC provided assurance the Maternity Services are meeting the standards for safety action one for work and for CNST. The report gives a synopsis of the perinatal mortality cases for 1st October until present time and includes three neonatal deaths that were all born elsewhere and moved to New Cross for high level neonatal intensive care and no stillbirths. The grading for each of these cases showed no significant concerns with the care for neonatal deaths showing one case where lessons could be learned and that has been implemented into care. KC advised the meeting of six open maternity SUI HSIB cases currently as detailed in the appendix. Five cases are being investigated by HSIB currently. KC alerted the committee with regards to the Maternity local dashboard that bookings remain high and a slight increase in trend. The overall plan for 5000 births is still looking to be a realistic number for us. Monitoring of both booking and birth rates are taking place monthly. Smoking at time of delivery remain above target of 6% nationally by March 2023. We have seen a reduction in quarter two. We are still in discussions for a fully commissioned service	**All**

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	for smoking cessation and so currently remains as a cost pressure following some funding from NHSE previously. KC said Induction rates for quarter three are stabilising and overall remain around 36% in line with the national rates. Work is ongoing at regional level as part of a quality improvement project across the LM&S around escalation and collaborative working for Maternity services and around reducing the delays once inductions have started. Influencing factors why the rates are so much higher than it used to be around complex pregnancies – The increase of women with complexity pregnancies which require a higher rate of inductions and changes in guidance and increase surveillance for those high risk pregnancies in line with saving babies lives. LT said the QSAG report showed that the one to one care in labour is being maintained but the report suggested that in 19% of the shifts they were two midwives short. KC said they have a staffing plan and are actively recruiting. A problem not faced in Wolverhampton before is difficulty in recruiting to the vacancies. Further challenges have included staff who were here during covid and then deciding to retire, staff who had retired and returned to work then deciding to fully retire and having a cohort of students qualifying once a year. In addition there is a lot of investment following Ockendon into specialist posts across the whole of the LM&S. We have seen that staff we are developing and getting ready for promotion have gone into these roles either at an LM&S level or senior roles in other organisations which is great but it means that all the Trusts are in the same position. KC said locally we do our staffing huddle and we will be introducing a duty manager who will make sure the flow of staff moves according to the activity throughout the day and take the pressure of the Band 7 coordinator on delivery suite through the busy periods in the day so that we can redeploy staff to the most appropriate place. The ante natal ward has opened although not fully staffed yet it is hoped to be fully staffed and open the beginning of January 2023. This will mean women who are not in labour can be moved off the top floor much quicker. There will be somewhere to take patients when they are on triage and hopefully the levels of staff across the board. KC said a recruitment day was held yesterday and some staff recruited and we are on conversation with our students to make sure they know there will be jobs for them. LT said one of the universities is doing two intakes a year that being September and January with the first group coming out in 12-18 months. LT said we are a level three neonatal unit and in the QSAG report it says we are required to have 2000 care days in order to maintain that level 3 status. TL asked how far are we from that. KC advised this is not being achieved currently and will not be achieved this financial year. 2000 care days if the minimum requirement for a level 3. KC said she did not think there was any possibility of us losing our level 3. What is concerning is that to maintain competence you have to that sort of level of intensive care babies, not just for the medics but for the nursing staff as well. We need babies to be able to train our qualified youth speciality nurses currently on the course. We need to make sure they are getting exposure to level three babies.	

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	The challenges to achieving the care days are, firstly getting our babies moved back to the level two units and when they are at HDU level. Other units generally accept if they were born or booked at their unit. What we need to see is babies from Wolverhampton that have booked and born here that are now requiring HDU or special care level that they go to the level 2 units and this is not happening. We are working with the network to try and get this right. Secondly the other challenge is through delivery suite. Our transfers are getting refused at delivery suite because of increased workload and staffing. The mortality and morbidity risk if you transfer Ex-Uterine Transfer – (EUT - after the baby is born) is significant and so we need to get these babies as an inta-uterine Transfer (IUT). DH said clearly there is a significant culture risk required not just within the network but within our populations. DH asked KC if in terms of the movement in terms of stepping down the level two it is more of a regional problem or is it a much wider. Numbers wise is it more local to us or is it more national. KC replied there is more acceptance of a national baby going back from us. If we have taken a baby in we stand a better chance of getting them back out if they are out of our area. Due to the West Midlands being a small geographical area even the parents do not want to move back. Even though they may have been booked and born at another unit once they have had level three care here they do not want to move anywhere else because they feel their baby is in the safest possible place. It is a cultural change. The network have appointed some staff to their team and it is hoped communications can be put out and all women at booking are told. It has been suggested t have a sign put up stating we are part of the LM&S network and we are one of the neonatal unit. KC said the aspiration is to have one triage service across Wolverhampton and Walsall. When women phone in to that service and sound like they are pre-term birth they will come to us. KC said the CQC preliminary report was received for factual accuracy and has now been returned to the CQC team for a final report to be received. Immediate feedback received stated women phoning in were not getting to speak to a midwife as quickly as they would like to see. Immediate changes have been made to the phone system to include call waiting and press1,2 etc for the reasons stated. This will enable us to dilute the number of calls going through to triage and also looking at the staffing of the areas to ensure there is somebody there to just take phone calls. This ideally will be out of the department in order to judge people purely on what they are telling us. LT said she had visited triage the other week and this is exactly what they were doing. BM said when talking about staffing it might be worth linking that to the opening of the ARC given that ambulance offloads are one of our key issues and opening ARC to its full potential given the staffing issues.	
9	**Evaluation of Meeting** The meeting finished on time. JJ said it was a good meeting. Having read the papers on Tuesday two important papers were missed that had not been circulated therefore felt she did not do as good a job today as she could have done had she had time to digest the papers.	

Item No		Action
	BM felt the discussion around the risk register was a more productive one aligning to the key issues. MA advised the group that herself and KW had met and discussed some of the issues regarding delay in papers that occurred at the last meeting. There are no iBabs or IT issues presenting now and we still struggle with getting papers in in a timely manner in terms of follow up. We do follow up prior the due date and follow up thereafter. We will make it a priority to get them out on time as soon as we get them. LT said mandatory training goes across Wolverhampton and Walsall but if people have done training elsewhere it has to be repeated here due to not being able to transfer that training across. LT thought there had been some discussion regarding passporting training across. LT said appraisals are low but what is not clear is if it is a particular group that are not getting the appraisal and it is that particular group all the time. DH advised we do get breakdown by grouping and will either send out or bring to the next meeting.	
10	**Date and time of Next Meeting:** **Wednesday 25th January 2023 at 1.00pm to 3.00pm, Via MS Teams**	