The Royal Wolverhampton NHS Trust

Public Trust Board Bundle

Date	06/06/2023
Time	10:00 - 11:37
Location	MS Teams Virtual Meeting
Chair	Sir David Nicholson

1 10:00	**Apologies for absence Jonathan Odum, Martin Levermore, Dr Umar Daraz, Lord Carter** Lead Chair Sir David Nicholson Additional Attendees Jon Fordham, Customer Success Manager GE Healthcare Sheila Gill Healthwatch Wolverhampton Cyril Randles, member of the public
2 10:01	**To receive declarations of interest from Directors and Officers** Lead Chair Sir David Nicholson Action to note
3 10:02	**Minutes of the meeting of the Board of Directors held on 4 April 2023** **Action** To approve **Lead** Chair Sir David Nicholson
4 10:04	**Matters arising and Board Action Points from the minutes of the meeting of the Board of Directors held on 4 April 2023** Lead Chair Sir David Nicholson Action to note
5 10:08	**Patient Story** Lead Head of Communications Hannah Murdoch Action to note Presenters Kate Cheshire, Deputy Director of Midwifery Katie Haywood Matron 11634014Patient Story Katherine v2 - YouTube
6 10:18	**Staff Voice - Radiotherapy physics team** Lead Group Director of Workforce, Alan Duffell attendees

Douglas Northover Clinical Scientist
Michelle Poulton

7 **Chief Executive's Report - verbal update**

10:28 Lead Group Chief Executive Officer Prof. Loughton/ Group Strategy Officer Simon Evans
this comprises the CEO Report and approved TMC minutes
Action to note

Comprises the CEO Report, approved TMC minutes and Freedom to Speak Up Report (including annual report) which is a national Requirement of organisations. Together with updates from the Group Chief Strategy Officer regarding the progression of

- the Group Strategic Aims and Objectives
- the Black Country Collaborative
- the Black Country Partnership

Please see the reading room (item 13) for relevant information 13.1.1, 13.1.2, 13.1.3 and 13.1.4, 13.3.4
Action to note

7.1 **Freedom to Speak Up Report**

Kerry Flint Lead Freedom to Speak up Guardian
Action to note

8.1 **OneWolverhampton Progress update Report**

10:33 Lead Group Chief Strategy Officer, Simon Evans
Action to note

Please see the reading room (item 13.4.8) for relevant information

8.2 **Quality Account approval**

Lead Group Director of Assurance Kevin Bostock
Action to approve

Please see the reading room (item 13.3.3) for relevant information

8.3 **Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy approval**

Lead Group Chief Strategy Officer, Simon Evans
Action to approve
Please see reading room (item 13.1.3) for relevant information

9.1 **People Organisational and Development Committee - Chair's Report May**
10:38
Presenter Alison Heseltine
Action to discuss

9.2 **Quality Governance Assurance Committee (QGAC) - Chair's Reports April and May**
10:43
Lead Prof. Louise Toner
Action to discuss

9.3 **Performance and Finance - Chair's Reports April and May**
10:48
Lead John Dunn
Action to discuss

9.4 **Audit Committee - Chair's Report**
10:58
Lead Julie Jones
Include the annual review of the activities.
Action to discuss

10.1 **Report of the Chief Financial Officer - Months 12 and 1**
11:03
Lead Group Chief Finance Officer and Deputy Chief Executive Officer Kevin Stringer
Action to discuss and note

10.2 **Chief Nursing Officer Director Nursing Report**
11:13
Lead Director of Nursing Debra Hickman
Comprises CNO Report, Nursing Midwifery Workforce, Patient Experience and Complaints Report, Infection Prevention and Safeguarding.
Action to discuss and note

10.3 **Midwifery Services Report**
11:18
Lead Director of Midwifery Tracy Palmer
Action to discuss and note

10.4 **Group Chief People Officer - Workforce Report**
11:23
Lead Group Chief People Officer Alan Duffell
Action to discuss and note

Please see the reading room (item 13.4.1) for relevant information

11.1 **Learning from Deaths Report**

11:28 Lead Chief Medical Officer, Brian McKaig
Action to discuss and note

12.1 **Any Other Business**

11:30

12.2 **Integrated Quality and Performance Report**

11:35 Lead Director of Nursing Debra Hickman/Chief Operating Officer Gwen Nuttall
Action to discuss and note.

Please see the reading room (item 12.2) for relevant information

12.3 **Questions from members of the public**

12.4 **Date and time of the next meeting 2 August 2023**

12.5 **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**

13 **Reading Room - Reference Packs for Information**

13.1.1 **CEO's Report and Strategic Reports**
additional information relating to agenda item 7

13.1.2 **Chief Executive's Report of the TMC held on 28 April 2023 and 26 May 2023**
Lead Group Chief Executive Officer Prof. Loughton
Action to note

13.1.3 **Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy**
Lead Group Chief Strategy Officer, Simon Evans
Action to approve
Additional information relating to agenda item 8.3

13.1.4 **Black Country Provider Collaboration Update**

Lead Group Chief Strategy Officer, Simon Evans
Action to note

13.2 Approved Committee minutes to note

13.2.1 Performance and Finance Committee minutes 22 March 2023 and 26 April 2023

13.2.2 People Organisational Development Committee Minutes 24 March 2023

13.2.3 Quality Governance Assurance Committee minutes 22 March 2023 and 26 April 2023

13.2.4 Trust Management Committee 28 April 2023 and 24 March 2023

13.2.5 Audit Committee minutes 9 February 2023 and 26 May 2023

13.3 Annual Reports

13.3.1 Emergency Preparedness Annual Report
Lead Chief Operating Officer, Gwen Nuttall
Action to note

13.3.2 Infection Prevention and Control Annual Report
Lead Director of Infection Prevention Dr Mcave
Action to note

13.3.3 Quality Account
Lead Director of Governance Kevin Bostock
Action to approve

Additional information relating to agenda item 8.2

13.3.4 Freedom to Speak Up Report
Lead Group Chief Executive/Kerry Flint Lead Freedom to Speak up Guardian
Action to note

13.4 Regular Reports

13.4.1 Executive Workforce Report

Lead Group Chief People Officer Alan Duffell
Action to note

Additional information relating to agenda item 10.4

13.4.2 Patient Experience & Complaints Report

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

13.4.3 Integrated Quality and Performance Report

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

Additional information relating to agenda item 12.2

13.4.4 Quality Improvement Team Update

Lead Group Strategy Officer Simon Evans
Action to note

13.4.5 Safeguarding Adults and Children Q4 Report

Presenter Fiona Pickford
Lead Director of Nursing Debra Hickman
Action to note

13.4.6 Nursing Skill Mix Report

Lead Director of Nursing Debra Hickman
Action to note

13.4.7 Three year delivery plan for maternity and neonatal services March 2023

Lead Director of Midwifery
Action to note

13.4.8 OneWolverhampton Progress update Report

Lead Group Chief Strategy Officer, Simon Evans
Action to note

Additional information relating to agenda item 8

13.4.9 Covid – 19 National Inquiry update

Lead Group Director of Assurance Kevin Bostock

Action to note

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 Development)	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
Ann-Marie Cannaby	Group Chief Nurse	Loyalty Interests	Professor	Vice-Chancellor's Health Advisory Board (Coventry University)
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. Unpaid 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
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
Susan Rawlings	Associate 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 (Residential 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 - Native 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
David Nicholson	Chairman	Outside Employment	Sandwell and West Birmingham Hospitals NHS Trust	Chair
David Nicholson	Chairman	Outside Employment	Non-Executive Director – Lifecycle	Non-Executive Director
David Nicholson	Chairman	Outside Employment	Global Health Innovation, Imperial	Visiting Professor

College

David Nicholson	Chairman	Shareholdings and other ownership interests	David Nicholson Healthcare Solutions	Sole Director
David Nicholson	Chairman	Outside employment	IPPR Health Advisory Committee	Member
David Nicholson	Chairman	Outside employment	KPMG Global	Advisor
David Nicholson	Chairman	Loyalty Interest		Spouse appointed National Director of Urgent and Emergency Care and Deputy Chief Operating Officer of the NHS (full-time)
David Nicholson	Chairman	Outside employment	Healthfund (investor in healthcare Africa)	Senior Operating Partner
David Nicholson	Chairman	Loyalty Interest		Spouse was Chief Executive of Birmingham Women's and Children's NHS Foundation Trust
David Nicholson	Chairman	Outside Employment	The Dudley Group NHS Foundation Trust	Chair

The Royal Wolverhampton NHS Trust (RWT)

Minutes of the meeting of the Board of Directors held on Tuesday 4 April 2023 at 9:30 am virtually via Microsoft Teams (MT)

PRESENT:

Mr J Dunn	Deputy Chair/Non-Executive Director
Prof. D Loughton (v) CBE	Group Chief Executive Officer,
Mr S Evans	Group Chief Strategy Officer,
Mr A Duffell	Group Chief People Officer,
Prof. L Toner	Non-Executive Director,
Ms S Rawlings	Associate Non-Executive Director,
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)	Non-Executive Director,
Ms D Hickman	Director of Nursing,
Prof. A-M Cannaby (v)	Group Chief Nursing Officer,
Mr M Levermore (v)	Non-Executive Director,
Mr K Bostock	Group Director of Assurance,
Dr J Odum (v)*	Group Chief Medical Officer,
Dr G Pickavance	Associate Non-Executive Director,
Ms P Boyle	Group Managing Director of Research and Development,
Ms A Harding	Associate Non-Executive Director,
Dr U Daraz	Associate Non-Executive Director,
Ms A Heseltine	Associate Non-Executive Director.

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

IN ATTENDANCE:

Ms S Banga	Operations Coordinator for the Company Secretary, RWT,
Ms M Zajac	Senior administrator for the Company Secretary, RWT,
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 C Wilson	Deputy Director of Nursing, RWT
Ms M Morris	Deputy Director of Nursing, RWT
Ms L Nickell	Group Director of Education and Training
Ms G Nightingale	Executive Assistant to Group Chief Executive
Ms R Jones	Healthcare Account Manager Netcall, member of the public
Mr J Vukmirovic	Reporter Express and Star, member of the public
Ms H Murdoch	Head of Communications, RWT
Mr T Nash	Communications Officer, RWT
Mr T Shayes	Deputy Chief Strategy Officer, RWT
Ms K Hickman	Contracts Manager, RWT
Ms H Williams	Business Development Manager RWT and WHT
Ms K Barrett	Contracts Manager, RWT
Ms J Cotton	Business Development Support Officer, RWT

APOLOGIES:

Sir David Nicholson	Chairman
Dr B McKaig	Chief Medical Officer
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Mr J Hemans	Non-Executive Director

Ms T Palmer	Director of Midwifery
Lord Carter	Strategic Advisor to the Board
Mr K Wilshere	Group Company Secretary

Part 1 – Open to the public
Mr Dunn welcomed all to the public meeting.

TB.9085: Nolan Principles
Mr Dunn highlighted the importance of the Nolan Principles being on the agenda. He said the principles included the way business was done, selflessness, integrity, objectivity, accountability, openness, honesty and leadership. He said the Trust's mission was to develop exceptional care together with improving the health and well-being of its community. He said it was important for all to role model both the Nolan Principles and Trust Values.

TB.9086: Apologies for absence
Mr Dunn noted apologies from Sir David Nicholson, Mr Wilshere, Mr Hemans, Ms Evans, Dr McKaig, Ms Palmer and Lord Carter.

TB.9087: To receive declarations of interest from Directors and Officers
Mr Dunn confirmed that there were no changes to the declarations published or that he had been notified of any conflicts arising from or in addition to the list of declarations provided, reviewed, and published in the papers. He reminded all Board members that they must review, identify, and declare any conflicts of interests arising from the business of the meeting prior to the meeting.

TB.9088: Minutes of the meeting of the Board of Directors held on 7th February
Mr Dunn asked if there were any specific comments for the accuracy of the minutes. Ms Hickman mentioned an amendment was required on the wording within the Integrated Quality and Performance report section. Mr Dunn asked that Ms Hickman liaise with Ms Banga to clarify wording of the paragraph, and not the minutes as an accurate record for the meeting.

Resolved: that the Minutes of the Board of Directors held on 7th February 2023 be approved as a true record subject to the amendments to be addressed by Ms Hickman.

TB.9089: Matters arising from the minutes of the meeting of the Board of Directors held on 7 February 2023

7 February 2023/TB 9053
Review of GI02, Financial Management Policy Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation
"Mr Stringer to arrange to speak with Ms Rawlings on how to improve the processes in Charity."
Mr Stringer said the Trust had appointed a dedicated finance resource to improve the process from the Charitable Committee whilst ensuring the Standing Financial Orders and Standing Orders are fully adopted. Mr Stringer said he would speak to Ms Rawlings after the meeting.
Action: it was agreed the action be closed.

7 February 2023/TB 9045
Infection Prevention & Control (IPC) and Infection Prevention Board Assurance

Framework (BAF) report
"Ms Hickman to speak to colleagues in relation to ventilation and timescales and feedback to Ms Heseltine."
Ms Hickman confirmed the timescale for the ventilation review had recently been confirmed by Estate colleagues and feedback had been forwarded to Ms Heseltine in answer to her question. She said feedback from the review would be shared with colleagues at the Quality Governance Assurance Committee (QGAC).
Action: it was agreed the action be closed.

TB.9090: Patient Story – no Patient Story this month
Mr Dunn expressed his disappointment of there not being a patient story and asked a Patient Story be made available for the next meeting. Ms Rawlings also expressed her disappointment and felt it was important for the Board to be connected to patients at each Board, and that the Board were aware of any positive or negative news. She asked that a library of stories be created.

Prof. Cannaby said a meeting had been arranged with the Communications team and Patient Advice and Liaison Service (PALS) team together with Directors of Nursing to ensure the situation did not occur again.

Resolved: Patient Story be made available at the next Board meeting.

Chief Executive and TMC Reports

TB.9091: Chief Executive's Report
Prof. Loughton introduced his report and highlighted a number of Consultant appointments had been made including 2 in emergency medicine, 3 in anaesthetics, 2 in lower limb surgery. He said 1 included a Consultant appointed via the Trust's Clinical Fellowship Program.

Prof. Loughton mentioned Exceeding Expectation Awards. He said a list should be prepared with details of the awards presented and how people had exceeded expectations. He said it was positive to see the many humbling people had received awards.

Prof. Loughton said following Prof. Tim Briggs visit to Cannock Chase Hospital the Trust had been successfully accredited as one of the eight Trusts for Elective Surgical Hubs and would obtain capital funding. He finally mentioned his concerns with disruptions which could arise should the Doctors strike action take place next week. He said during this period a robust plan needed to be in place.

Resolved: that the Chief Executive's report

TB.9092: Chief Executive's Report of the TMC held on 24 February 2023 and 24 March 2023
Resolved: that the Chief Executive's Report of the TMC held on 24 February 2023 and 24 March 2023 be received and noted

People and Engagement

TB.9093: People Organisational and Development Committee – Chair's Report February

and March

Ms Rawlings introduced the report and said the Trust had received £200 thousand from the Hope Project to work in the Community with volunteers. She said a deep dive had taken place with the Radiology Department. She said positive improvements had been made with recruitment, retention and health and wellbeing of staff. She said the Committee also looked at targets for workforce and the development of the Joint People and Organisation Development Strategy, which was being produced jointly with Walsall Healthcare NHS Trust (WHT).

Ms Rawlings said as positive work was being undertaken by the Trust with retention it was agreed by the Committee that a Board Assurance Framework (BAF) Risk was not required at this stage but would be monitored.

Ms Rawlings said the Committee looked at health and well-being together with the food bank and support, staff were receiving. She also mentioned a new menopause policy was in place, having been created in line with national directive.

Resolved: that the People Organisational and Development Committee – Chair's Report February and March be received and noted

TB.9034: Executive Summary Workforce Report

Mr Duffell introduced the report and said work was in progress to create a single People Strategy across both RWT and WHT.

Mr Duffell said it was positive to note the Trust had a vacancy rate of 2.68% and there was a key focus on retention. He also mentioned the deal offered for the agenda for change being 5% uplift for all staff and 10% for the lowest bands had not as yet been signed as members needed to feedback to individual unions as to whether it would be accepted.

Mr Duffell mentioned a 4-day strike was planned for Junior Doctors which, he said could have a severe impact on the organisation.

Resolved: that the Executive Summary Workforce Report be received and noted

TB.9095:Terms of reference to the committee

Mr Duffell said the terms of reference had been amended to bring in line with WHT.

Resolved: that the terms of reference of the People and Organisational Committee be approved.

TB. 9096:Education and Training the Clinical Fellowship Program

Ms Nickell introduced the report and highlighted positive news of 17 additional doctor training posts for 2023. She said for undergraduate medicine the first cohort 58 Aston Medical School Student Graduates had commenced. She also mentioned a joint single Strategy for Education and Training together with a delivery plan was in place for WHT and RWT. Finally, she mentioned there had been an increase in demand for training and training facilities due to the change in curriculum, which had created issue in capacity at both Trusts. She said a business case was being prepared to address the issue.

Prof. Loughton asked how the numbers for the additional 17 Doctor training posts compared with other organisations. Ms Nickell said the Trust was the biggest recipient for Doctors in training compared to other organisation and had the same number as Queen Elizabeth Hospital

Ms Rawlings said feedback for postgraduate medical education was positive and asked whether there were any areas which required improvement.

Ms Nickell said General Surgery had been a challenge across the Country as a result of post Covid experiences with trainee surgeons having difficulty in getting access to the competencies they required. She said internal visits had been planned to look at the area.

Prof. Toner asked why the resuscitation trolley replenishment system was contained within the report. Ms Nickell said the clinical skills team who assist with the resuscitation of the organisation were creating a business case for the replacement of the resuscitation trolleys following concerns raised around replacement of consumables on the trolley. She said a business case was corporately led for that.

Prof. Toner asked what issues there were with learning platforms across different higher education institutions, and whether that was affecting learning for students.

Ms Nickell said existing and current staff accessed learning platforms based on My Academy modules and other students accessed learning platforms via different platforms and occasionally had difficulty accessing them in a space that was private to them. She said to overcome this issue the Trust had purchased 9 pods on the 1st floor of the library to enable students to access those platforms in a private area and complete their training.

Ms Heseltine asked whether there was a safety issue with the resuscitation trolleys.

Ms Nickell said originally it was identified as a safety issue as it was recognised that to have a fully stocked replenished cardiac arrest trolley was a better system by an independent organisation providing than depending on staff in busy periods to ensure that the replenishment was 100% provided. She said the Trust brought 2 robotic dispensary systems which sealed trolleys for replacements.

Ms Heseltine asked whether there had been interest from other organisations for Physician Associates (PA), if so, who had shown an interest and who was this aimed for.

Ms Nickell said she would make enquiries and respond to Ms Heseltine. She said the University of Wolverhampton had closed their program and the Trust had partnered with the University of Aston, University of Birmingham and Keele University. She said she would obtain numbers of students for each of those individual Universities and respond back to Ms Heseltine.

Ms Heseltine asked whether there was interest for this PAs rather than exact numbers.

Ms Hickman said the new resuscitation trolley system provided greater clarity, oversight and better standardisation for a safer system. Prof. Loughton asked that Prof. Cannaby and Ms Hickman ensure CQC were aware of the changes implemented by the Trust in providing the systems.

Resolved: that the Education and Training the Clinical Fellowship Program report be received and noted.
Action Ms Nickell to forward details of whether interest had been shown from other organisations for Physician Associates, it so who the organisation was and who was it aimed for.

TB.9097:National Staff Survey
Mr Duffell highlighted nationally since Covid there had been a decrease in the position of the staff survey. He said it was positive to note the Trust was above national average on key

themes within the survey. He said the Trust was significantly higher to other organisations with staff morale, care of patients and service users, organisations top priority and would recommend the organisation as a place to work. He said in the previous staff survey there were concerns staff felt discriminated as a result of ethnicity. He said there had been an improvement since the 2021 position and it was positive to see the benefits of the work being undertaken by Equality Diversity and Inclusion (EDI) team. He said a review was to take place of a new behaviour framework across WHT and RWT. He said a Staff Survey Oversight Committee had been created to review all actions. He said PODC would be looking at what key issues required focus at an organisational level and Divisions would be taking ownership of their actions.

Ms Harding said the vacancy rate was positive news and felt this may be due to programmes available at the Trust to fill those vacancies. She asked whether it was known how reflective of the local community workforce was for those jobs appropriate to training provided by the Trust rather than national programs.

Mr Duffell said figures were routinely reported through the Workforce, Race Equality Standards (WRES). He said the Trust was reflective of the local community. He said more work was required at Senior Management level with the EDI agenda across all levels of bandings. He said work was in place with reverse mentoring programs, support packages, BMA dedicated training and development lead development programs at a system level.

Prof. Loughton said the Trust had a large catering unit and was always seeking contracts from other hospital as with expansion it would lead to an expansion of workforce with local people. He also mentioned work needed to be done with the pathology department following the results of staff survey.

Resolved: that the National Survey Report be received and noted.

Patient Safety, Quality and Experience

TB.9098: Patient Experience (& Complaints Report)

Ms Dowling introduced the report and highlighted as of today the Trust had reintroduced uncontrolled visiting, where visitors would not need to book visiting through the centralized booking system. She said during the last 12 months 103,000 bookings had been made via the centralised booking system.

Ms Dowling said it was positive news the Trust had been awarded £220 thousand for the Hope Project, from NHS England Charities Together. She said some was to specifically address the social isolation and positive mental well-being for communities and the voluntary sector. She said there had been a reduction in PALS and complaints. She said the Trust had adopted an early intervention approach and 70 cases achieved local resolution without the need to escalate. Ms Dowling said there were no cases to the Ombudsman of opened for fully investigation and no outcomes from cases. She said two initial assessments had been completed and deemed no full investigation was required.

Ms Dowling said work was being undertaking with the Quality Team to produce a series of themed reports where there had been a decline in performance. She said all the quality and safety metrics along with the patient experience metrics were being reviewed and triangulated. She said this would be shared with the relevant wards and departments for improvements to be considered. She also mentioned there had been an improvement in the Friends and Family Test for maternity services.

Mr Dunn asked what Committee the report was submitted to. Ms Dowling said it was reported at Quality Safety and Governance Group QSAG together with Trust Management Committee prior

to Board.

Prof. Toner asked for clarification on page 4 of the report, the mention of a maternity patient being on a Continuous positive airway pressure (CPAP) machine, she said it mentioned the word “he” on 2 occasions but also mentioned emergency caesarean section. Ms Dowling said she would make enquiries and feed back to the Board.

Ms Hickman provided assurance that visiting would be controlled and managed locally by wards and departments where there were Infection Prevention (IP) issues.

Resolved: that the Patient Experience (& Complaints Report) be received and noted
Action: Ms Dowling to clarify content of maternity patient section on page 4 within the report and report back to the Board.

Governance, Risk and Regulatory

TB.9099: Quality Governance Assurance Committee (QGAC) Chair’s Report

Prof. Toner introduced the report and highlighted the positive news on the approval of the Cannock Chase Hospital Surgical Hub. She said a medical lead had been appointed for Cancer Services. She also mentioned the Trust would be providing in the future a dermatology micrographic surgery, skin cancer expert clinic, across the Black Country.

Prof. Toner said meetings were to be arranged with herself, Ms Heseltine and the Executive team to discuss each individual risk on the Trust Risk Register. She said the Cancer Improvement Plan remained challenging and there had been an increase in cancer referral rates which was affecting the 62 day wait. She said mutual aid had been secured from 3 hospitals to assist with the reduction of waiting times for patients with renal tumours. She said the delays with diagnostics and histopathology, together with the junior Doctor Strike would impact on restoration and recovery plans. She said there had been an improvement with Ambulance waiting times together with Emergency Department (ED) waits. Prof. Toner finally mentioned the Embrace report was presented at QGAC and an in-depth discussion took place.

Ms Nuttall highlighted in March following the strike action 1600 patient’s appointments and procedures were cancelled, most of which were outpatients. She said it was predicted next weeks Junior Doctors strike would impact on approximately 2000 appointments and procedures. She said communication to patients had commenced. She said this had an impact of the 78 weeks expectation. She said by the end of March the Trust had not achieved the target to treat all patients who had been waiting up to 78 days waiting time. She said the figure at that time was 83 patients waiting. She said the standard had been moved centrally to the end of April, and the Trust was forecasting that it would not achieve the target. She mentioned mutual aid was being sought in 3 challenging specialities, general surgery, urology and gynaecology. She asked all to note the impact on patient waiting times was not all due to the Junior Doctor strikes, some were due to capacity and increase in referrals.

Dr Odum mentioned a surgical robot was in use at Dudley Group NHS Foundation Trust and surgical training was taking place to accommodate nephrectomy and partial nephrectomy for the patients with renal cell cancers. He said the use of robotic surgery and the additional capacity at Dudley Group NHS Foundation Trust would ultimately allow the Trust to become self-sufficient in delivering that service within the Black Country via the services provided by Dudley Group.

Mr Levermore said it was positive to see the use of new technology in the improvement of service and asked whether the Trust was producing regular productivity matrix on the use of such technology and if so how was that being recorded.

Dr Odum said there had been 2 robots which had been procured with the Provider Collaborative, one being the Da Vinci robot at Dudley Group and the Da Vinci robot at Sandwell and West Birmingham Hospital. He said there was a clear plan of how those robots would be used within the system to deliver surgery for different subspecialties, including urology, pelvic, renal cancer, colorectal and gene oncology. He said there were various training programmes taking place at the hospitals being monitored by robotics group which sat within the Black Country.

Prof. Loughton said it had been 12 years since RWT had the first surgical robot in Wolverhampton, being the 4th robot in the country at that time. He said there had been improvement, but there was learning of working with the robot and reduction in productivity, until experience was gained on using the robot.

Ms Nuttall said currently productivity of cases per list, the Trust was reliant on the company who provided the robots to do their own benchmarking. She said the information was available dependant on the company supporting it. She said it was not as yet part of the Model Hospital or the Getting it Right First-Time national programme (GIRFT).

Resolved: that the Quality Governance Assurance Committee (QGAC) Chair's Report be received and note

TB.9100 Terms of reference of the committee.

Prof. Toner said the terms of reference had been reviewed and amended.

Resolved: that the terms of reference of the Quality Governance Assurance Committee (QGAC) be approved.

TB.9101: Chief Nurse/Director of Nursing (DoN) Report

Ms Hickman introduced the report and highlighted the positive recruitment activity at the Trust. She said the skills mix which underpinned that recruitment was supported by national evidence base and work was done within the Safer Nursing Care Tool. She said it was recognised vacancies were low, however there were 124 whole time equivalents in the pipeline. She said work was being done corporately and divisionally to ensure new starters had sufficient robust preceptorship programmes. She said the Trust had reviewed Objective Structures Clinical Examination (OSCE) outcomes since the standards had been amended to ensure the education programme the Trust had to support Clinical Fellows, was based on learning evidence and feedback. Ms Hickman said summits had taken place for work for pressure ulcers and falls.

Prof. Toner said it was positive news for staff who had been nominated and or received awards.

Dr Pickavance asked whether new international staff received any additional extra teaching when they arrived in the Country, as with international medical graduates there was a different teaching level that would have taken place in their original countries.

Ms Hickman said there was a cultural transition which needed to be borne in mind. She said the teaching programme was to address the Objective Structures Clinical Examination (OSCE) requirements to achieve the needs that were required to attain their place on the register. She said it was also seen that the utilization of equipment was a challenge. She said key was getting international nurses to understand the requirements in an NHS organisation.

Resolved: that the Chief Nurse/Director of Nursing Report be received and noted.

TB.9102: Integrated Quality and Performance Report

Ms Nuttall introduced the report and said all alerts had been raised by Prof. Toner in the QGAC report.

Ms Hickman highlighted there had been an increase in observations on time with the Trust sustaining at approximately 80%. She said there was focus on high turnover areas. She said C-Difficule remained transient and there had been a national increase of approximately 20% to 25%. She said there was also challenges with capacity and flow. She said there was a Patient Equipment Cleaning Centre which continued to operate and support wards predominately in the C Block at the Trust. She also mentioned there was a national piece of work on C-Difficule together with a local action plan which linked within the plan.

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

Break 10: 45 - 10:55

TB.9103: Midwifery report

Ms Cheshire introduced the report and highlighted "listening to service users" remained a priority. She said the results of the National Patient Survey were positive. She said the Trust was making progress with its "must dos" and "should dos" element with the CQC action plan. She said positive support was being received from Local maternity and neonatal system (LMNS) and joint collaborative work was being considered with the LMNS together with collaborating with WHT. She also mentioned there was focus on the pressures with midwifery staffing and additional work was taking place with workforce.

Prof. Toner asked whether the 15 steps report had been received. Ms Cheshire said the report had not as yet been received. She said high-level feedback had been received on the day and the report had been chased.

Ms Heseltine mentioned she was arranging to meet with Ms Palmer to go through some of the data and assist with understanding the data.

Resolved: that the Midwifery report be received and noted

TB.9104:Quality Framework (QF) – For Nurses | Midwives | Health Visitors | Allied Health Professionals (AHP)| Pharmacists

Prof. Cannaby introduced the report and said the AHP and nursing plan at RWT ended in December and a joint plan between RWT and WHT had been created. She said within the attachment were 5 streams of work which integrated together including AHP, midwifery, Paediatrics, adults and community calendar. She said the plan was to be launched this week with various roadshows and communication. She thanked all involved.

Mr Dunn said it was a good report and asked whether there would be ongoing communication about the achievement of the objectives that had been put in place. Prof. Cannaby said this would be reported quarterly within the Chief Nurse, Directors of Nursing reports at each Trust.

Prof. Toner said it was a good report and clearly there would be a lot of measurable outcomes within the plan.

Resolved: that the Quality Framework (QF) – For Nurses | Midwives | Health Visitors | Allied Health Professionals | Pharmacists be approved.

TB.9105: Infection Prevention & Control (IPC) and Infection Prevention Board Assurance Framework (BAF) report

Ms Hickman introduced Mr Reid. Mr Reid highlighted there had been 62 cases of C-Difficule against the year objective of 58. He said there had been a national increase and work was being done with National Health Service England (NHSE) collaboratives. He said work was to take place with patient equipment, cleaning centre and infantile work. He also mentioned there were 2 methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia's and there had been a reduction of probable or definite cases of Covid Healthcare Associated Infections (HCIA) to 140.

Mr Reid referred to the IPC Board Assurance Framework summary, he said there were 97 key lines, 3 were deemed as amber and 0 red. He said NHS England had created a working group for BAF which incorporated to the hygiene code, and RWT together with WHT would be trialling and feeding back comments to the working group.

Ms Cowley said there had been an increase with Covid infections and there had been the complete step down of testing within adult social care for symptomatic staff and individuals. She asked whether extra transmissions were anticipated and was any support to be provided to community teams to support the element of the health and social care sector.

Mr Reid said the changes were published on Friday and were being reviewed which also included documents on management of healthcare staff.

Prof. Cannaby said part of the team looked at community facing support and oversight as previously provided would continue.

Resolved: that the Infection Prevention & Control and Infection Prevention Board be received and noted

TB.9106: Audit Committee - Chair's Reports

Ms Jones introduced the report and said the Trust was good at implementing internal audit recommendations, but these needed to be marked off on the iBabs system to gain assurance that everything was complete.

Ms Jones mentioned a phishing exercise took place by the cyber security team together with counter fraud auditors who had sent a pretend malicious e-mail to staff. She said 28% of users clicked on the pre-mail and a further 17% entered their names and passwords. She said this was part of a process to see what education and training was required to ensure people did not do that.

Mr Stringer said cyber-attacks were always of concern and the more education, training and awareness that could be published from Board members and others was very important. He stressed the need for staff not to click on emails that had attachments which had not been verified correct and from a professional body.

Resolved: that the Audit Committee - Chair's Report be received and noted

TB.9107: Covid – 19 National Inquiry

Mr Bostock introduced the report and said the Trust was participating in module 3, which looked at acute healthcare delivery throughout the pandemic and impact the pandemic had on it. He said the Trust attended the preliminary hearing which took place on 28 of February and had provided the data requested.

Resolved: that the Covid – 19 National Inquiry

Performance and Finance

TB.9108: Performance and Finance - Chair's Report February and March

Ms Cowley introduced the report and said some elements relating to performance and trajectories had already been highlighted by Prof. Toner in the QGAC report. She said the committee looked at trajectories going forward into 2023/24. She said there had been an improvement in Emergency Department (ED) with ambulance handovers and length of stay. She said it was noted that it was still challenging, and the ongoing support of staff was positive.

Ms Cowley said a lengthy discussion took place regarding the finance situation, together with discussions for next year's budget. She also mentioned an additional Board meeting had taken place to discuss the budget in more detail. She said there was also a review of winter plan. She said Stew Watson from the Trust had been working collaboratively across the Black Country for the public sector decarbonisation scheme She said there was also a discussion about Cannock Chase Hospital in terms of community diagnostic centre and the theatres. She said there was ongoing pressure both in terms of cost and time frames from a construction perspective. She said the committee where assured that the team are working through those with construction partners and funders.

Resolved: that the Performance and Finance Chair's reports for February and March be received and noted

TB.9109: Report of the Chief Financial Officer – Months 10 and 11

Mr Stringer introduced the reports, and it was anticipated the Trust would break even in revenue. He said to get to that position the Trust was reliant on other colleagues in the system delivering their part of the risk share agreement. He said should this occur, the Trust would receive £3.8 billion to assist in getting into the break-even position. He said the Trust was effectively as part of a system working collectively together towards a coordinated financial year end and also the financial plan going forward. He said it had been an incredibly complex difficult year for the estates development team working through with operational colleagues on the number of very late capital monies that came into the system, however the Trust was expecting to reach the capital resource limit. He acknowledged the hard work by the teams.

Resolved: that the Report of the Chief Financial Officer – Months 10 and 11 be received and noted

TB.9110: Budget (Income/Expenditure Plan) - Verbal Update

Mr Stringer said the Trust together with many Integrated Care Boards (ICB) were finding the planning for the next year challenged. He said ICB's were planning currently for a deficit for next year characterized by one loss of income from the centre due to Covid, together with costs which had been incurred pre-Covid to current levels built within organizations underlying position, and specifically for the Black Country a significant reduction in flexibility and balance sheets.

Mr Stringer said a verbal update had been provided that the plan submitted last week by the Black Country ICB would not be approved due to the size of the deficit which was currently being assumed and a further planning date is yet to be confirmed. He said currently there was not an approved NHS England system and provider financial plan for 23/24.

Resolved: that the verbal update of the Budget (Income/Expenditure Plan) be noted.

Strategy, Business and Transformation

TB.9111: Joint RWT/WHT Quality and Safety Strategy

Ms Morris introduced the report said the strategy outlined the focus for the next three years, and fully aligned to the structural strategy, specifically the care objective. She said key focus was based on key national and local policies and guidance, including NHS long term plan, patient safety strategy, local quality accounts, our nursing, midwifery, health visitors and AHP quality framework. She said the strategy had been approved by all key operational quality safety groups, including a support level oversight groups across both organizations.

Resolved: that the Joint RWT/WHT Quality and Safety Strategy be approved.

TB.9112: Black Country Provider Collaborative

Mr Evans introduced the report and said the update was following the away day which took place as a Provider Collaborative. He said under the clinical improvement programme three key priorities were identified, cancer health outcomes, elective recovery and service transformation and beneath these were a series of different work streams as well the corporate improvement program. He said for the corporate improvement programme there was focus was on HR, procurement and payroll.

Mr Evans mentioned the target operating model and said the Black Country Provider Collaborative had been unsuccessful in the bid submitted as part of the National Innovator Scheme.

Resolved: that the: Black Country Provider Collaborative report be received and noted

TB.9113: OneWolverhampton Place Update

Mr Evans introduced the report and highlighted approval was required by the Board to the Partnership Agreement. He also mentioned the Annual report which detailed key work that had been done as OneWolverhampton. He said each of the partners as part of OneWolverhampton are required to commit and sign up to the agreement. He said it was not legally binding in terms of what was placed on the individual partners. He said the agreement was for a commitment that all would work to deliver on the priorities and outcomes that were identified within the work plan for this year.

Mr Evans said positive progress had been made with the Annual Report, examples being the Covid vaccination, getting that the winter plan agreed and signed off, getting the funding for winter plan to pay for things like staffing for the ambulance receiving centre.

Mr Evans said three Co chairs had now been appointed representing each of the three key providers, Primary Care, the Local Authority and himself through RWT. He finally mentioned in relation to performance, improvements that had been made by each of the four places across the Black Country were detailed within the report.

Dr Pickavance said positive work had taken place with the medically fit for discharge patients. She asked whether there would be a deterioration due to the winter funding being stopped, which she said had been distributed to GP Sunday opening, Ambulance Receiving Centre and additional self-care beds for discharge.

Mr Evans said a lot of funding that was secured during the winter period went on some of the things Dr Pickavance described. He said there was closer teamworking now and better

integrated working. He said OneWolverhampton was the only place across the whole of the Black Country that had a clinical summit led by operational teams at RWT and the local authority. He said there was closer integrated working between RWT and the local authority. He felt with some of the solutions in place that would mean more benefits would be seen. He said however if funding was taken away for some of those things, there could be a risk.

Mr Levermore said it was positive and benefits were being seen, he asked how the Board could assist to ensure continuity.

Mr Evans said RWT provided significant support to place terms of partnership director. He said the ICB provided non-recurrent value to try and put some of the infrastructure support which needed to continue in order for Place to be successful.

Resolved: that the Partnership Agreement be approved and the OneWolverhampton Place Update be received and noted

TB.9114: Integrated Care Board (ICB) Update

Mr Evans introduced the report and said the operating model was approved last week at the ICB Board meeting. He said it detailed how work was to be done from a strategic and planning perspective, together with how work was to be done in terms of the delivery vehicles that they had inside the system architecture. He said strategy and planning was to remain with the ICB. He said the proposal was to have 7 delivery vehicles that reported into the ICB, broken down by 4 places being OneWolverhampton, Walsall Together, Sandwell Health and Care Partnership and Dudley Health and Care Partnership. He said in addition to that would include 3 collaboratives being mental health and Learning Disabilities , Black Country Provider Collaborative and primary care collaborative. He said the ICB was looking for the provider collaborative to generate those things.

Mr Evans said from a Place perspective it was looking for integration of care through multidisciplinary team working, Continuity of care, around long-term conditions and better care coordination for complex care, and the final element prevention and demand management. He said the financial framework to support this was not yet confirmed. He said it was intended that a proposed scheme of delegation would be developed, and work would commence with the Trust. He said the work would be towards a single joint chair for Boards working towards a single joint committee through which decisions and discussions could take place.

Mr Levermore asked where data and diagnostics would be managed and whether that had been discussed.

Mr Evans said part of a discussion had taken place around health inequalities and understanding the causes that lead people to ultimately get referred into secondary care settings. He said the data element was being discussed through Place. He said the Trust had been successful in securing the Community diagnostic Centre for Cannock Chase hospital and the Trust was in the process of bidding for Bilston, which was still in development, which was where the data element would take place.

Resolved: that the Integrated Care Board (ICB) Update be received and noted

TB.9115: Joint Committee Steering Group Chair's report

Prof. Toner said the first meeting took place for the Joint Committee Steering Group, previously known as Committee in Common. She said 3 groups had been created quality improvement, research improvement innovation and research group and a digital group. She said a quality team was created at both RWT and WHT who had detailed plans of what they

were looking to achieve.

Prof. Toner said ongoing work was taking place on strategy implementation to try and ensure it was aligned across both Trusts.

Mr Evans said there would be a transitional period as moving forward into a single chair process. He said the Committee were looking at ways to provide consistency across the whole of the governance arrangements. He said the terms of reference for the Joint Steering group and the remit of work together with the business of the Joint Steering Group had been shared with Dudley Group Foundation NHS Trust and Sandwell and West Birmingham NHS Trust.

Resolved: that the Joint Committee Steering Group Chair's report be received and noted

TB.9116: Charity Committee - Chair's Report

Ms Rawlings introduced the report and highlighted the winter wellness support and food bank. She said during the first 3 weeks 1260 staff received breakfasts and 968 members of staff had accessed the food bank. She mentioned the opening of the paediatric sensory room where representatives from the 5/344 Transport and General Workers Union Benevolent charity attended. She thanked the Benevolent charity for their donation and support over the years. She said the Charity Key Performance Indicators (KPI) had been achieved which was positive news. She said one business case had been submitted for chairs for the chemotherapy service at Cannock Chase Hospital. She said the Committee was in the process of preparing annual spending plans.

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

TB.9117: Staff Voice - Contracting Team

Mr Duffell introduced the contracting team, inductions were made. Mr Duffell said following the pandemic due to the significant change the Trust was operating, had this effected any challenges for the team for their work on a day-to-day basis.

Ms Williams said there were not as many competitive tenders as prior to Covid. Ms Barrett said there were a lot of changes during Covid. She said there was a more collaborative approach to working with Commissioners NHSE and the ICB.

Mr Duffell asked how well the team felt supported by the Trust during the last couple of years during the Covid.

Ms Cotton said she felt well supported by colleagues and managers. She said the Trust had introduced working from home which assisted with a work life balance.

Ms Rawlings asked about work life balance and had the introduction of working from home effected managing the team.

Mr Shayes said he felt there had not been many challenges in managing the team but the benefit of meeting face to face as a team was recognised and the team were meeting once a week

Mr Levermore asked why the team worked for the Trust. Ms Barrett said she saw it as a great opportunity to work at RWT. She said staff were friendly, welcoming and willing to help.

Mr Evans said many of the reports he presented at Board were written by the team. He said

the team provided a considerable amount of support to the Trust in ensuring good processes were in place, ensuring the Trust received the maximum amount of income revenue possible. He said each member of the team was redeployed during Covid, which for many meant coming onto site during Covid to work in ward areas. He said he was immensely proud of the team and thanked them for their commitment and work.

Prof. Loughton thanked the team and said there were benefits and disadvantages of working from home and felt there should be strategy across both trusts, outlining how things were done differently and how they should be managed.

Ms Harding asked if there was one thing that could be changed what would it be.

Ms Barrett felt there could be an improvement with the IT capabilities and functionalities that were available. She felt more work for collaboration, productivity and effective working could be achieved.

Resolved: that the staff voice item be noted

TB.9118: Items to Note

There were no items to note.

TB.9119: 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 Minutes 25 January 2023 and 22 February 2023, QGAC Minutes 25 January 2023 and 22 February 2023, Audit Committee minutes 13 December 2022, People and Organisational Committee minutes 24 February 2023 be received and noted.

General Business

TB:9120: Any other business

None were raised.

TB.9121: Questions from the public, TB.9122: Date and time of next meeting:

Ms Banga confirmed no questions had been received. Mr Dunn confirmed that the next meeting was to take place on Tuesday 6 June 2023 via MS Teams.

Resolved; that the resolution be approved

The meeting closed at 12:40 pm

The Royal Wolverhampton NHS Trust

31 May 2023 16:26

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 04/04/2023 9 Patient Safety, Quality and Experience - Section Heading				
1223.	Clarify content of maternity patient section	Dowling, Alison	29/05/2023	Completed
	Explanation action item Ms Dowling to clarify content of maternity patient section on page 4 within the report and report back to the Board.			
	Explanation Dowling, Alison the case related to a premature baby needing care but the case was assigned to maternity services which was where he was an inpatient.			
Public Trust Board 04/04/2023 8.4 Education and Training (inc Clinical Fellowship Programme)				
1222.	Physician Associates	Nickell, Louise	29/05/2023	Completed
	Explanation action item Ms Nickell to forward details of whether interest had been shown from other organizations for Physician Associates, it so who the organization was and who was it aimed for.			
	Explanation Nickell, Louise Currently RWT engages with the following HEIs: • University of Wolverhampton: Course is closed to new applicants however RWT is still progressing placements for students until all current students will have completed their studies (16 total) • University of Birmingham: On placement we currently have 3 students for their first placement year of their studies, and 6 on year two placements, (9 total) • University of Keele: We have 8 first years and 3 second years (11 total)			

	• Aston University: PA programme is due to start Sept 2023 , and plans are for RWT to take on 20 students (subject to actual numbers recruited): 10 at RWT 10 at WHT.

The Royal Wolverhampton NHS Trust

Trust Board/Trust Management Committee

Meeting Date:	6th June 2023
Title of Report	Freedom to Speak Up (FTSU) Annual Report 2022/23
Action Requested:	National Requirement of organisations Freedom to Speak Up Report to be presented to Trust Board bi-annually, which includes an annual report
For the attention of the Board	
Assure	• FTSU & RWT continues to develop in line with the Trust's Strategic Objectives and the requirements of the National Guardians Office (NGO) • Continuous recording and monitoring of FTSU concerns ensuring that they are compliant with the NGO requirements (data is submitted to the NGO quarterly). • Any trends and themes of concerns are highlighted through the FTSU route and shared with suitable management for action.
Advise	• This report advises of the actions to be taken by the FTSU Guardian based on its findings during the past year
Alert	• N/A
Author and Responsible Director Contact Details:	Tel: 01902 307999 Ext 86566 Email: Kerry.Flint1@nhs.net Mob: 07775 036501
Links to Trust Strategic Objectives	***Strategic Aim (SA)*** **Support our Colleagues** • 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 **Effective Collaboration** • Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes **Excel in the Delivery of Care** • We will embed a culture of learning and continuous improvement at all levels of the organisation
Resource Implications:	None
Report Data Caveats	This report is generated using the data from the previous financial year
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:
Equality and Diversity Impact	N/A
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A
Public or Private:	Public
Other formal bodies involved:	National Guardians Office (NGO) NHSE/I
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:	Freedom to Speak Up (FTSU) Annual Report 2022/23
Item/paragraph 1.0	**Introduction** Annual report to summarise the following: • RWT's Objectives • FTSU Updates • FTSU Data from previous year • FTSU service feedback from reporters • FTSU Training • FTSU Next steps 2023/24
2.0	**FTSU Strategic Objectives** All 5 objectives have been met however the FTSU Team will continue to improve on these to ensure that RWT continues to meet those objectives of the NGO and NHSE/I
3.0	**FTSU Update** • The FTSU Team have created a Standard Operating Procedure • Updated the FTSU Policy to sit in line with NHSE/I • Created the Speak Up Champions role • Followed recommendations following an internal audit • Encouraged senior leaders to do the online "Follow Up" training available via My Academy
4.0	**FTSU Data** This shows a large increase in cases over the past 12 months including numbers of reports around bullying and harassment and inappropriate behaviours within the workplace. We have already started to work in collaboration with the Organisational Development Team around culture change, what this looks like and different ways to work with teams and individuals who have been affected and have reached out to FTSU for support. Registered Nurses and midwives have seen the highest number of concerns raised this year not just at RWT but nationally according to the National Guardians Office statistics. On reflection there could be a number of reasons for this: ○ Many FTSU drop in sessions and walk abouts have been done on wards and departments where there is a high percentage of nursing staff working. ○ The Ockenden report specifically concentrated on Maternity services at Shrewsbury and Telford Hospital however it was expected to have an impact on services Nationwide. ○ The aftermath of COVID19 and how this affected the entire workforce Staff survey results have declined since last year on all areas which cover Speaking Up and staff confidence in the service however the overall figures are still above the average for the Speaking Up questions.

5.0	**FTSU Staff feedback** A large percentage of people who have spoken up when asked for anonymous feedback have said that they were very satisfied with the service that they received and many of those have also said that they would use the service again. The FTSU aims to improve on these figures and work collaboratively with other areas of the Trust to help to achieve this.
6.0	**FTSU Training** Training will continue to be done across the Trust including information sessions There are the online training packages provided by the NGO, these are available through My Academy via am E-Learning for Health link Speak Up Listen Up Follow Up (this is the latest package available for senior leaders – RWT have already has 229 people who have completed this training)
7.0	**Next Steps** • Working closely with stakeholders to achieve objectives. • Make attempts to uniform the service across both Wolverhampton and Walsall • Analyse the data from the past year and look at where improvements can be made • Work alongside our Organisational Development team to help to improve culture • Encourage our remaining senior leaders to complete the “Follow Up” training • Continue to work with Speak Up Champions and communications team to advertise the service
8.0	**Summary** There is an indication that the work being done by the FTSU team is positive as numbers are rising, whilst this may initially be seen as a negative, as a Trust we need these figures to increase to allow us to see the full, clear picture. The FTSU team will continue to work hard with other departments to improve the culture of the Trust and to learn from previous experiences not just at RWT but Regionally and Nationally by engaging with other Guardians.

The Royal Wolverhampton NHS Trust

Trust Board	
Meeting Date:	6 June 2023
Title of Report:	OneWolverhampton Progress Update
Action Requested:	The Board is asked to note the report.
For the attention of the Board	
Assure	After one year in operation OneWolverhampton continues to strengthen its partnership relationships and expand its work programme. A review of the annual priorities involving stakeholders from across the city is underway to ensure OneWolverhampton is responding to the needs of our citizens and partners. Shining a spotlight on our Care Closer to Home work demonstrates we are achieving or exceeding national requirements.
Advise	Since July 2021 Care Coordination have taken 4532 calls from West Midlands Ambulance Trust and triaged almost 3500 patients to alternative pathways to ED. We are achieving the national target for the percentage of patients responded to within 2 hours of referral. We have received almost 1500 referrals to virtual ward in 22/23, with referrals increasing month on month. Feedback has shown patients feel empowered by taking control of their healthcare monitoring.
Alert	Not Applicable
Author and Responsible Director Contact Details:	Author: Sian Thomas - Deputy Chief Operating Officer (RWT) and Partnership Director OneWolverhampton Responsible Director: Simon Evans, Group Director of Strategy Tel 01922 695782 Email sian.thomas22@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Safe and responsive urgent and emergency care c) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Be in the top quartile for vacancy levels b) Improve overall staff engagement
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience d) Facilitate research that improves the quality of care
Resource Implications:	None
Report Data Caveats	Not applicable
CQC Domains	**Effective: Caring: Responsive: Well-led:**
Equality and Diversity	Not applicable

Impact	
Risks: BAF/ TRR	Not applicable
Risk: Appetite	Not applicable
Public or Private:	Public
Other formal bodies involved:	Not applicable
References	Not applicable
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:	OneWolverhampton Progress Update
Item/paragraph 1.0	There are six Strategic Working Groups (SWGs) in OneWolverhampton: • Adult Mental Health • Living Well • Urgent and Emergency Care • Primary Care Development • Children and Young People • Care Closer to Home Following the annual report, presented at the last Trust Board, covering the first operating year of OneWolverhampton we are now reviewing the 23/24 to 24/25 annual priorities for each SWG. All Partners are positively engaged in this process. At each OneWolverhampton Board a focus on a specific SWG will be undertaken, and then reported to all Partners. This month's focus will be on Care Closer to Home. The Care Closer to Home SWG brings together partners from health, care, the voluntary sector, housing, and other specialist agencies such as the fire service, to support people to stay at home when they become unwell or get home more quickly if they require hospital care. The SWG has five priorities (noting the review process underway). 1. To enhance our integrated care co-ordination function across community nursing, therapy, social care and housing; giving professionals, partners and patients a single contact to access services and provide alternatives to ED and hospital. 2. To ensure the right services with the right capacity are available in the community to support effective and appropriate discharge from hospital, ensuring people can return to the place they call home in a safe and timely manner once they are medically fit for discharge. 3. To deliver a high-quality palliative and end of life service (PEoLC) that delivers the 6 national ambitions and 9 Integrated Care Board PEoLC commitments.

4. To ensure we have the services, training and education in place that support ageing well; including expanding our falls prevention and response offer, ensuring our care home support offer is more integrated and rolling out a city-wide healthy ageing service.
5. To Expand new services in the community, delivering the national ambition for virtual ward and 2-hour urgent community response.

This paper focuses on priority 1 and 5. Attached at appendix 1 is a full presentation on the model, performance, impact and next steps. They key points to note are:

Priority one:

Since July 2021 Care Coordination have taken 4532 calls from West Midlands Ambulance Trust and triaged almost 3500 patients to alternative pathways to ED. All patients are reviewed after 72 hours to determine if the right decision was made regarding pathway disposition.

Priority five:

We are achieving the national target for the percentage of patients responded to within 2 hours of referral. A set of nine key clinical conditions that all services need to deliver by the end of 23/24 has now been published; we are compliant with 7 of the 9 clinical conditions with plans in place for the remaining two. It should be noted that we offer a range of other pathways and conditions.

We have received almost 1500 referral to virtual ward in 22/23, with referrals increasing month on month. There is an almost even split between step up (preventing admissions) and step down (facilitated discharges) referrals. For step down we have seen a decreasing average length of stay prior to referral, from 7.8 to 5.2 days, therefore saving acute bed days.

The use of digital tools on virtual ward has had benefits for staff and patients:

- When observations are submitted regularly, the data provides an **individualised snapshot of the patient's health** over a course of time, any peaks or abnormalities alert staff to make contact with the patient. This has enabled for **early detection of deterioration**.
- Patients have felt reassured having **direct access to the same contact** via remote monitoring as opposed to going through a secretary or Switchboard.
- Feedback has shown patients feel empowered by **taking control** of their healthcare monitoring.

The Royal Wolverhampton NHS Trust

Meeting Date:	Quality Governance Assurance Committee (24th May 2023), Audit Committee (26th May 2023) TMC (26th May 2023) Trust Board (6th June 2023)
Title of Report:	Quality Account 2022/23
Action Requested:	For approval
For the attention of the Board	
Assure	• Information has been provided by leads identified across the Trust and where appropriate signed off by Head of Department or Executive. • The national guidance and updates have been followed and implemented and are included in 'advise section' to note.

Advise	• The report is subject to proofreading and design/format which is being led by Communications.
	• Note that the following elements will be added and are subject to change in the final version as they are awaiting receipt or sign off.
	  ○ Quality statements from external stakeholders
	  ○ Data protection and security statement on assurance statements
	• Note that the Quality Account must be published by no later than 30th June 2023
	• Integrated care boards (ICBs) have assumed responsibilities for the review and scrutiny of Quality Accounts. ICBs must clarify with providers where they are expected to send their Quality Account.
	• The National Quality Board has been undertaking a review of Quality Accounts to determine how they could be improved and updated. This review does not affect the 2022-23 Quality Accounts requirements; however it is anticipated that changes may come into effect for the 2023-24 requirements.

Alert	• The 7 Day Service Audit is currently ongoing, and data is unavailable for the Quality Account. • Core Quality Indicator – Patient Reported Outcome Measures (PROMS) data for (hip/knee) replacement surgery is unavailable for 2022/23
Author and Responsible Director Contact Details:	Sue Hickman, Compliance Manager **Kevin Bostock, Group Director of Assurance** Tel 01902 307999 extn. 85116 Email suehickman@nhs.net
Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	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 community and populations
Support our Colleagues	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 Standards
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
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:	None
Report Data Caveats	Included in alert section.
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:	
References	If required/appropriate e.g., if addressing a national policy priority.
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:	Draft Quality Account 2022/23
Item/paragraph 1.0	The annual Quality Account for the year 2022/23 has been drafted (see appendix 1) and will be circulated through the following committees of the Trust in order to seek final approval by the Trust Board on 6th June 2023 in readiness for final submission on the 30th June 2023. Committees: Quality Governance Assurance Committee (QGAC) Trust Management Committee (TMC) Audit Committee (AC)

	The Quality Account details the progress made against the previous year's objectives together with details of the key objectives for the forthcoming year. The Committee is advised that in terms of the external assurance of Quality Accounts, the assurance audit is once again not required for the 2022/23. NHS England and Improvement have confirmed that the processes for producing Quality Accounts remain the same as previous years, with exceptions to NHS providers as Integrated care boards (ICBs) have assumed responsibilities for the review and scrutiny of Quality Accounts and ICBs must clarify with providers where they are expected to send their Quality Account. During 2022/23, the Trust set out the next steps to further develop the strategic collaboration between the two Trusts and across the wider Black Country (BC) acute provider collaboration arrangements. Part of this collaboration involved the development and agreement of the first joint Quality and Safety and Patient Experience Enabling strategies for the organisations. The joint Quality and Safety Enabling strategy defines how we will strive to excel in the delivery of care, which is one of the four strategic aims of the joint Trust Strategy. The Patient Experience Enabling strategy encompasses the Trusts overall objectives and ambition to become an Integrated Care System with the aim to work in partnership with local councils and others, to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population served. The priorities for 2023/24 included in this year's Quality Account have been aligned to both joint strategies of the Trusts. External stakeholders will receive copies of the draft Quality Account in May 2023 prior to readiness for submission by 30th June 2023 and their response to the Quality Account will be included in the final version. **The Committee is requested to:** • Confirm that the scope of the content provides a level of assurance and that it accurately captures, and is a good reflection, of quality for 2022/23. • Consider and provide a view on the improvement priorities for 2023/24 in line with joint Quality and Safety Enabling and Patient Experience Enabling strategies. • Note that the Quality Account must be published by no later than 30th June 2023.

	• Note that the Quality Account is in the process of being proof read and is not in its final format/version this is being managed via Communications/Medical Illustration. • Note that on the NHS Digital website there is the following statement relating to PROMS (Hip/Knee) data. "In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time. We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known."

The Royal Wolverhampton NHS Trust

Trust Board Meeting	
Meeting Date:	6 June 2023
Title of Report:	Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy
Action Requested:	Note and approve
For the attention of the Board	
Assure	• Delivery metrics have been agreed to provide assurance over the achievement of strategic objectives
Advise	• Regular updates will be provided against these metrics through the sub-committee structure
Alert	• Some metrics are outside of the control of RWT alone, e.g. PLACE based objectives
Author and Responsible Director Contact Details:	Tim Shayes - Deputy Chief Strategy Officer – Planning, Performance and Contracting Tel 01902 694366 Email timothy.shayes@nhs.net Responsible Director – Simon Evans, Chief Strategy Officer Email: simon.evans8@nhs.net
	Links to Trust Strategic Aims & Objectives
Excel in the delivery of Care	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 community and populations
Support our Colleagues	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 Standards
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
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:	None from the strategy specifically
Report Data Caveats	Not applicable
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	N/A – the strategy seeks to address inequalities
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A
Public or Private:	Public
Other formal bodies involved:	N/A
References	The strategy takes account of the key national policy documents, including:

	• The NHS Long Term Plan • NHS Operational Priorities 2022/23 • 'Integrating Care: Next steps to building strong and effective integrated care systems across England' (NHSEI November 2020) • 'Integration and Innovation: working together to improve health and social care for all' (Department of Health and Social Care, February 2021) • 'Legislating for Integrated Care Systems – five recommendations to Government and Parliament' (NHSEI February 2021) • 'NHS Provider Selection Regime – consultation on proposals' (NHSEI February 2021) Health and Social Care Act, 2022
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

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 since last Board meeting:	26 May 2023
Chair of Committee/Group:	Allison Heseltine, Non-Executive Director
Date of Report:	5 June 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 will be aware of the current situation in relation to industrial action. The committee received an update on the industrial action position at the time of the meeting. The Board should be aware of the ongoing risk of industrial action from Junior Doctors and the impact, particularly on elective recovery. Industrial Action is currently planned by this staff group from 14 – 17 June. • There is further risk in the industrial relations climate with the British Medical Association (BMA), British Dental Association (BDA), Society of Radiographers (SoR) and Royal College of Nursing (RCN) balloting their membership on industrial action.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Performance is not meeting the targets in respect of turnover, sickness absence and appraisals, although turnover has seen improvements for the last four months. • A detailed review of performance against the strategic objectives was undertaken. Good performance noted in relation to vacancies and wellbeing. In relation to the WRES metrics, results were more mixed with improvements in some areas and worsening performance in others. Further updates will be considered through the Trust's equality reporting. • An update was provided on the Staff Survey action plans and the Staff Survey Oversight Group chaired by the Group Chief People Officer. Further assurance was sought on the delivery of a number of actions. • The Committee Objectives were reviewed with some minor changes made to reflect the importance of wellbeing and the actions necessary in relation to EDI. Further consideration to be made on the appropriateness / nature of any objective relating to workforce productivity.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The workforce targets and thresholds that had previously been reviewed, have had the targets associated with retention and bank fill further reviewed. The retention targets are now aligned across RWT, WHT and DGH. There remains some variation in the targets for bank fill recognising the differing levels of maturity of the banks. • Performance is meeting agreed targets in relation to vacancies, retention and mandatory training. • A deep dive into workforce issues in Division 1 was considered. This provided good assurance that the key issues were being managed withing the Division with particular focus on Women's and Neonatal Services. • The annual age profile report update was received. • A summary update on the work in relation to Organisational Development was provided, which provided good assurance on this programme of work.
Recommendation(s) to the Board/Committee	• The Board is asked to note this 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 and it was confirmed that a risk would not be raised in relation to retention.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• Trust Commitment to Flexible Working to be reasserted through David's Despatch. • New aligned targets to be reflected in Exec Workforce Report – complete. • Committee to consider objective in relation to workforce productivity. • Identification of further NED member(s) to ensure quoracy.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	**Actions** **Flexible Working Pledge** The Committee received an update on the Flexible Working Pledge that had been at WHT and were advised that RWT has a similar Commitment to Flexible Working espoused in the policy. The Commitment to be re-asserted through David's Despatch. **Review of Targets** The Committee had previously reviewed the targets, however, had posed questions regarding alignment with other Black Country Providers for retention rates and bank performance at its prior meeting. Following a review, the retention indicator was adopted as presented following confirmation from DGH and WHT that it was consistent. Some variation in targets for bank fill rate recognising that Trust banks were at different stages of maturity.

Key Updates

Pay Deal and Industrial Relations/ Action

The Committee were provided with an update on the pay deal for staff on NHS Terms and Conditions of Service. The pay award which provided for a 5% uplift in 2023/24 and non-consolidated payments for 2022/23 was agreed by the Trade Unions collectively and will be implemented from June. A number of unions including the RCN and Society of Radiographers remain in dispute with the government over the pay deal and are balloting their membership on further industrial action. Results are expected in late June.

In relation to Medical and Dental Terms and Conditions:

- There is a ballot for industrial action underway by the British Medical Association (BMA) and British Dental Association in respect of Consultant staff pay and pension benefits.
- The BMA (Junior Doctors) and the Hospital Consultants and Specialists Association (HCSA) have a mandate for industrial action and the has called for action from 14 – 17 June 2023.

Executive Workforce Report

The Committee received the Executive Workforce Report, which will be presented in summary format to the Board. It was noted that the report was against the new targets agreed at the previous meeting of the Committee. Of note the vacancy levels remained below threshold whilst mandatory training and retention were meeting the standards. Appraisal compliance, turnover, and sickness absence are meeting the target with improvements in turnover for the fourth consecutive month.

The Committee will receive an update on hard to fill posts and actions to resolve at its June meeting.

	Strategic Objectives The Committee received an update on the strategic objectives agreed initially in 2021/22 and refreshed for the 2022/23 financial year. In summary, it was noted that: - Performance in relation to the objective to have the lowest vacancy rate was good; - The Trust had met its objective in relation to health and wellbeing with best quartile performance for staff responding positively to say the Trust took interest in their health and wellbeing. - Staff engagement remained positive, albeit at 36th/124 when compared with other Trusts it was slightly outside the upper quartile. A particular focus on staff being able to make improvements was noted as required. There had been some progress against equality objectives e.g. with Black, Asian and Minority Ethnic (BAME) colleagues more likely to recommend the Trust than their white colleagues, increases in the proportion of the workforce from a BAME background and in respect of BAME colleagues being able to access training. However, challenges remained in relation to BAME staff reporting that they were more likely to experience bullying and harassment than their white colleagues. The Committee agreed to receive further information on this through the equality updates and the strategic objectives would also be reviewed as part of the review of the People and OD Strategy.

Deep Dive – Division 1

The Committee received a Deep Dive into Division 1, which provided an overview of the workforce issues across the Division and a greater insight particularly into Women's and Neonatal Services.

The overall review considered workforce performance across the Division with a review of key performance indicators as well as the age profile, reasons for leaving and Freedom to Speak Up (FTSU) data. Particular focus in the division on retention and Work Life Balance was recognised as a key factor.

The 12 month forward look generally provided for continued work with the FTSU Guardian with drop in sessions in a number of areas and the appointment of a Senior Matron lead for Workforce, Retention and Education with specific responsibility for improving support to international nurses.

The focus on the Women's and Neonatal Services included updates on:

- The National Perinatal Leadership Development Programme which the leadership of the directorate have been fully engaged with.
- The update reflected that the support of the Board has been notable with all four members of the leadership able to undertake the full leadership programme, unlike in other organisations participating in the programme.
- The outputs from the leadership programme have been triangulated with the work by Deloite and the next phase, including the development of a refreshed service strategy with focus on empowerment and supporting the teams delivering care.

Following successful participation in the National Perinatal Leadership Programme, the leadership have been invited to join the National Implementation Group shaping the programme for others.

Beyond the leadership programme in Women's and Neonates an update on the OD programme aimed at improving the culture was provided setting out details of the development of Culture Champions, Appreciative Enquiry sessions and the Improve Well Staff App pilot.

Further discussion took place in relation to exit feedback processes, which are currently based on the national exit feedback questionnaire in ESR and the (relatively) high proportion of FTSU matters presented in Ophthalmology.

The Committee were assured that exit processes were under review and that FTSU data for Ophthalmology was being triangulated with other data for the service such that appropriate action could be taken in light of the combined picture.

Annual Age Profile

The Committee received the annual update report on the age profile of the organisation. The report presented to the committee had previously showed a high proportion of staff in the age brackets that are approaching retirement.

This report showed that whilst the proportion of the workforce over 50 remained substantial, there had been a reduction over the last year.

Turnover was highest in the over 65 and under 25 age groups and elevated for the 25 – 35 age group.

The Committee noted the progress identified by the report and that the data had been shared with Divisions in order that local nuances and risks could be understood and planned for.

Organisational Development Update

The Committee received a summary update on the Organisational Development work in the Trust including:

- The development of the OD Toolkit, including interventions such as appreciative enquiry, action learning sets, de Bono 'Six Thinking Hats' facilitation, coaching conversations using the GROW model and compassion circles.
- The Civility and Respect workstream which has been delivered across nine areas within the Trust since its launch in late 2022.
- The development of the Behavioural Framework across RWT and WHT with colleagues at WHT.
- Long Service Awards.
- Staff Survey delivery.
- Talent Management.

The Committee noted the comprehensive update on Organisational Development.

Staff Survey Action Plans

The Committee received for assurance an update on the Staff Survey Action Plans. The report set out the work of the Staff Survey Oversight Group, chaired by the Group Chief People Officer through which the Trust wide plans in response to the staff survey are overseen alongside Divisional plans. The Committee noted key focus on health and wellbeing in Divisions 1 and 2 and a Trust wide focus on Civility and Respect.

The Committee was assured by the work of the Staff Survey Oversight Group. The Committee did note that due to the timing of the report a number of actions had passed their due date and some were recorded as ongoing. The Staff Survey Oversight Group to assure itself that actions had been completed and that actions noted as ongoing were progressing.

Key Risks and Board Assurance Framework

- No new committee risks were identified.
- The BAF was reviewed and the updates to SR 17 noted.

	Committee Objectives The Committee objectives, which were set in 2022/23 were reviewed. For 2023/24 these have been updated to reflect an increased focus on wellbeing and action in relation to EDI. The Committee objectives are: - To examine the issues, data and impact in relation to staff turnover and retention. - To monitor ongoing sickness absence position and the wellbeing of the workforce together with the actions being taken to address. - To monitor Equality, Diversity and Inclusion areas of concern and ensure action in place to improve. The Committee discussed whether any further objectives linked to workforce productivity should be included. It was agreed that work would be undertaken outside of the Committee to provide insight into the manner in which workforce productivity could be managed for a further discussion.
Self-evaluation/ Terms of Reference/ Future Work Plan	• Meetings was not quorate – Trust Secretary to identify NED for committee following personnel changes. • Quality reports provide good overview and triangulation between reports. • Discussion and debate around key issues.
Items for Reference Pack	• Operational Workforce Group Minutes and Action Log • Attract and Retain Group – Action Log • Academy Steering Group – Minutes • Medical Workforce Group – Action Log • Staff Survey Oversight Group – Action Log

Trust Board/Committee/Group Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee/Group:	Quality Governance Assurance Report
Date(s) of Committee/Group Meetings since last Board meeting:	24th May 2023
Chair of Committee/Group:	Louise Toner
Date of Report:	26th May 2023

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	**Cancer Improvement Plan** It was reported that there had been no written confirmation of the Trust moving into Tier 2 scrutiny, however weekly meetings with the ICB continue. 62 day waits continue to be the most challenging metric with 231 patients affected. Mutual aid has been offered to renal patients with 11 going to Dudley and 3 to Frimley Park in London. In addition. RWT is providing more renal lists. Additional patients could have mutual aid, however, many do not want to or are unable to travel to Leeds or London for surgery and it is the patient's choice to go or not. Some of the cancer metrics are improving e.g., breast whilst other continue to be problematic given increased referrals or mutual aid being provided by RWT increasing numbers. Gynaecological patient referrals continue to increase significantly and mutual aid is being sought. The Trust has provided NHSE with action plans for both the 62 week wait and the provision of Chemotherapy and both of these have now been "signed off." Histopathology turnaround times remain challenging despite outsourcing services and continuing discussions with providers to label specimen appropriately. However, it was reported that the choices that are offered by the system for such specimens do not enable clinicians to do this effectively. Further, many areas do not utilise or are unable to utilise the electronic system further adding to the time delays. **Ambulance waits and ED Breaches** Overall, this is an improving position with 4 hour waits better than the national target.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	**Other** Medically Fit for Discharge/ Criteria to reside patient numbers have reduced with approximately 54 patients waiting with those out of area being the most difficult to secure care packages to facilitate discharge. Discussion took place regarding Mental Health Capacity Assessments. Staff have received the required training; however, this does not seem to be translated into actual assessments in the practice setting. Further, a recent audit identified that even when audits are undertaken many do not meet the required standard. It was reported that the documentation process is challenging, and staff members are visiting other Trusts with high compliance to see how they have facilitated staff completing the required documentation. Scanning capacity within maternity services is a cause for concern with 2 SUI's identifying scanning challenges within the cases referred to HSIB. Mutual aid is being discussed with WHT to free up resources at RWT. Concerns remain regarding the need for greater cultural awareness for overseas recruits. The ongoing education and training programmes continue to be provided. Sickness rates have increased slightly, and retention rates reduced slightly . There remains a good staffing pipeline. C Difficile cases remain above trajectory and discussion/ clarification took place regarding deep cleaning given bed capacity. It was confirmed that daily cleaning and cleaning between patients continues with the decant facility available to clean equipment. It was reported that there is a deep clean decant plan for over the summer months. In addition, the need for accountability for IP&C from the divisions was acknowledged as well of the need to fully embed the IP&C awareness and promotion. Observations on time continue to improve. Induction of Labour remains higher than the set metric as does smoking at the time of delivery. Both have actions in place to improve the situation as far as is possible. Concerns remain regarding the reduced funding to facilitate ongoing community related initiatives that keep patients within the community were discussed given the success of these initiatives. It was identified that some services will cease but it is not clear at present which one and alternative funding is being sought. It was noted that there has been a decrease in referrals to the RIT this is being explored further.

	It was confirmed that the Annual EDI report confirms that 5 reviews had been completed and that the revision of the EDI strategy is underway. It was noted that the Patient Experience 6 monthly update report demonstrates compliance with statutory requirements with formal complaints reducing and compliments increasing. Neonatal Intensive Care activities continues to be below that required of a level 3 unit. However, given changes to improve patient outcomes, it is likely that activities will increase on the unit. It was reported that despite the VTE group supporting departments to improve VTE risk assessment compliance this remains variable across the divisions. It was reported that there is a 7% vacancy rate in Maternity Service but there had been a successful recruitment day and once all of the new recruits are in place the service should be up to establishment. Within the delivery suite Entonox exposure has been identified and actions are underway to try and improve the situation. The age of the building is making solutions challenging. The Perinatal Mortality Report confirms compliance with CNST requirements Health Visiting shortages remain with plans in place to enable statutory requirements to take place. It is recommended that 2 sets of blood cultures be taken to improve the accuracy of results, However, this will cost an additional 1.5 million due to increases in lab activity and workforce and whilst best practice is challenging so discussions being held with BCPS to discuss the clinical risk. It was reported that a number of external reviews had taken place three of which were RED rated and 4 Amber. Those rated red were related to FY doctors in surgery, the critical care medical workforce ad Paediatric Diabetes Peer Review. Actions are in place for all reviews.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	It was reported that of the 46 patients who have waited over 104 days for cancer treatment it was confirmed that there had been no physical or psychological harm identified. Furthermore, these patients are being reviewed by the now up to strength cancer team and as a result the reporting should improve moving forward. Referral to Treatment 78+ weeks has 83 patients in this category with all bar 20 (all urology) with plans in place to achieve 0 waiting by the end of June 2023. Triage compliance in maternity services, a CQC must do requirement, is at 97%. A recent LMNS “deep dive” was reported to have been supportive and reassuring.

Links to Trust Strategic Objectives	Given that this is a quality and patient safety report all of the strategic objectives are applicable.	
Links to Strategic Objectives	Excel in the delivery of Care	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 community and populations
	Support our Colleagues	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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
	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
Recommendation(s) to the Board/Committee	There were none.	

Changes to BAF Risk(s) & TRR Risk(s) agreed	There was 1 New Risks identified: **ID 5957 – Clinisys no longer supporting CSAS system** This risk could result in a delay/failure to send the results of cervical cytology safely to women. This was recognised as a national issue that should have a national solution. This was identified at the April meeting but formally accepted onto the register. **ID 6006 – Non - Availability of Medical Equipment** This relates to neonatal transfers equipment whereby an external company is required to undertake checks. Assurance was provided that the equipment is available within the hospital for use if required but ideally should be sited within Neonates. 2 Risks were removed from the register **ID 4913 – Emergency Gynaecology service in D18 and lack of Gynaecological Ward (COO)** It was noted that this risk has been deescalated to the Divisional Risk Register. **ID 5610 – Increase in Haemodialysis (HD) numbers (COO)** These were reported at the May meeting and confirmation was provided that these had now been formally removed from the TRR. It was reported that there 27 risks on the register of which 8 are red risks. 3 risks with overview reviews two of which relate to Provision of Mental Health Beds and CAMH's patients on ward A21 both of which are national issues and are being considered from a risk perspective. The risks that have been on the register for 4 years and over -5- were briefly discussed one of which 1984 has moved from Amber to Red - ID 1984 the backlog of Ophthalmology Review patients. The Heat Map summary was discussed.

ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	Members to forward any further comments re the Quality Account 2022/23 to Sue Hickman. Discussion to be held with Keith Wilshere re the timings of QGAC to facilitate sufficient time to do the papers received justice.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	Cancer Improvement Plan Trust Risk Register Update Board Assurance Framework – received Integrated Quality and Performance Report QSAG Chairs Report • IQPR Report Division 1 Infection Prevention Report • Draft IP BAF May 2023 Quality Accounts – 2022/2023 Midwifery Governance Report • Anonymised CNST Compliance 1st Jan to 31st March 2023 • Maternity Dashboard • RA Entonox Exposure in Maternity • Sui Report for DoM (HSIB Safety Recommendations) Mortality Quality Improvement Plan • Learning from Deaths Update May 2023
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	Discussion took place with regards to the financial deficit and the challenges associated with achieving the Cost Improvement Plan without negatively impacting on quality and patient safety. Other discussion related to the areas identified above.

Matters presented for information or noting	There were none
Self-evaluation/ Terms of Reference/ Future Work Plan	Some good discussion too place regarding a number of important issues as indicated above. Further, the importance of receiving papers in a timelier manner was identified to enable members to really do them justice given the time and effort that the authors put into their development.
Items for Reference Pack	There were none

Trust Board/Committee/Group Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee/Group:	Quality Governance Assurance Report
Date(s) of Committee/Group Meetings since last Board meeting:	25th April 2023
Chair of Committee/Group:	Louise Toner
Date of Report:	3rd May 2023

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	**Cancer Improvement Plan** It was reported that it was likely that RWT, as a result of some of the cancer metrics, would be escalated to Tier 2 level of scrutiny whereby there would local/regional intervention in respect of performance and metrics. Formal notification is awaited. There are 2 metrics where the Trusts performance has not been of the required standard, these are: 62 day waits – it was reported that this metric has been a challenge for the Trust since pre covid days. The current performance metric is based on the number of patients waiting over 62 days. At present the Trust has 12% of patients waiting over 62 days (in the top 20 nationally). It was confirmed that approximately 50% of those waiting over 62 days are urology patients with a high proportion awaiting nephrectomy/partial nephrectomy. A recovery plan is currently in development which includes: • Increasing productivity at RWT • Mutual aid for urology patients • Renal patients referred to RWT from Russell's Hall Hospital to be transferred back given they now have a robot and consultant expertise. Patients with Gynaecological and Colorectal issues are increasing the latter following a national campaign re Bowel Cancer screening. The second area that has given rise to the escalation is Chemotherapy turnaround times – however the performance metrics in this area are improving and it is not anticipated that this will be a significant focus. The Trust has provided NHSE with action plans for both the 62 week wait and the provision of Chemotherapy. In addition to the above, histopathology turnaround times remain challenging despite outsourcing services. Partial assurance has been given by the System Cancer Board following a presentation

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	**Ambulance waits and ED Breaches** It was reported that performance was variable across March but has improved during April despite the delays over one hour. Covid and increases in length of stay were contributing factors. Clarification was sought re ongoing funding for services and the likelihood of this being reduced e.g., Virtual Ward and the Rapid Intervention Team and the impact of this. It was recognised that a risk assessment will be required to determine how to reduce capacity and potentially the availability of some services. Discussions taking place with Local Authorities and the need to secure funding for patients out with areas as it takes longer to secure the required support to return these patients home/to other services. Medically fit for discharge/criteria to reside are currently in the region of 76 patients. **Staffing** Whilst staffing continues to improve, 2% vacancy rate, concerns remain regarding the need for greater cultural awareness for overseas recruits. There are ongoing education and training programmes and targeted activities have been put in place in place to improve this situation. In addition, skill mix concerns have been expressed given the high numbers of new nurses. C Difficile cases remain above trajectory with a spike in numbers during March there is an ongoing action plan in place. It was acknowledged that whilst there is now the space to facilitate deep cleaning of equipment it is not ideally located, and additional facilities are being explored or a more centralised facility secured. The report from the external review undertaken by the Regional Infection Prevention and Control Lead has been received and it was confirmed that there was no additional information over and above what was reported at the time of the visit and the issues identified are already being acted upon. Observations on time are improving across most areas with additional support in place for areas struggling to meet the target. Audit completion rates continue to be variable across the divisions, and it is likely that the targets will not be met. However, staffing challenges have made it difficult to secure accurate data. Those audits not completed will be reviewed in respect of any quality and safety issues that need to be continued. completions Induction of Labour remains higher than the set metric and clarity was sought in respect of the QI project and had it been started. It was confirmed that the project is one being led by the LMNS. Project ongoing.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	Smoking at the time of delivery continues to be above the set target and additional staff are in place to support cessation activities. It was reported that, as a result of a system error, the VTE Documentation on Badgernet enables information to be completed re delivery in advance of the delivery taking place. This has been escalated. The activity within Neonatal Intensive Care continues to be below that required of a level 3 unit. It was reported that the VTE group is maintaining their support with departments to improve VTE risk assessment compliance. There are specific challenges within the ED with regards to Lower Limb Immobilisation, particularly from a documentation perspective however, work is ongoing to manage/resolve the situation. It was reported that the Nutrition Support Steering Group have initiated a range of actions to improve patient care, however concerns remain regarding a number of areas that require additional work including weight measurement, the completion of documentation staffing issues in dietetics and speech and language therapy. BMc advised that a possible Never Event in Dermatology had been externally reviewed and the subsequent report forwarded to the commissioners. The view of the external expert was that it was not a Never Event given the patients underlying condition and that the actions of the dermatologist were reasonable. However, it was acknowledged that the learning from the situation were being managed. It was reported that the review of patients waiting more than 104 days for cancer treatment – there were 32 in February – had been carried out and it was confirmed that there had been no physical or psychological harm identified. Across the Trust a plan is underway whereby smokers admitted to hospital are being offered NHS Tobacco treatment services. Initial findings suggest this is having a positive impact.

Links to Trust Strategic Objectives	Given that this is a quality and patient safety report all of the strategic objectives are applicable.	
Links to Strategic Objectives	Excel in the delivery of Care	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 community and populations
	Support our Colleagues	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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
	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
Recommendation(s) to the Board/Committee	There were none.	
Changes to BAF Risk(s) & TRR Risk(s) agreed	There was 1 New Risks identified: **ID 5957 – Clinisys no longer supporting CSAS system** This risk could result in a delay/failure to send the results of cervical cytology safely to women. This was recognised as a national issue that should have a national solution.	

	2 Risks were removed from the register **ID 4913 – Emergency Gynaecology service in D18 and lack of Gynaecological Ward (COO)** It was noted that this risk has been deescalated to the Divisional Risk Register. **ID 5610 – Increase in Haemodialysis (HD) numbers (COO)** It was agreed that moving forward the rationale for the removal of risks be provided. The Heat Map summary and detailed Risk Register was Provided and discussed.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	To agree the need for scheduling of the Draft Internal Safety Head of Audit Opinion Report. To agree the scheduling of the Quality Safety Enabling Strategy – April is the suggested meeting date.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	Cancer Improvement Plan Trust Risk Register Update Integrated Quality and Performance Report Internal Audit Opinion QSAG Chairs Report
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	Discussion took place regarding the Draft Head of Internal Audit Opinion report. It was reported that in previous years there had been a joint QGAC and Audit Committee meeting, however, this no longer takes place. It was felt that this report may have been brought to QGAC as a result of this. Whilst those in attendance had read the report and Mr. Hussain provided explanations and clarity, it was felt that given the limited details within the report it was more appropriate for it to go to Audit Committee prior to QGAC and discussion to take place on whether this is required moving forward. It was identified that there have been positive discussions with the divisions with reporting following the format of the Trust Board IQPR.

Matters presented for information or noting	There were none
Self-evaluation/ Terms of Reference/ Future Work Plan	A short meeting due to the agenda, nevertheless some useful discussion.
Items for Reference Pack	There were none

Trust Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee/Group:	Performance & Finance Committee Meeting
Date(s) of Committee/Group Meetings since last Board meeting:	26 April 2023
Chair of Committee/Group:	Lisa Cowley
Date of Report:	26 April 2023

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	Primary area of focus is 2023/24 financial planning • An updated 2023/24 financial plan report was tabled in the meeting, this has moved the projected deficit to £42.1m. • The current plan presents a high level of risk to RWT in terms of achievement, with only £4.4m of the cost improvement areas (9.1%) currently identified. The current best case scenario still identified a financial gap of £22.7m in relation to budget achievement. • The committee agreed that further work should be undertaken specifically in relation to workforce budgets and NHS England identified areas for investigation and a full board meeting convened to discuss the revised model and agree an operating budget for Q1. Elective Recovery • The achievement of the 78 week target by the revised target date of end of May 2023, is currently unlikely to be achieved with potentially 260 individuals without an agreed plan. Cancer • It is anticipated that RWT will move into tier 2 in relation to 62 day wait for treatment based on the percentage of patients waiting beyond this date. The committee have been provided with further information regarding the specialisms implicated and action plans in place including mutual aid. Procurement • Concerns were raised regarding the presentation of a retrospective approval for the award of a contract. The committee were assured that the contract award process had been a fit and proper process using appropriate frameworks, but committee and board approval had not been given for the contract award before the service started. The committee have requested an investigation to be tabled at the May meeting.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	Elective Recovery • Discussions around areas of concern including Diagnostics, and outpatient transformation. The team are exploring a range of options and working creatively with partners to pilot new models. It was agreed that PODC would explore Diagnostics in relation to staff recruitment, retention and engagement. • The committee will receive a quarterly update on outpatient transformation.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	2022/23 Financial Position • The Trust has achieved the 2022/23 budgeted position (breakeven) with a £90,000 surplus subject to External Audit. The committee noted the work across the trust required to achieve this position. Financial Recovery Group • The committee discussed the tabled paper and congratulated the team on the progress made in 2022/23 and noted the plans for 2023/24. Annual PFI Contract update • The committee received a positive report regarding the contract at RWT for the Radiology Building and related services and the effective collaborative relationships that have been built by the team.
Links to Strategic Objectives	Excel in the delivery of Care 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 community and populations.
Recommendation(s) to the Board/Committee	• The board are recommended to note this report, further papers regarding the 2023/24 financial and operational plans will be submitted for approval.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• The BAF updates are now presented bi-monthly, nothing to highlight this month.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• 2023/24 financial and operational plans will be further developed and presented to the committee and board for approval.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Elective Care Recovery Programme • IQPR extract • Monthly Financial Report • 2023/4 Financial and operational planning • Financial Recovery Group Report

	• Annual PFI Contract update • Supplies & Procurement Quarterly Update • REAF 611
Matters presented for information or noting	• Capital Report • High Value Contract Report • Supplementary Finance Report • 5 year capital review • Temporary Staffing Dashboard Report • Committee Work Plan
Self-evaluation/ Terms of Reference/ Future Work Plan	• The Work Plan is a live document that is updated and circulated monthly. • The Self-evaluation was completed January 2023 and is a biennial evaluation that is next due to be completed January 2025. • The Terms of Reference were updated 24th November 2022 and are due for review 20th December 2023.

Trust Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee/Group:	Performance & Finance Committee Meeting
Date(s) of Committee/Group Meetings since last Board meeting:	24th May 2023
Chair of Committee/Group:	John Dunn
Date of Report:	24th May 2023

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	The committee reviewed the Trusts Performance for April 2023 and the forecast performance against National and Trust Targets. **Summary:** • Referral to Treatment (RTT) incomplete pathway: slight increase in month but in line with the trajectory expected for a continued rise throughout 2023/24 as demand from the pandemic restores. • RTT 78+ week wait: the trend of increasing breaches has been reversed with a fall of two breaches in month. Additional weekend activity is planned to reduce the number of 78 week waits further ahead of the end of June target. This indicator has been impacted by the Junior Doctor Industrial Action in March/April 23 and subsequent cancellations. A total of 2,988 patients were affected (373 admitted & 2,615 outpatients) were cancelled or rescheduled. • Diagnostics: performance has remained relatively static during April 23 with the biggest waits in endoscopy, echocardiography and ultrasound - all driven by staffing challenges. Remedial action plans are in place with an expectation that performance improves throughout 2023/24. • Emergency Department (ED) 4 hour: Performance improved in month, exceeding the new national standard of 76%. The Streaming/Navigation pilot has been extended with an evaluation of its effectiveness planned. We continue to benchmark well both locally and nationally. • Cancer Two Week Wait (2ww): we continue to see high volumes of 2ww referrals and is driving our underperformance. Mutual aid is being sought where available and likewise, RWT is continuing to offer mutual and support to Walsall within the Skin specialty. • Cancer 62 day: the referral numbers above, combined with delays within histopathology and some specialty specific constraints continue to impact on our 62 day performance. Additional capacity has been procured outside of the system to support with the transfer of some urology patients. **Elective Recovery Programme** • The Trust is on track to achieve the 78 week target at the end of June, 20 patients still require a plan but the target will be achieved via waiting list initiatives. • The Trust has been escalated into Tier 2 for cancer performance and referrals remain at 120% of 19/20 levels with the backlog relatively static. **Overview of Financial Performance** • The Trust is reporting an in month adjusted deficit of £8.29m, this is £2.3m adverse to plan.

	• Month 1 position is very challenged, even with adjusted calendarization there is a larger deficit than expected. • There are challenges on assumptions for sickness. • There has been a net increase due to the impact of the Junior Doctor Industrial Action. • The Trust's Cost Improvement Programme (CIP)is not delivering to expectations. • There is good control over agency but Q1 targets are unlikely to be met. **CIP - Financial Recovery Group** • The Trust has identified 159 schemes on the CIP pipeline, work will take place to identify savings via the PID process. However, there will be limited delivery during Q1 and Q2 with the CIP plan being back ended to Q3 and Q4. **Investment Reviews:** The committee reviewed the Following business cases: **Investigation into Renal dialysis service:** • An investigation has taken place into the circumstances surrounding a service commencement prior to governance approval. The investigation and recommended actions have been referred to Audit Committee. **Contract Extension for the Provision of Insourcing Endoscopy Services:** • A nine month extension to the current contract with 18 weeks service for the period 1st July 2023 to 31st March 2024. The committee reviewed the extension to the current contract and endorsed its approval by the Trust board. **Contract for the Supply of Frozen, Chilled and Fresh Food Tender Evaluation Report** • The committee noted the position that the contract had already commenced prior to governance approval and was subject to the changes of process recommended in the above investigation. **FBC Update: Cannock Chase Hospital: Theatres Proposal (North Hub)** • The committee's Had an update surrounding the current status of the major capital project at the Cannock site and concluded that further information was needed on the projected costs, implementation timescales and in depth meeting was needed to appraise the Trust board on the Final business case. The meeting to be scheduled within 2 weeks. **Winter Plan Review** • Due to time constraints, the item was deferred until the June meeting.
ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	**Elective Recovery Programme** • The Trust's cancer performance has led to greater scrutiny from NHS England. • The Trust's backlog is increasing and the profiling in the backlog is pushing more patients towards longer waits. • The activity plan for next year, at 106.9% falls slightly short of the 108% Trust target. The Trust continues to work to identify further activity to increase this further but this level will not be sufficient to reduce the waiting list overall. The national focus remains on 65 and 78 week waits. • Whilst remedial actions are in place for the remainder of the year, diagnostics performance is impacting on overall waiting times, e.g. ultrasound generally, histopathology in cancer and echocardiography in cardiology. The committee requested further action to understand the forecast position for Q1 and Q2 across all performance parameters and the options for increasing capacity and whilst

	focusing on patients with the longest wait times. A clear understanding of the capacity constraints and the options and plans available to increase overall throughput was critical. **Monthly Financial Report** • Further action is currently underway to understand the detail of the financial under performance and to review all plans namely: Divisional run rates, Tree and branch review of CIP, Reenergise the efficiency programme linked to increasing capacity for restoration.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	**Elective Recovery Programme** • Other than activity and diagnostics performance is either in line or better than the trajectories that were submitted and accepted by NHS England. • Additional capacity has been identified at weekends to reduce the Trust's 78 week waits. Additional capacity beyond June will be needed and is being explored.
Links to Strategic Objectives	Excel in the delivery of Care 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 community and populations.
Recommendation(s) to the Board/Committee	•
Changes to BAF Risk(s) & TRR Risk(s) agreed	• The BAF was not discussed at the meeting due to time constraints.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	•
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Elective Care Recovery Programme • IQPR extract • Monthly Financial Report • 2023/4 Financial and operational planning • Financial Recovery Group Report • Investigation into REAF 611 • REAF 885 Supply of Frozen, Chilled and Fresh Produce for Retail and Patient Feeding (noted) • REAF 1100 18 Week Ltd Endoscopy Support (approved in part) • Full Business Case Update – CCH Theatres Proposal (North Hub)
Matters presented for information or noting	• Annual Work Plan • Capital Report • High Value Contract Report • Contracting & Business Development Report • Sustainability Report • Supplementary Finance Report

	• Temporary Staffing Dashboard Report
Self-evaluation/ Terms of Reference/ Future Work Plan	• The Work Plan is a live document that is updated and circulated monthly. • The Self-evaluation was completed January 2023 and is a biennial evaluation that is next due to be completed January 2025. • The Terms of Reference were updated 24th November 2022 and are due for review 20th December 2023.

Trust Board Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee:	Audit Committee
Date(s) of Committee Meetings since last Board	26 May 2023
Chair of Committee:	Julie Jones
Date of Report:	30 May 2023

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	• The Committee had previously escalated to Trust Management Committee their concern that recommendations raised by internal audit were not being updated on iBabs to demonstrate that actions had been addressed in accordance with the agreed timescales. Whilst there has been some improvement, the committee again noted that updates were required.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Following escalation from P&FC, members noted that committee's investigation into retrospective procurement approvals and discussed the linkage with the internal audit report of Private Sector Contracts, which gave '**reasonable** assurance' but raised parallel concerns in some areas. The committee will follow this up at its September meeting once further work has been undertaken for P&FC.

ASSURE **Positive assurances & highlights of note for the Board**	• The committee reviewed the BAF and discussed current risks, in particular the importance of the Cost Improvement Plan. • The quarterly security report gave assurance that risks were being managed. • In addition to Private Sector Contracts, internal audit reports of Research & Development (LCRN) and the Data Security & Protection Toolkit were received, with no high-risk recommendations raised. The committee also received oral assurances that the BAF/TRR audit had been completed and a report giving '**substantial** assurance' would be issued. • The internal audit plan for 2023/24 was reviewed. • The committee received the Local Counter Fraud Service annual report together with a progress report. • External audit outlined the results of their audit for the year ended 31 March 2023 and the committee was assured that there were no material unadjusted errors or significant control weaknesses. • A significant item of business for the committee this meeting was reviewing the Trust's annual report and financial statements for the year ended 31 March 2023, as supported by detailed explanatory papers by officers. Based on the reports provided and the feedback from external audit, the financial statements were recommended to the Trust Board for approval. • In addition, the draft Quality Report for 2022/23 was also reviewed. • The committee received a report detailing Single Tender Actions and Suspension Breaches.
Recommendation(s) to the Board	• Losses and special payment proposed write offs were agreed for final approval by the Trust Board. • The Trust's financial statements for the year ended 31 March 2023 were recommended to the Trust Board for approval.
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. • Members and visitors had previously been tasked with completing a self-assessment of the committee's effectiveness. The committee reviewed the outcome of this self-assessment but noted that less than ideal numbers of responses had been received. It was agreed that the survey would be recirculated. That said, it was clear from those responses received that the committee should review the level of information it receives under each agenda item; members agreed to meet outside of committee to discuss this.

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 noted that the meeting had a full agenda of almost 700 pages with some very important documents to consider, but that thanks to the quality and timeliness of the papers the meeting was able to be conducted efficiently. • Members noted the need for a new committee member to be appointed to replace Mr Hemans.
Items for Reference Pack	• None

Audit Committee – Review of Activities 2022/23

Meetings held in Year

The Audit Committee met four times in the year (May, September, December 2022, and February 2023).

Membership/Attendance

Membership during the year has changed with R Dunshea and M Martin ceasing to be a member of the committee in May 2022. J Jones, J Dunn and J Hemans joined the committee in May 2022 with J Jones becoming the Chair in September 2022.

The Audit Committee has been quorate at each of its meetings, with attendance over the four meetings being as follows: -

	May 2022	**September 2022**	**December 2022**	**February 2023**
R Dunshea (Chair to May 2022)	✓ (last meeting)			
M Martin	X (last meeting)			
L Toner	✓	✓	✓	✓
J Jones (Chair from September 2022)	✓	✓	✓	✓
J Dunn	✓	✓	✓	X
J Hemans	✓	✓	✓	X

Business Conducted

In the course of its four meetings, the Committee has considered and where required, taken a view on the following: -

- The Trusts Annual Accounts 2021/22 and Annual Report and the related reports from both Internal and External Auditors

- Charity Fund Annual Accounts and Annual Report 2021/22 and the related report of the External Auditors

- The Annual Reports of Internal Audit (including the Head of Internal Audit Opinion) and of the Local Counter-Fraud Specialist for 2021/22

- Risk Management and Board Assurance Framework

- Regular reports form the Head of Security and Car Parking and the Annual Report

- The External Auditors Annual Audit Letter for 2021/22

- The External Audit Plans 2021/22 for both the Trust and the Trusts Charitable Funds

- Internal Audit and LCFS plans for 2021/22 and regular reports detailing progress against the agreed plans.

- Regular reports identifying the progress the Trust has made in implementing recommendations agreed in Action Plans consequent on Internal Audit reports, with particular attention paid to "high" and "medium" priority recommendations.

- Reviewed and agreed the Trust Fraud Policy based on best practice.

- The Trusts Annual Governance Statement for 2021/22, was discussed at the Audit Committee meeting in May 2022.

In addition to the above, the Audit Committee has: -

- reviewed its Terms of Reference and draft Head of Internal Audit Opinion

- held regular private meetings with Internal and External Auditors and LCFS

- submitted the minutes of its meetings to the Board, with the Chairs report highlighting any issues of significance.

- Commenced a performance review of its activities and agreed KPIs for the three main assurance providers – Internal Audit, External Audit and LCFS

The Committee has reviewed its work plan together with its Terms of Reference and concluded that it has complied with its Terms of Reference.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	6th June 2023
Title:	Report of the Chief Financial Officer - Month 1
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	**Excel in the delivery of care** We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
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 1
Item/paragraph 1	This paper reports the in-month, year-to-date and the draft year end position for the Trust as at Month 1. The paper also reports on delivery against financial targets.

The Royal Wolverhampton NHS Trust

Reference Pack

Report of the Chief Financial Officer

Finance Report
April 2023 - Month 1

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Dashboard

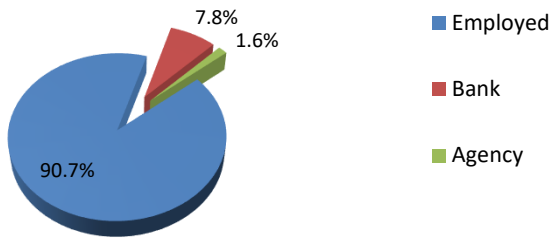
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Patient income	53.48	53.48
2. Other income	14.65	14.65
Total	**68.12**	**68.12**
Expenditure	**76.41**	**76.41**
Surplus/ (deficit)	**(8.29)**	**(8.29)**
Planned surplus/(deficit)	**(5.99)**	**(5.99)**
Variance to plan	**(2.29)**	**(2.29)**

Workforce

(see page 8)



Patient Income

Elective recovery fund income in April is £0.4m behind the Trust activity plan, which is £0.8m behind the submitted stretch plan, mainly in elective and daycase activity. Other variable income relating to drug, devices and diagnostics is £0.6m behind plan. All other income is within the block.

Cost Improvement Programme (CIP)

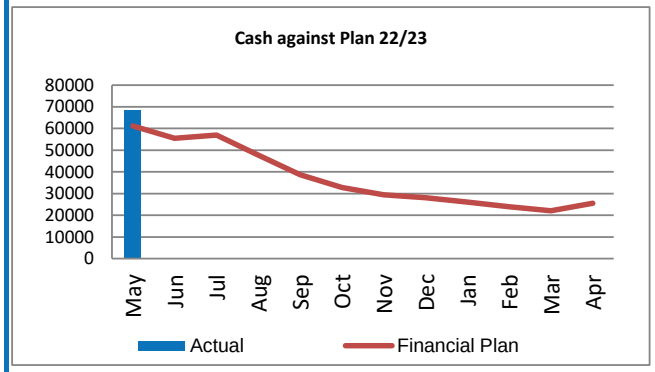
(see page 9)

Against an in month target of £1.57m, the Trust has achieved £179K. Of this, £8K is recurrent. The 23/24 target for the trust is £45m & the trust had identified savings with full year effect of £2.15m.

Cash in the Bank

(see page 7)

Plan £61.2m
Actual £68.4m



Covid-19 Expenditure

In month 1 there was a total of £124k expenditure relating to Covid-19.

Of this amount £80k is reimbursed for testing.

Reserves

(see page 9)

£2.9m of reserves are released into the position at month 1 of an annual value of £37.5m

Actual Outturn

(see page 5)

£8.29m defecit in month (and year to date)
(£2.3m adverse to plan)

Overview of Financial Performance

The Trust is reporting an in month adjusted deficit of £8.29m, this is £2.3m adverse to plan.

The in month position is materially impacted by the strike action in April, with direct pay costs estimated to be £1.1m. However elective recovery performance is also behind plan by £0.8m, of which £0.4m is stretch target. In addition pay has overspent by a further £1.5m largely related to continued cover for high levels of sickness absence and premium bank costs in the period, above budget, however there appears to have been a run rate increase of circa £0.5m (under review) of which £0.1m is related to Urology. Non-Pay is £0.3m overspent and is made up of a number of activity related under and overspends and Drugs is £0.3m under spent also related to activity. CIP under performance is £1.4m against plan, and the position is partially off set by £2.9m of reserves.

System Updates

There is limited reporting of the system financial position in month 1, however the ICB is reporting a £20.1m deficit in month, £7.45m behind plan, and all but two organisations running a deficit.

Capital

The Trust have spent £3.4m of capital YTD to 30th April 23. Of this £3.4m, £0.7m relates to capital spend which the ICS is measured against. The Trust anticipates meeting its planned CRL of £20.9m. The balance of capital YTD £2.7m relates to capital spend on grant funded items relating to PSDS Phase 3.

The Trust has a planned gross capital expenditure of £72.3m, which consists of £20.9m ICS CRL (internally generated funds); PDC £23.4m, Grant funding of £17.3m, IFRIC 12 related capital spend of £9.2m and IFRS 16 new leases £1.5m.

Income and Expenditure Run Rates

	£m	22/23 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	23/24 Apr
	Patient Income													
1	Plan	52.92	53.09	55.94	54.24	54.79	61.89	57.85	57.06	57.44	58.17	58.41	97.46	54.90
2	Actual	52.60	53.12	55.67	56.40	54.82	60.56	56.79	60.38	54.88	57.79	58.18	100.44	53.48
3	Variance	(0.32)	0.02	(0.27)	2.17	0.03	(1.33)	(1.06)	3.32	(2.56)	(0.38)	(0.23)	2.99	(1.42)
	Non Patient Income													
4	Plan	11.60	17.19	15.53	11.30	11.67	17.01	13.26	12.41	21.15	13.07	14.23	30.98	16.11
5	Actual	10.72	17.70	15.61	11.60	11.80	11.49	19.22	13.75	16.99	14.40	18.15	17.82	14.65
6	Variance	(0.89)	0.51	0.08	0.30	0.13	(5.52)	5.97	1.34	(4.16)	1.33	3.92	(13.16)	(1.46)
	Pay Expenditure													
7	Plan	39.52	39.50	42.73	41.29	41.49	46.92	42.71	42.54	43.20	40.89	43.28	82.72	44.10
8	Actual	41.08	41.96	41.42	42.23	42.75	48.28	43.60	42.16	40.52	42.64	42.71	82.05	46.78
9	Variance	(1.56)	(2.46)	1.31	(0.94)	(1.27)	(1.37)	(0.89)	0.38	2.69	(1.75)	0.57	0.67	(2.67)
	Non Pay Expenditure													
10	Plan	17.14	16.02	17.80	16.48	16.35	16.60	17.14	17.10	18.15	17.43	19.31	18.47	17.22
11	Actual	16.55	16.25	16.52	15.94	16.24	16.32	17.23	17.78	15.75	15.85	17.87	24.20	17.52
12	Variance	0.59	(0.23)	1.28	0.54	0.12	0.28	(0.09)	(0.68)	2.40	1.59	1.43	(5.72)	(0.31)
	Drugs Expenditure													
13	Plan	5.65	5.31	5.74	5.51	5.58	6.10	5.55	5.65	5.98	5.97	5.70	6.03	5.92
14	Actual	5.78	5.59	5.63	5.66	6.03	6.58	5.91	5.95	6.32	6.47	5.83	6.56	5.66
15	Variance	(0.12)	(0.28)	0.11	(0.15)	(0.45)	(0.48)	(0.36)	(0.30)	(0.34)	(0.50)	(0.12)	(0.54)	0.27
	CIP over/ (under) achievement													
16	Variance	(0.42)	(0.13)	0.08	(0.79)	(0.76)	(0.41)	(1.19)	(1.83)	(1.86)	(0.74)	(1.44)	0.58	(1.39)
	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	(0.14)	(0.10)	(0.07)	0.00
	Reserves supporting position													
17	Actual	2.81	2.49	(1.70)	(0.71)	0.68	1.58	1.47	1.59	(0.48)	2.50	0.95	(0.31)	2.85
	Other Non Operating Expenditure													
18	Plan	(2.98)	(4.37)	(3.27)	(3.61)	(3.61)	(3.27)	(3.78)	(3.78)	(3.78)	(3.80)	(3.84)	(3.83)	(3.79)
19	Actual	(3.17)	(3.72)	(3.79)	(3.58)	(3.54)	(3.53)	(3.75)	(3.57)	(3.54)	(3.54)	(3.52)	(2.04)	(3.77)
20	**Variance**	(0.19)	0.65	(0.53)	0.03	0.08	(0.26)	0.03	0.21	**0.24**	**0.26**	**0.32**	**1.79**	**0.02**
	Total													
	Plan	(3.24)	2.64	3.46	0.06	(0.58)	4.76	1.65	0.62	**9.81**	**1.54**	**1.10**	**17.18**	**(1.48)**
	Actual	(3.25)	3.30	3.91	0.60	(1.93)	(2.66)	5.52	4.68	**5.74**	**3.69**	**6.41**	**3.42**	**(5.60)**
	Variance	(0.01)	0.65	0.45	0.54	(1.35)	(7.42)	3.87	4.06	**(4.07)**	**2.16**	**5.31**	**(13.76)**	**(4.12)**

Commentary on variances and trends:

Patient Income - For 2023/24 the income plan consist of two elements; a variable element for elective activity and applicable pass through costs such as drugs and a fixed element for all other income. There has been a reduction in the income run rate for April as the new financial year has seen a reduction in non recurrent support from commissioners, such as a reduction in covid funding and an increased efficiency applied. Furthermore the April run rate and variance is lower due to bank holidays and strike action, with ERF activity being £0.4m behind the Trust activity plans and a further £0.4m behind stretch plan. The remaining £0.6m variance is due to other variable income for drug, devices and diagnostics which is offset by expenditure.

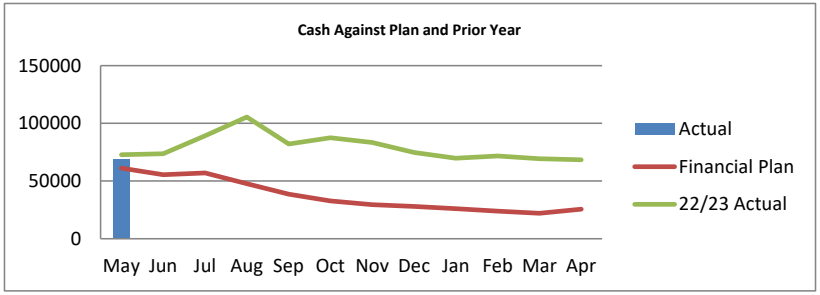
Non Patient Income - has underperformed in month by £1.46m. This includes expenditure matched underperformance on Grant Income capital schemes of £1.9m. Private patient income is on plan. Education and research income is underperforming by £0.2m due to phasing of education contract income from NHSE. These are partially offset by an overperformance across the directorates of £0.7m, including £0.3m additional partner charges from BCPS.

Pay - is showing an overspend of £2.65m in month. This includes total estimated costs of £1.1m related to additional payments to medical staff for cover provided during the four days of junior medical strikes. In addition there are overspends in Division 1 £0.6m caused by bank and agency cover for sickness and maternity, backdated pay and additional PA's (£196k) along with posts that were externally funded last year which have not yet been confirmed this financial year (£30k). Division 2 £0.7m due to ward bank cover for absences in excess of budget and bank/agency cover for medical staff vacancies and absences. Division 3 (£0.2m) again for temporary staffing cover.

Non Pay - The in month overspend of £0.3m is caused partially by BCPS £237k, income has been received as noted above to cover this. There is also an overspend on Corporate areas where lead recruiter activity awaits a budget decision. Division 3 has overspends on Radiology due to the hire of scanners £50k, disability and wheelchair activity increases £85k, children's diabetes pumps and consumables £37k and pharmacy one off costs of £30k. The overspends are offset by reduced activity costs in division one due to cancelled activity related to the junior medical staff strike and Estates also undertook less routine maintenance. The non pay run rate remains broadly in line with that experienced towards the end of the last financial year.

Drugs - In month are £270k underspent. This has occurred across a number of specialties who have all seen a reduction in Drug usage, some of this will have been caused by the reduction in activity seen due to the strike. Most notably underspends occurred in Ophthalmology (£112k) and Gastro (£56k).

Cash Position



The cash balance as at 30th April 2023 is £68.4m, a £0.9m decrease on the previous month and an increase of £7.2m on financial plan. This is mainly driven by £5.9m Health Education Funding received ahead of when expected.

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:

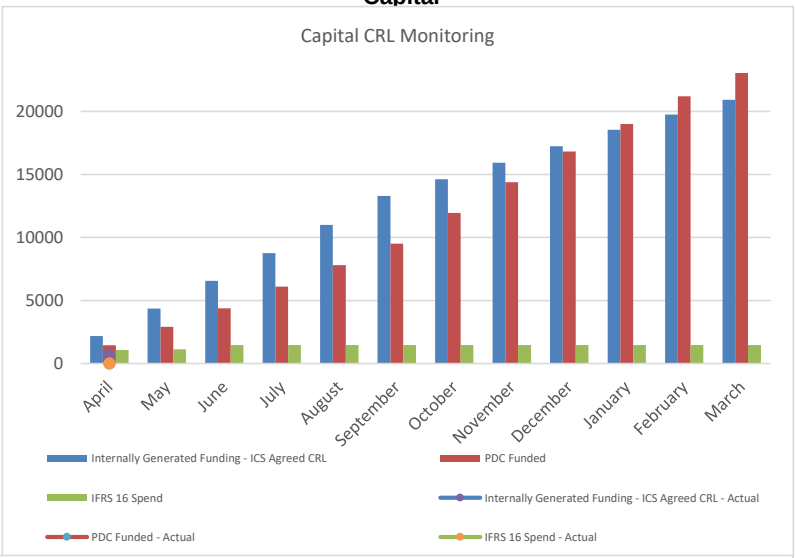
	M1 23/24	Cumulative	M12 22/23	Cumulative
Value	95%	95%	97%	93%
Volume	94%	94%	96%	90%

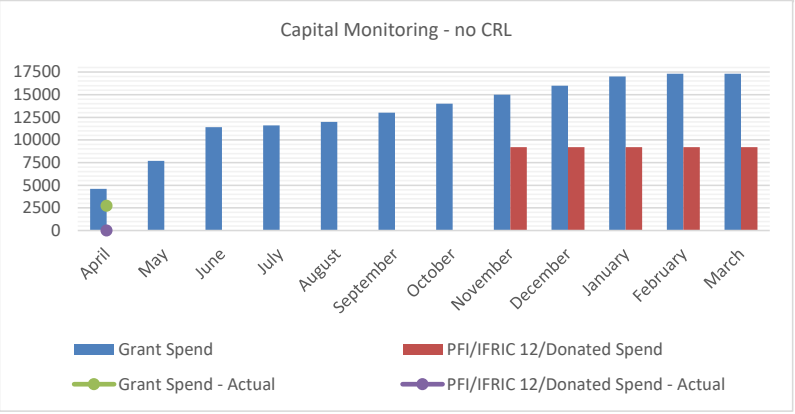
Debtor Days

Calculated Debtor Days for the year are:-

	M1 Actual	M12 Actual
Total	8.95	7.3
Being:-		
NHS	9.50	7.5
Non NHS	6.91	6.56

Capital





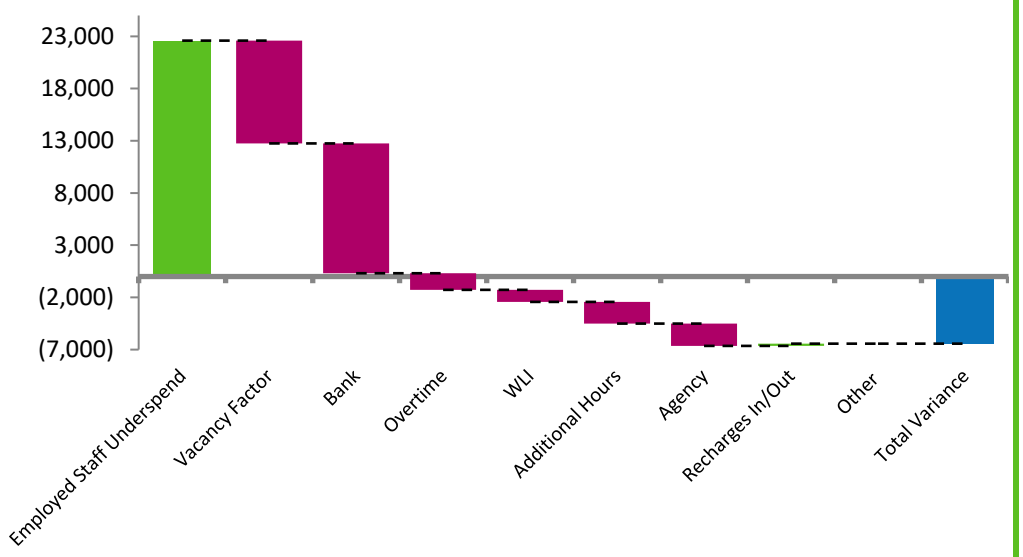
The Trust have spent £3.4m of capital YTD to 30th April 23, which is an underspend of £5.9m against planned M1 capital spend of £9.3m. Of this £3.4m YTD spend:

Capital CRL Monitoring - £0.7m relates to capital spend which the ICS is measured against, this is an underspend of £1.4m against Plan due to timing of orders. The Trust envisages meeting the ICS CRL of £20.9m. There has been £0.0m spend YTD on PDC due to the business cases still being agreed creating variance to Plan of £1.5m. There was £0.0m spend YTD on IFRS 16 due to leases (predominantly BCPS) still being commercially agreed, creating a variance to Plan of £1.1m.

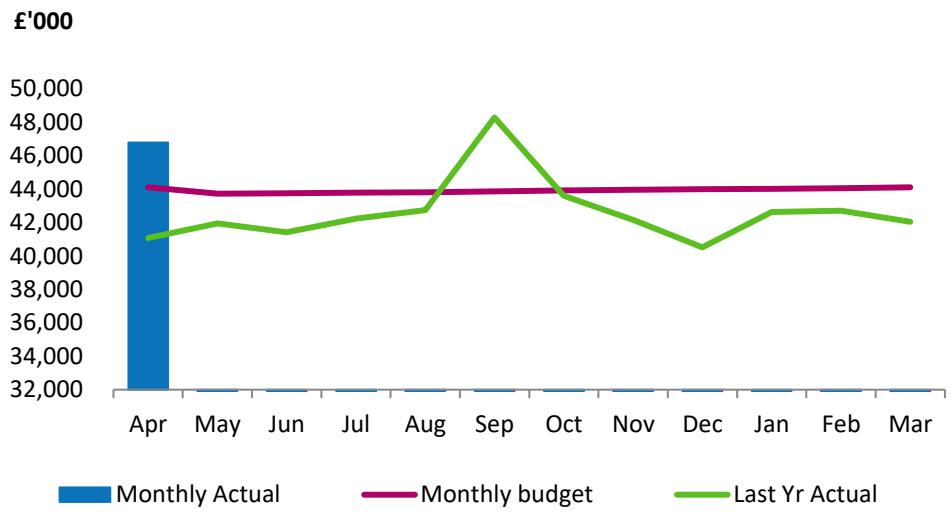
Capital Monitoring - non CRL - The balance of the capital YTD, £2.7m, relates to capital spend on grant funded items with £2.7m relating to PSDS Phase 3. This is variance of £1.9m against Planned Grant spend of £4.6m due to timing of orders. The Trust are forecasting to meet the Plan capital expenditure spend for 23/24 of £72.3m.

Pay Expenditure

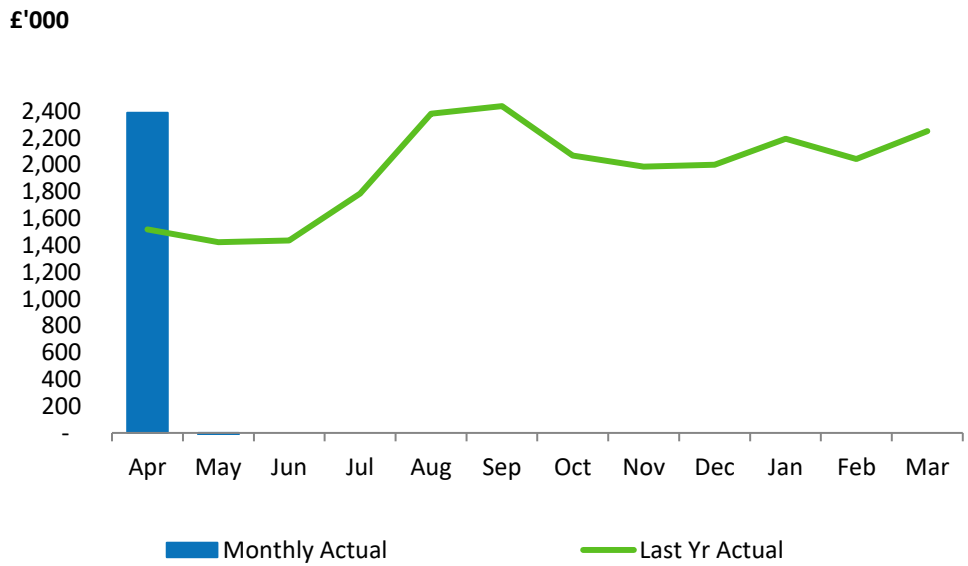
Year to Date Variance to plan



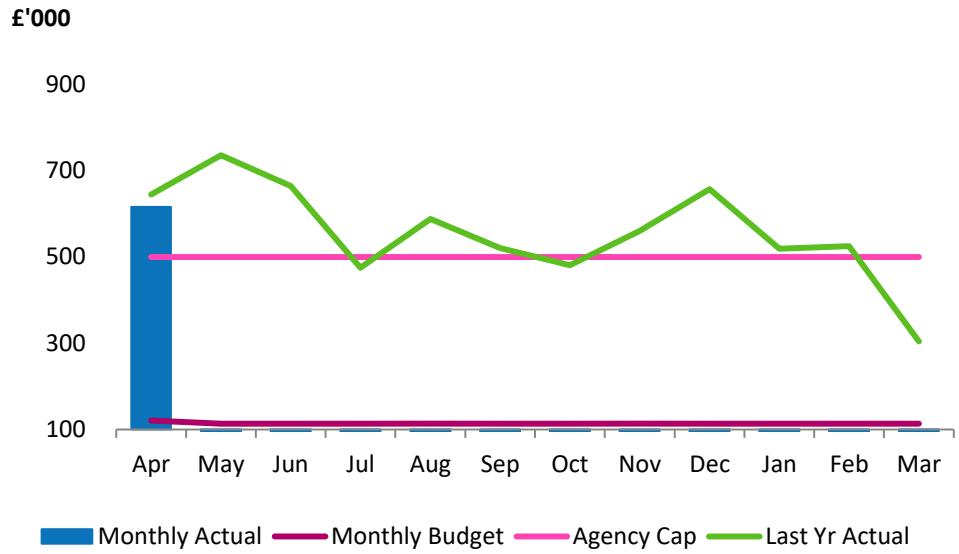
Total Pay Expenditure Trend



Bank Expenditure Trend



Agency Expenditure Trend



Cost Improvement

Current Month Division	Target	Non Recurrent	Recurrent	Total Achieved	Variance From Target
Corporate		£3	£227	£229	£229
Division 1		£2,701	£6,620	£9,321	£9,321
Division 2		£132	£401	£533	£533
Division 3		£132	£844	£976	£976
Estates And Facilities			£260	£260	£260
Trustwide	-£1,573,840	£168,044		£168,044	-£1,405,796
Grand Total	**-£1,573,840**	**£171,012**	**£8,353**	**£179,364**	**-£1,394,476**

2023/24 FYE Division	Target	Non Recurrent	Recurrent	Total Achieved	Variance From Target
Corporate		£32	£2,720	£2,752	£2,752
Division 1		£32,412	£79,444	£111,857	£111,857
Division 2		£1,586	£4,812	£6,398	£6,398
Division 3		£1,586	£10,128	£11,715	£11,715
Estates And Facilities			£3,125	£3,125	£3,125
Trustwide	-£45,152,568	£2,016,525		£2,016,525	-£43,136,043
Grand Total	**-£45,152,568**	**£2,052,142**	**£100,229**	**£2,152,372**	**-£43,000,196**

Against an in month target of £1.57m, the Trust has achieved £179K. Of this, £8K is recurrent. The 23/24 target for the trust is £45m & the trust had identified savings with full year effect of £2.15m.

There are approved PIDs of £1.41m, £1.35m recurrent and £60k non-recurrent with £1.353m of schemes in progress.

Reserves

Start point			29,923,856
Additional Income allocated to reserves			1,578,809
Full Year Effect of reserves 'drawn down' upto current month			5,970,871
Reserves phased into position			(2,854,967)
Reserves available for future months			**34,618,570**
Earmarked Reserves	Division 1	(5,594,194)	
	Division 2	(6,238,840)	
	Division 3	(6,659,695)	
	Division 4	(49,223)	
	Estates and Facilities	0	
	Corporate & Other	(728,233)	
	Less: Expected Slippage	(1,175,209)	
			(20,445,394)
	Available Balance		**14,173,176**
Balance made up of	Drugs	0	
	Inflation	10,579,439	
	Trustwide Education/LDA	1,071,549	
	Contingency	909,973	
	CDC - Trustwide	1,612,215	
Less:	Expected Balance Sheet Release	0	
			14,173,176

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				
52,601	54,900	53,476	(1,424)	Patient Activity Income	679,246	54,900	53,476	(1,424)
29	127	74	(53)	Other Patient Care Income	1,521	127	74	(53)
830	0	0	0	Top Up Income	0	0	0	0
3,975	4,508	4,305	(203)	Education, Training & Research Income	52,250	4,508	4,305	(203)
0	4,600	2,737	(1,863)	Non Patient Care Other Income	17,321	4,600	2,737	(1,863)
4	55	54	(1)	Private Patient Income	660	55	54	(1)
5,879	6,816	7,477	661	Income on Directorate Budgets	80,457	6,816	7,477	661
63,317	**71,005**	**68,122**	**(2,883)**	**Total Income**	**831,454**	**71,005**	**68,122**	**(2,883)**
				Expenditure				
41,078	44,103	46,777	(2,674)	Directorate Expenditure Budgets - Pay	527,091	44,103	46,777	(2,674)
16,546	17,215	17,525	(309)	Directorate Expenditure Budgets - Non Pay	201,360	17,215	17,525	(309)
5,778	5,923	5,657	266	Directorate Expenditure Budgets - Drugs	71,396	5,923	5,657	266
0	2,709	0	2,709	Activity Changes/Service Dev./Cost Pressures/Inflation Reserves	36,417	2,709	0	2,709
0	146	0	146	Contingency Reserves	1,056	146	0	146
0	(1,394)	0	(1,394)	Cost Improvement Savings	(43,000)	(1,394)	0	(1,394)
0	0	0	0	BCPS Savings	0	0	0	0
63,402	**68,702**	**69,959**	**(1,257)**	**Total Expenditure**	**794,320**	**68,702**	**69,959**	**(1,257)**
(85)	**2,303**	**(1,836)**	**(4,140)**	**EBITDA Surplus/(Deficit)**	**37,134**	**2,303**	**(1,836)**	**(4,140)**
2,048	2,581	2,613	(32)	Depreciation	32,978	2,581	2,613	(32)
160	47	(4)	51	(Interest Receivable) / Payable	1,581	47	(4)	51
962	1,158	1,158	0	Other Charges	13,900	1,158	1,158	0
3,169	**3,786**	**3,767**	**19**	**Other non operating items**	**48,459**	**3,786**	**3,767**	**19**
(3,255)	**(1,483)**	**(5,604)**	**(4,121)**	**Net Surplus/(Deficit) before Adjustments**	**(11,325)**	**(1,483)**	**(5,604)**	**(4,121)**
38	(4,509)	(2,683)	1,826	Adjustments as per NHSI reported position	(15,425)	(4,509)	(2,683)	1,826
(3,217)	**(5,992)**	**(8,287)**	**(2,295)**	**Adjusted Financial Performance as NHSI**	**(26,750)**	**(5,992)**	**(8,287)**	**(2,295)**
0	*0*	*(92)*	*(92)*	*Adjustments as per ICS reported position*	*0*	*0*	*(92)*	*(92)*
(3,217)	***(5,992)***	***(8,379)***	***(2,387)***	***Adjusted Financial Performance as ICS***	***(26,750)***	***(5,992)***	***(8,379)***	***(2,387)***

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2023/24 Balance Sheet as at 30th April 2023

	April 2023 Plan	April 2023 Actual	March 2023 Actual	Movement in Month	March 2023 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	493,234	487,630	486,739	891	486,739
Intangible Assets	6,098	5,738	5,860	(122)	5,860
Other Investments/Financial Assets	12	11	11	0	11
Trade and Other Receivables Non Current	1,397	1,415	1,415	0	1,415
PFI Deferred Non Current Asset	4,652	4,634	4,634	0	4,634
TOTAL NON CURRENT ASSETS	**505,393**	**499,429**	**498,660**	**769**	**498,660**
CURRENT ASSETS					
Inventories	8,347	8,509	8,347	162	8,347
Trade and Other Receivables	49,658	62,099	59,601	2,498	59,564
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	61,171	68,399	69,265	(866)	69,265
TOTAL CURRENT ASSETS	**119,176**	**139,008**	**137,213**	**1,795**	**137,176**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**624,569**	**638,437**	**635,873**	**2,564**	**635,836**
CURRENT LIABLILITES					
Trade & Other Payables	(104,211)	(113,669)	(114,266)	597	(114,207)
Liabilities arising from PFIs / Finance Leases	(6,199)	(6,048)	(6,048)	0	(13,462)
Provisions for Liabilities and Charges	(4,017)	(4,181)	(4,109)	(72)	(4,201)
Other Financial Liabilities	(10,315)	(19,651)	(10,424)	(9,226)	(10,424)
TOTAL CURRENT LIABILITIES	**(124,743)**	**(143,549)**	**(134,847)**	**(8,702)**	**(142,294)**
NET CURRENT ASSETS / (LIABILITIES)	**(5,567)**	**(4,541)**	**2,366**	**(6,907)**	**(5,118)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**499,827**	**494,888**	**501,026**	**(6,138)**	**493,542**
NON CURRENT LIABILITIES					
Trade & Other Payables	(287)	(283)	(287)	4	(287)
Other Liabilities	(13,173)	(12,353)	(12,883)	530	(5,470)
Provision for Liabilities and Charges	(1,780)	(1,780)	(1,780)	0	(1,780)
TOTAL NON CURRENT LIABILITIES	**(15,240)**	**(14,416)**	**(14,951)**	**534**	**(7,537)**
TOTAL ASSETS EMPLOYED	**484,587**	**480,472**	**486,075**	**(5,604)**	**486,005**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	305,676	305,676	305,676	0	305,676
Retained Earnings	70,942	66,827	72,431	(5,604)	72,361
Revaluation Reserve	109,197	109,196	109,196	0	109,196
Donated Asset Reserve	0	0	0	0	0
Financial assets at FV through OCI reserve	(1,418)	(1,418)	(1,418)	0	(1,418)
Other Reserves	190	190	190	0	190
TOTAL TAXPAYERS EQUITY	**484,587**	**480,472**	**486,075**	**(5,604)**	**486,005**

2023/24 Cash Flow as at 30th April 2023

	Apr-23 Plan £'000	Apr-23 Actual £'000	Apr-23 Variance £'000	Apr-23 In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit)	**53,575**	**38,296**	(15,279)	0
Depreciation	33,118	26,961	(6,157)	0
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(43,889)	(28,722)	15,167	0
Interest Paid	(3,084)	(2,422)	662	0
Dividends Paid	(12,649)	(6,126)	6,523	0
Release of PFI /Deferred Credit	0	0	0	0
(Increase)/Decrease in Inventories	0	(162)	(162)	(69)
(Increase)/Decrease in Trade Receivables	9,945	(15,132)	(25,077)	0
Increase/(Decrease) in Trade Payables	(20,592)	2,502	23,094	0
Increase/(Decrease) in Trade Payables Ann Leave Acc	0	(5,869)		0
Increase/(Decrease) in Other liabilities	0	3,555	3,555	0
Increase/(Decrease) in Provisions	0	(4,049)	(4,049)	0
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**16,424**	**8,832**	**(7,592)**	**(69)**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	285	1,700	1,415	0
Payment for Property, Plant and Equipment	(91,260)	(52,914)	38,346	0
Payment for Intangible Assets	(355)	(14)	341	0
Receipt of cash donations to purchase capital assets	44,320	28,722	(15,598)	0
Proceeds from sales of Tangible Assets	0	119	119	0
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(47,010)**	**(22,387)**	**24,623**	**0**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(30,586)**	**(13,555)**	**17,031**	**(69)**
FINANCING				
New Public Dividend Capital Received	30,062	6,023	(24,039)	0
Capital Element of Finance Lease and PFI	(7,570)	(5,456)	2,114	0
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**22,492**	**567**	**(21,925)**	**0**
INCREASE/(DECREASE) IN CASH	**(8,094)**	**(12,987)**	**(4,893)**	**(69)**
CASH BALANCES				
Opening Balance at 1st April 2023	69,265	69,265	0	
Opening Balance at 1st March 2023				69,265
Closing Balance at 30th April 2023	61,171	68,399	7,228	69,196

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	No meeting
Title:	Report of the Chief Financial Officer - Month 12
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	**Excel in the delivery of care** We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
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 12
Item/paragraph 1	This paper reports the in-month, year-to-date and the draft year end position for the Trust as at Month 12. The paper also reports on delivery against financial targets.

The Royal Wolverhampton NHS Trust

Reference Pack

Report of the Chief Financial Officer

Finance Report
March 2023 - Month 12

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Performance and Finance Committee Report	
Meeting Date:	22nd February 2023
Title:	Performance and Finance Committee – Supplementary Finance report
Executive Summary:	To update the Performance and Finance Committee on the Month 12 financial position.
Action Requested:	The Committee is requested to note this report.
Report of:	Kevin Stringer, Chief Financial Officer
Author: **Contact Details:**	Mark Greene - Deputy Chief Financial Officer Email: mark.greene2@nhs.net
Resource Implications:	None
Links to Trust Strategic Objectives:	**Excel in the delivery of care** We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
References: **(e.g. from/to other committees)**	N/A
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

The Royal Wolverhampton NHS Trust

Report of the Chief Financial Officer

Supplementary Finance Report
March 2023 - Month 12

Safe & Effective | Kind & Caring | Exceeding Expectation

Performance and Finance Committee - Supplementary Pages - Contents

Dashboard

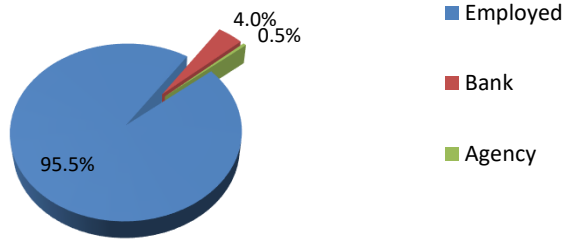
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Block payment	100.44	721.65
2. Other income	17.38	174.50
3. Top-up payment	0.44	4.74
Total	**118.27**	**900.89**
Expenditure	**116.01**	**900.80**
Surplus/ (deficit)	**2.26**	**0.09**
Planned surplus/(deficit)	**0.80**	**(0.00)**
Variance to plan	**1.46**	**0.09**

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)

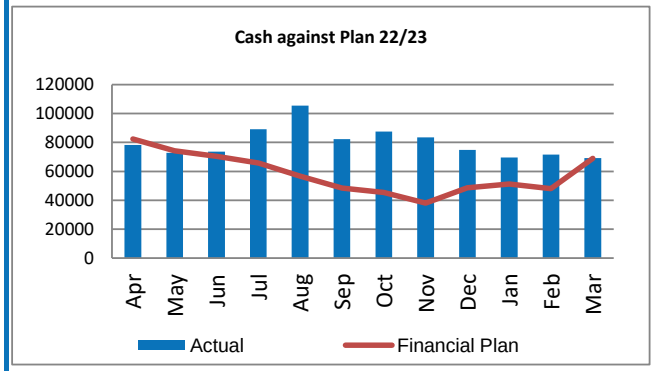
YTD CIP achievement is £18.16m against a target of £19.09m, with £7.97m of the year to date achievement related to cost avoidance schemes that do not reduce the expenditure run rates.

£9.31m of this CIP is being achieved recurrently.

Cash in the Bank

(see page 7)

Plan £69.1m
Actual £69.3m



Covid-19 Expenditure

In month 12 there was a total of £589k expenditure relating to Covid-19.

Of this amount £554k is reimbursed for testing.

Reserves

(see page 9)

£10.9m of reserves are released into the position at month 12

Actual Outturn

(see page 5)

£2.3m surplus in month
(£1.5m favourable to plan)

and £0.09m surplus year to date
(£0.09m ahead of plan)

Overview of Financial Performance

The Trust is reporting an in month adjusted surplus of £2.3m, £1.5m favourable to plan and year end surplus £0.09m. This has been achieved through non-recurrent support £8m and ICB risk share arrangement £2.7m (a reduction of £1.1m due to deterioration elsewhere in the ICB), as well as a significant level of releases of provisions and accruals no longer required £29.1m (£5.7m income related, £14.4m pay related and £9m non-pay related). Support from the risk

£8.9m (adverse) of the year end position relates to budget reduction CIP that was planned to be delivered, of which £7.9m do not have budget or run rate related reductions as they relate to productivity and cost avoidance schemes.

There are year end reported overspends on pay of £4.6m net of £14.4m release of accruals, and drugs of £3.5m relating to activity and the application of block contract arrangements to costs previously passed through to CCGs. Non-pay is £1.4m underspent at the year end after £9m release of accruals. £10.6m of reserves remained not drawn down. .

System Updates

The ICB reported a surplus of £0.4m and through the risk share no organisation reported deficits. This position was supported by non-recurrent income and reductions to provisions and accruals no longer required across the ICB. Part of this non-recurrent income includes not incurring ERF clawback, in line with national guidance, despite performance being substantially below the ERF target level. A total of £101.7m efficiencies were found across the ICB from a plan of £106.6m, though £64.2m of these were non-recurrent. Whilst RWT managed agency costs within the system cap the ICB as a whole over spent by £14.2m.

The ICB met its capital allocation requirements.

Capital

The Trust have spent £73.8m of capital YTD to 31st March 23. Of this £73.8m, £19.7m relates to capital spend target (CRL) which the ICS is measured against. The trust is reporting a small underspend of £16k against agreed Full Year ICS CRL of £19.7m

Of the remaining YTD balance of capital of £54.1m relates to capital spend on grant funded items of £28.5m, made up of £5.5m PSDS Phase 2, £21.9m PSDS Phase 3 and £1.0m ERDF Grant; £5.2m for new leases for BCPS which are capitalised under IFRS 16 (offset by £0.8m of Linac Lease which has been transferred using PDC monies to owned asset); £19.8m of PDC monies; £0.5m PFI additions; and £0.8m of donated assets.

The planned gross capital expenditure has moved from prior month forecast of £89.4m due to additional PDC monies £0.8m; reduction in IFRIC 12 related capital spend of £4.7m; reduction in IFRS 16 leases of £0.9m due to leases not beginning in 22/23 as previously planned; and deferral of grant spend of £10.0m into 23/24.

Income and Expenditure Run Rates

	£m	21/22 Mar	22/23 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Avg	Move-ment
	Patient Income															
1	Plan	87.42	52.92	53.09	55.94	54.24	54.79	61.89	57.85	57.06	57.44	58.17	58.41	97.46	*56.53*	*40.93*
2	Actual	88.60	52.60	53.12	55.67	56.40	54.82	60.56	56.79	60.38	54.88	57.79	58.18	100.44	*56.47*	*43.97*
3	Variance	1.18	(0.32)	0.02	(0.27)	2.17	0.03	(1.33)	(1.06)	3.32	(2.56)	(0.38)	(0.23)	2.99	*(0.05)*	*3.04*
	Non Patient Income															
4	Plan	12.38	11.60	17.19	15.53	11.30	11.67	17.01	13.26	12.41	21.15	13.07	14.23	30.98	*14.40*	*16.58*
5	Actual	22.72	10.72	17.70	15.61	11.60	11.80	11.49	19.22	13.75	16.99	14.40	18.15	17.82	*14.67*	*3.15*
6	Variance	10.34	(0.89)	0.51	0.08	0.30	0.13	(5.52)	5.97	1.34	(4.16)	1.33	3.92	(13.16)	*0.27*	*(13.43)*
	Pay Expenditure															
7	Plan	59.97	39.52	39.50	42.73	41.29	41.49	46.92	42.71	42.54	43.20	40.89	43.28	82.72	*42.19*	*(40.54)*
8	Actual	69.33	41.08	41.96	41.42	42.23	42.75	48.28	43.60	42.16	40.52	42.64	42.71	82.05	*42.67*	*(39.38)*
9	Variance	(9.36)	(1.56)	(2.46)	1.31	(0.94)	(1.27)	(1.37)	(0.89)	0.38	2.69	(1.75)	0.57	0.67	*(0.48)*	*(1.15)*
	Non Pay Expenditure															
10	Plan	17.89	17.14	16.02	17.80	16.48	16.35	16.60	17.14	17.10	18.15	17.43	19.31	18.47	*17.23*	*(1.24)*
11	Actual	25.99	16.55	16.25	16.52	15.94	16.24	16.32	17.23	17.78	15.75	15.85	17.87	24.20	*16.57*	*(7.62)*
12	Variance	(8.10)	0.59	(0.23)	1.28	0.54	0.12	0.28	(0.09)	(0.68)	2.40	1.59	1.43	(5.72)	*0.66*	*6.38*
	Drugs Expenditure															
13	Plan	5.92	5.65	5.31	5.74	5.51	5.58	6.10	5.55	5.65	5.98	5.97	5.70	6.03	*5.70*	*(0.32)*
14	Actual	6.03	5.78	5.59	5.63	5.66	6.03	6.58	5.91	5.95	6.32	6.47	5.83	6.56	*5.98*	*(0.59)*
15	Variance	(0.10)	(0.12)	(0.28)	0.11	(0.15)	(0.45)	(0.48)	(0.36)	(0.30)	(0.34)	(0.50)	(0.12)	(0.54)	*(0.27)*	*0.27*
	CIP over/ (under) achievement															
16	Variance	0.63	(0.42)	(0.13)	0.08	(0.79)	(0.76)	(0.41)	(1.19)	(1.83)	(1.86)	(0.74)	(1.44)	0.58	*(0.86)*	*(1.45)*
	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	(0.14)	(0.10)	(0.07)	*0.03*	*0.10*
	Reserves supporting position															
17	Actual	12.26	2.81	2.49	(1.70)	(0.71)	0.68	1.58	1.47	1.59	(0.48)	2.50	0.95	(0.31)	*1.02*	*1.32*
	Other Non Operating Expenditure															
18	Plan	(3.19)	(2.98)	(4.37)	(3.27)	(3.61)	(3.61)	(3.27)	(3.78)	(3.78)	(3.78)	(3.80)	(3.84)	(3.83)	*(3.64)*	*(0.18)*
19	Actual	0.46	(3.17)	(3.72)	(3.79)	(3.58)	(3.54)	(3.53)	(3.75)	(3.57)	(3.54)	(3.54)	(3.52)	(2.04)	*(3.57)*	*1.53*
20	**Variance**	**3.64**	**(0.19)**	**0.65**	**(0.53)**	**0.03**	**0.08**	**(0.26)**	**0.03**	**0.21**	**0.24**	**0.26**	**0.32**	**1.79**	*0.08*	*(1.71)*
	Total															
	Plan	**(0.06)**	**(3.24)**	**2.64**	**3.46**	**0.06**	**(0.58)**	**4.76**	**1.65**	**0.62**	**9.81**	**1.54**	**1.10**	**17.18**		
	Actual	**10.43**	**(3.25)**	**3.30**	**3.91**	**0.60**	**(1.93)**	**(2.66)**	**5.52**	**4.68**	**5.74**	**3.69**	**6.41**	**3.42**		
	Variance	**10.49**	**(0.01)**	**0.65**	**0.45**	**0.54**	**(1.35)**	**(7.42)**	**3.87**	**4.06**	**(4.07)**	**2.16**	**5.31**	**(13.76)**		

Commentary on variances and trends:

Patient Income - There is still no assumed ERF clawback from underperformance to target but this also means we have been unable to achieve additional ERF stretch. Following yearend agreements, additional income from NHSE and local ICBs has resulted in Patient Income over performing against the plan in March, and additional funding for the 'pay award offer' and central pension contribution following NHSE guidance has increased the run rate for the year end position.

Non Patient Income - has underperformed in month by £13.2m. This includes an underperformance on Grant Income of £16m, the capital schemes that this was due to fund have not yet been completed meaning the income cannot be recognised. Private patient income continues to underperform (£66k in month). Directorate income is overperforming by £2.6m due to the Urology services collaboration to cover costs, along with Covid Medicines unit, Mander Centre Hub and Primary Care overperformance in Division 3. In addition there is recognition of £1.5m income for PPE stock purchased through NHSE, this adjustment is required by NHSE at year end and is offset by an increase in non pay expenditure.

Pay - is showing an underspend of £670k in month. The underlying divisional spend trends have not changed, however as required for the annual accounts there is expenditure of £19.2m relating to an accrual for the 'pay award offer', and recognition of £20.8m of additional pension contributions causing the movement in month, both of these additional year end items are offset by increased patient income as described above.

Non Pay - The in month overspend of £5.8m is caused by a number of items - In corporate there is £742k overspend due to the adoption of a different method of recording work permit expenditure. Division 1 £445k predominantly due to Cardiology and Cardiothoracic activity levels, Division 2 £361k as a result of increased charges for referred oncology tests and additional renal activity. Within Division 3 there are a number of items driving an overspend of £747k including stock adjustments £40k, specialist patient equipment and bed hire £139k, additional PFI charges £125k, insulin pump activity and NHS property services charges for primary care.

Estates and Facilities have also overspent in month by £1m, this being a combination of core estates services, utilities (including increased water charges due to an ongoing leak on the New Cross site) and hotel services. Within Trustwide there have also been additional accruals at year end for items that have been recalculated for year end including disputed invoices and recognition of spend worth £1.5m for PPE stock purchased through NHSE.

Drugs - In month are £540k overspent and £3.5m YTD. in month Division 1 is £182k overspent and Division 2 £358k. Within Division 1 this is caused by activity increases in Ophthalmology, Womens and also Cardiothoracic, likewise in Division 2 activity in Gastro, Oncology and Clinical Haematology have caused the overspend.
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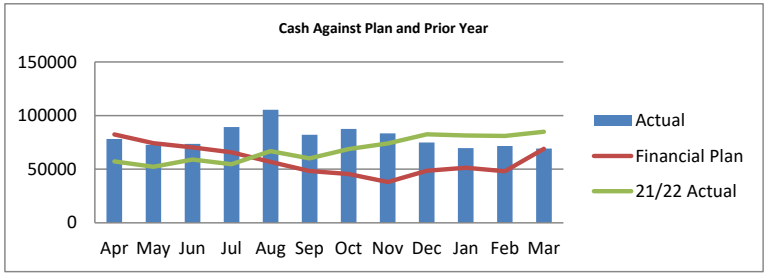
Cash Position



The cash balance as at 31st March 2023 is £69.3m, a £2.4m decrease on the previous month and an increase of £0.2m on financial plan.

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:

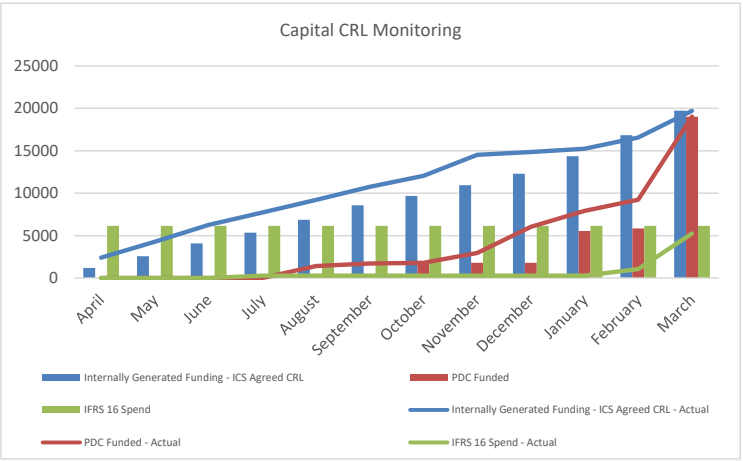
	M12 22/23	Cumulative	M11 22/23	Cumulative
Value	97%	93%	96%	93%
Volume	96%	90%	95%	90%

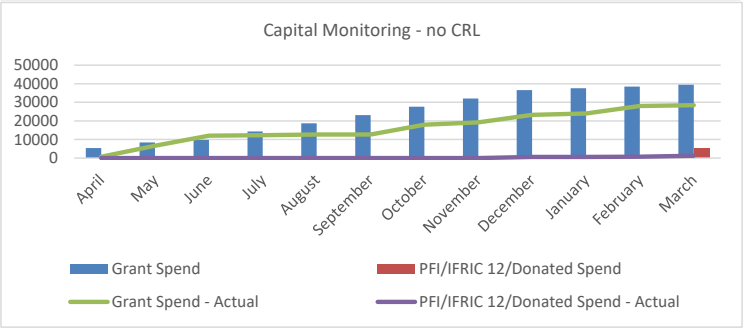
Debtor Days

Calculated Debtor Days for the year are:-

	M12 Actual	M11 Actual
Total	7.31	9.56
Being:-		
NHS	7.49	10.30
Non NHS	6.56	6.58

Capital





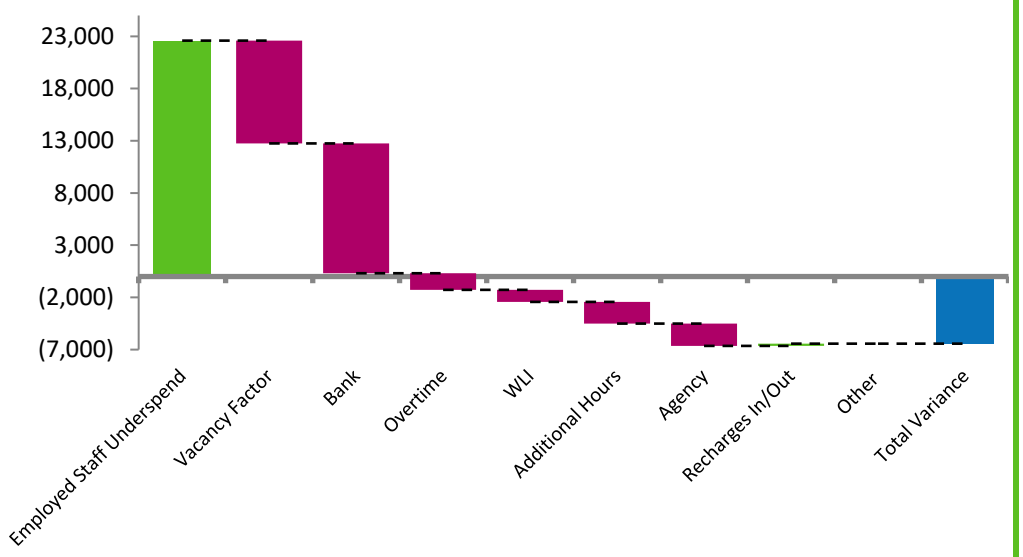
The Trust have spent £73.8m of capital YTD to 31st March 23.

Capital CRL Monitoring - Of this £73.8m, £19.7m relates to capital spend which the ICS is measured against. The Trust met this FY target with a slight underspend of £16k. There has been £19.0m spend YTD on PDC for Western Power supply to Cannock Chase hospital £1.4m, £10.4m for Cannock Community Diagnostic Hub, £2.1m IT spend, £0.7m TIF, £3.2m for diagnostics (including £0.8m to buy out Linac lease) and £1.2m for Black Country North Elective Hub. There was £5.2m spend YTD on IFRS 16 which is below forecast due to leases (predominantly BCPS), due to go-live in 23/24.

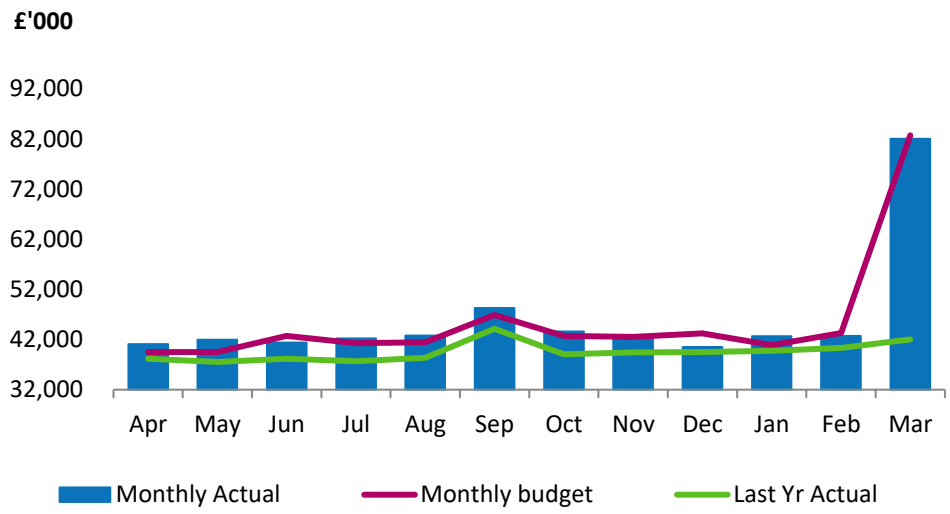
Capital Monitoring - non CRL - The balance of the capital YTD, £29.9m, relates to capital spend on grant funded items with £5.5m relating to PSDS Phase 2, £28.5m relating to PSDS Phase 3 and £1.0m relating to ERDF Grant. In addition there has been £0.8m of donated assets from RWT Charity.

Pay Expenditure

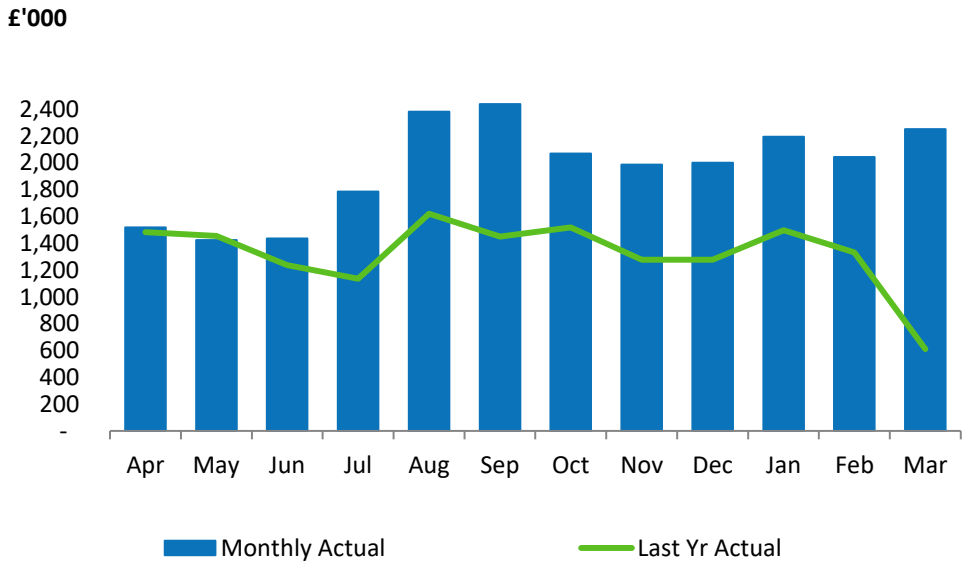
Year to Date Variance to plan



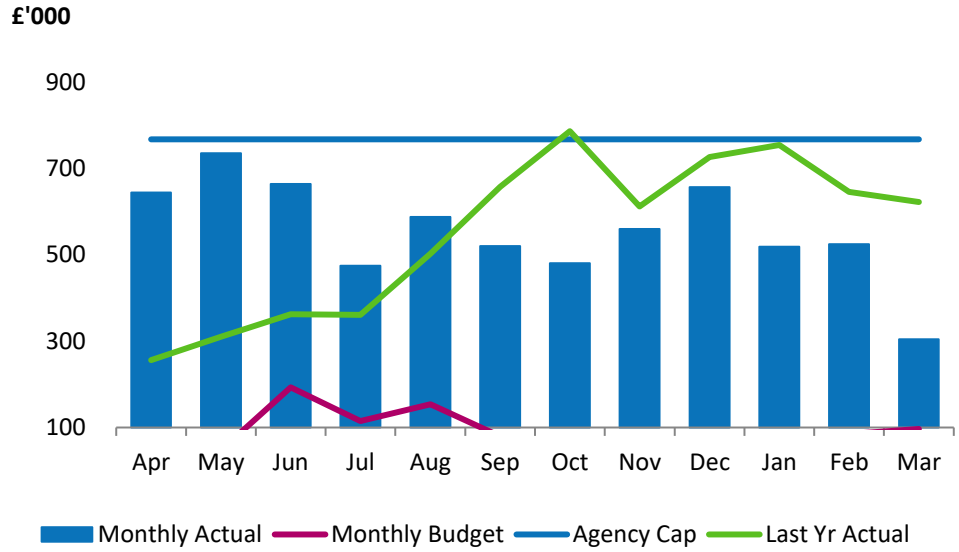
Total Pay Expenditure Trend



Bank Expenditure Trend



Agency Expenditure Trend



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	Year to Date: Unmet CIP
Division 1	7,090,685	3,168,358	867,856	4,036,214	3,054,472
Division 2	4,451,811	1,172,681	957,820	2,130,501	2,321,310
Division 3	3,450,606	1,094,114	393,024	1,487,138	1,963,469
Division 4	195,706	802	71	873	194,833
Estates and Facilities	1,914,988	1,026,837	53,079	1,079,916	835,071
Corporate	1,853,809	2,430,227	164,239	2,594,466	(740,658)
Trustwide	129,395	26,861	6,799,391	6,826,252	(6,696,857)
	19,087,000	**8,919,881**	**9,235,480**	**18,155,361**	**931,639**
Cash avoidance/ no budget reduction		*£ 26*	*£ 7,945*	*£ 7,971*	

Against an in month target of £2.12m, the Trust has achieved £3.45m. YTD £18.16m achieved against a target of £19.09m. £7.97m of this has been achieved through the rebasing exercise.

Recurrent savings are £9.2m, of which £8.3m are from the revised reporting.

There are approved PIDs of £8.295m, £2.235m recurrent and £6.06m non-recurrent with, £825k of schemes in progress.

Reserves

Start point	34,789,751
Additional Income allocated to reserves	43,226,034
Full Year Effect of reserves 'drawn down' upto current month	(67,125,217)
Reserves phased into position	(10,890,569)
Reserves available for future months	**0**

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				
666,222	97,458	100,445	2,987	Patient Activity Income	719,265	719,265	721,650	2,385
930	123	208	85	Other Patient Care Income	1,478	1,478	1,315	(163)
10,648	508	438	(70)	Top Up Income	4,932	4,932	4,737	(195)
50,208	4,640	4,989	349	Education, Training & Research Income	53,841	53,841	54,544	702
5,666	16,474	531	(15,943)	Non Patient Care Other Income	39,831	39,831	29,253	(10,578)
67	82	67	(16)	Private Patient Income	987	987	423	(564)
83,529	9,151	11,590	2,439	Income on Directorate Budgets	88,321	88,321	88,969	647
817,270	**128,437**	**118,268**	**(10,169)**	**Total Income**	**908,656**	**908,656**	**900,891**	**(7,765)**
				Expenditure				
501,513	82,723	82,051	673	Directorate Expenditure Budgets - Pay	546,780	546,780	551,394	(4,614)
204,319	18,471	24,195	(5,724)	Directorate Expenditure Budgets - Non Pay	207,989	207,989	206,479	1,510
65,730	6,026	6,565	(538)	Directorate Expenditure Budgets - Drugs	68,772	68,772	72,304	(3,532)
0	(143)	0	(143)	Activity Changes/Service Dev./Cost Pressures/Inflation Reserves	10,608	10,608	0	10,608
0	(163)	0	(163)	Contingency Reserves	282	282	0	282
0	584	0	584	Cost Improvement Savings	(8,903)	(8,903)	0	(8,903)
0	(73)	(0)	(73)	BCPS Savings	217	217	(0)	217
771,562	**107,426**	**112,811**	**(5,384)**	**Total Expenditure**	**825,746**	**825,746**	**830,176**	**(4,430)**
45,708	**21,010**	**5,457**	**(15,553)**	**EBITDA Surplus/(Deficit)**	**82,910**	**82,910**	**70,714**	**(12,195)**
23,279	2,610	2,569	41	Depreciation	29,621	29,621	29,530	91
2,099	201	0	201	(Interest Receivable) / Payable	2,096	2,096	722	1,373
8,020	1,016	(531)	1,547	Other Charges	12,194	12,194	11,042	1,152
33,398	**3,827**	**2,038**	**1,789**	**Other non operating items**	**43,911**	**43,911**	**41,295**	**2,616**
12,309	**17,183**	**3,419**	**(13,764)**	**Net Surplus/(Deficit) before Adjustments**	**38,998**	**38,998**	**29,419**	**(9,579)**
(7,855)	(16,382)	(1,157)	15,225	Adjustments as per NHSI reported position	(38,998)	(38,998)	(29,330)	9,668
4,455	**800**	**2,262**	**1,461**	**Adjusted Financial Performance as NHSI**	**(0)**	**(0)**	**90**	**90**
(20)	*0*	*(65)*	*(65)*	*Adjustments as per ICS reported position*	*0*	*0*	*(97)*	*(97)*
4,434	***800***	***2,197***	***1,396***	***Adjusted Financial Performance as ICS***	***(0)***	***(0)***	***(7)***	***(7)***

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2022/23 Balance Sheet as at 31st March 2023

	March 2023 Plan	March 2023 Actual	February 2023 Actual	Movement in Month	March 2022 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	515,228	486,739	458,917	27,822	416,282
Intangible Assets	5,103	5,860	5,385	475	6,462
Other Investments/Financial Assets	161	11	161	(149)	161
Trade and Other Receivables Non Current	1,794	1,415	1,795	(380)	1,795
PFI Deferred Non Current Asset	0	4,634	4,634	0	4,877
TOTAL NON CURRENT ASSETS	**522,286**	**498,660**	**470,892**	**27,767**	**429,576**
CURRENT ASSETS					
Inventories	8,253	8,347	8,726	(379)	8,253
Trade and Other Receivables	33,168	59,564	48,734	10,830	33,801
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	69,086	69,265	71,621	(2,356)	84,918
TOTAL CURRENT ASSETS	**110,507**	**137,176**	**129,080**	**8,096**	**126,973**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**632,793**	**635,836**	**599,972**	**35,863**	**556,548**
CURRENT LIABLILITES					
Trade & Other Payables	(87,278)	(114,207)	(109,738)	(4,469)	(106,225)
Liabilities arising from PFIs / Finance Leases	(6,596)	(13,462)	(9,459)	(4,002)	(2,101)
Provisions for Liabilities and Charges	(7,428)	(4,201)	(3,388)	(813)	(7,427)
Other Financial Liabilities	(8,204)	(10,424)	(11,759)	1,334	(8,204)
TOTAL CURRENT LIABILITIES	**(109,506)**	**(142,294)**	**(134,344)**	**(7,950)**	**(123,957)**
NET CURRENT ASSETS / (LIABILITIES)	**1,001**	**(5,118)**	**(5,264)**	**146**	**3,016**
TOTAL ASSETS LESS CURRENT LIABILITIES	**523,287**	**493,542**	**465,629**	**27,913**	**432,592**
NON CURRENT LIABILITIES					
Trade & Other Payables	(86)	(287)	(52)	(235)	(86)
Other Liabilities	(12,990)	(5,470)	(6,522)	1,053	(5,475)
Provision for Liabilities and Charges	(2,308)	(1,780)	(2,308)	528	(2,308)
TOTAL NON CURRENT LIABILITIES	**(15,383)**	**(7,537)**	**(8,883)**	**1,346**	**(7,869)**
TOTAL ASSETS EMPLOYED	**507,903**	**486,005**	**456,746**	**29,259**	**424,723**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	316,379	305,676	292,676	13,000	286,653
Retained Earnings	81,466	72,361	69,012	3,349	43,012
Revaluation Reserve	111,137	109,196	96,137	13,060	96,137
Donated Asset Reserve	0	0	0	0	0
Financial assets at FV through OCI reserve	(1,269)	(1,418)	(1,269)	(149)	0
Other Reserves	190	190	190	0	(1,079)
TOTAL TAXPAYERS EQUITY	**507,903**	**486,005**	**456,746**	**29,259**	**424,723**

2022/23 Cash Flow as at 31st March 2023

	Mar-23	Mar-23	Mar-23	Mar-23
	Plan £'000	Actual £'000	Variance £'000	In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit)	**53,870**	**38,296**	(15,574)	0
Depreciation	30,551	26,961	(3,590)	0
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(39,289)	(28,722)	10,567	0
Interest Paid	(2,789)	(2,422)	367	0
Dividends Paid	(12,649)	(6,126)	6,523	0
Release of PFI /Deferred Credit	0	0	0	0
(Hncrease)/Decrease in Inventories	0	(94)	(94)	379
(Hncrease)/Decrease in Trade/Receivables	0	(15,132)	(15,132)	0
Increase/(Decrease) in Trade/Payables	(17,143)	2,502	19,645	0
Increase/(Decrease) in Trade/Payables Ann Leave Acc	0	(5,869)		0
Increase/(Decrease) in Other liabilities	0	3,555	3,555	0
Increase/(Decrease) in Provisions	0	(4,049)	(4,049)	0
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**12,551**	**8,901**	**(3,650)**	**379**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	24	1,700	1,676	0
Payment for Property, Plant and Equipment	(91,343)	(52,914)	38,429	0
Payment for Intangible Assets	0	(14)	(14)	0
Receipt of cash donations to purchase capital assets	39,820	28,722	(11,098)	0
Proceeds from sales of Tangible Assets	0	119	119	0
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(51,499)**	**(22,387)**	**29,112**	**0**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(38,948)**	**(13,486)**	**25,462**	**379**
FINANCING				
New Public Dividend Capital Received	30,062	6,023	(24,039)	0
Capital Element of Finance Lease and PFI	(6,946)	(5,456)	1,490	0
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**23,116**	**567**	**(22,549)**	**0**
INCREASE/(DECREASE) IN CASH	**(15,832)**	**(12,918)**	**2,914**	**379**
CASH BALANCES				
Opening Balance at 1st April 2022	84,918	84,918	0	
Opening Balance at 1st March 2023				71,621
Closing Balance at 31 March 2023	69,086	69,265	179	72,000

The Royal Wolverhampton NHS Trust

Trust Board		
Meeting Date:	6th June 2023	
Title of Report:	Chief Nursing Officer and Director of Nursing Report.	
Action Requested:	Receive for assurance.	
For the attention of the Board		
Assure	• The Registered Nurse/Midwife vacancy percentage is 1.43% for those areas within the dashboard. • In the recruitment pipeline we have 131.16 WTE Registered Nurses and 29.62 WTE Unregistered Nurses. • In April 2023 we were awarded the NHS Pastoral Care Quality Award for our International Nurse Pastoral service.	
Advise	• We have submitted our application for the Interim Quality Mark Scheme (IQMS) for the Preceptorship Programme. • Professional Nurse Advocates (PNAs) recorded activity has increased. • The total number of Falls has reduced in month. • The improved Pressure ulcer and Moisture Associated skin damage performance remains static in month. • The Clinical Accreditation scheme has been launched. • The Quality Framework has been launched.	
Alert	• The Nursing and Midwifery Council have raised a national issue regarding their Test of Competence process which may impact on some of our International Nurses. Action is currently being taken by the NMC, no action is required to be taken by service providers at thispoint.	
Author and Responsible Director Contact Details:	**Authors:** Martina Morris – Deputy Director of Nursing (interim) Email – m.morris16@nhs.net Catherine Wilson – Deputy Director of Nursing Email – C.wilson12@nhs.net **Responsible Directors:** Professor Ann-Marie Cannaby – Group Chief Nurse/Deputy Chief Executive Email – ann-marie.cannaby@nhs.net Debra Hickman – Director of Nursing Email – debra.hickman@nhs.net	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	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 community and populations

	Support our Colleagues	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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequalities strategy. b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
	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:	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:** 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	No negative impact.	
Risks: BAF/ TRR	Corporate Risk Register: Mental Capacity, Deprivation of Liberty Safeguards (DoLs) Assessments (Risk reference: 5338).	
Risk: Appetite		
Public or Private:	Public	
Other formal bodies involved:	Quality Safety Assurance Group Policy Group Workforce Group Matrons, Senior Nurses, Midwifes and Health Visitors Group Subject matter specialist groups A variety of national policies and guidance apply to the matters outlined in this report.	

The Royal Wolverhampton NHS Trust

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:	Chief Nursing Officer and Director of Nursing Report
Item/paragraph 1.0	**Key points from the report include:** • Action plans are in place whereby triangulation of data utilising the Executive Nurse Directorate Dashboard for areas demonstrating outlying trends. • The Registered and Unregistered Nurse/Midwife vacancies continue to reduce for areas within the dashboard. The recruitment pipeline for Registered Nurses is 131.16 WTE and 29.62 WTE Unregistered. Of the Registrants 43.12 WTE have start dates and 11.83 for Unregistered Nurses. • In April 2023 we were awarded the NHS Pastoral Care Quality Award for our International Nurse Pastoral service. • The NMC has raised a national issue with their Test of Competence process for International Nurses. This is a step in the process called the Computer Based Test (CBT) which is undertaken before entry to the United Kingdom. The NMC has identified that International Nurses who attended a particular centre in Nigeria may need to repeat the CBT. The NMC has advised there is no action for Providers at this point, we await further communication. • Evidence has been submitted to Health Education England (HEE) in support of our application to achieve the Interim Quality Mark Scheme (IQMS) for the Preceptorship programme, we await the outcome. • Following the provision of a Professional Nurse Advocate (PNA) development workshop recorded activity has now increased in all areas and data will be reviewed monthly. • The improved Pressure ulcer and Moisture Associated skin damage performance remains static in month and the Tissue Viability Steering Group continues to provide oversight for the improvement actions. • Clinical Accreditation has now launched as planned in April 2023. 10 wards have been through the accreditation process and will have their accreditation outcomes confirmed by the Clinical Accreditation Board in May 2023. • The Quality Framework has been launched in April 2023. This provides the strategic direction for Nursing, Midwifery and Allied Health Professionals (AHPs) to be translated into an outcome-based improvement plan which can be replicated over timeframes. It is built on the above listed foundation blocks. Specific milestone plans have been developed for bespoke areas including Maternity, Adult Acute, Paediatrics, Community and AHPs.

Reference Pack – Detailed Chief Nursing Officer and Director of Nursing Report
Date 6th June 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.
- Other nursing quality data can be viewed on the Integrated Quality and Performance Report (IQPR).
- 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.

Executive Level Nursing Quality Dashboard – high level analysis

Data analysis both within the Executive Nursing Dashboard and Integrated Quality Performance Report is triangulated at Directorate, Divisional and Corporate level. Whereby trends have been identified action plans are in place for those noted as outliers.

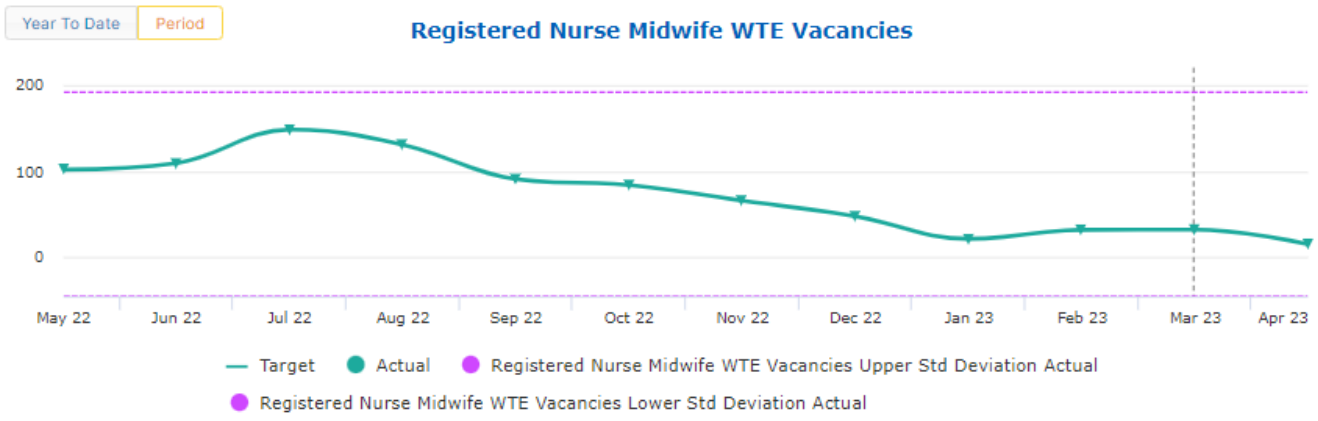
There is an anomaly with D7 observations data reported as 0% which is a data processing issue currently being investigated.

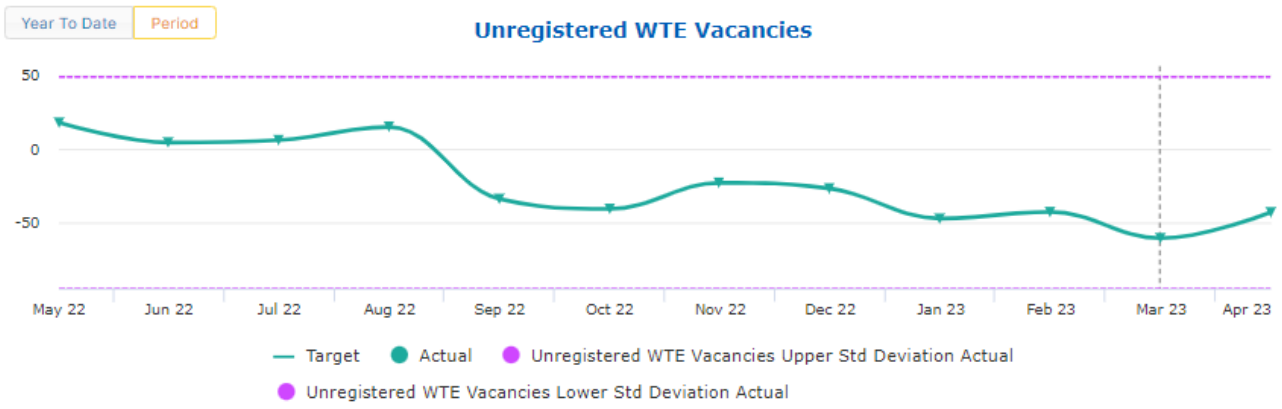
Please see the dashboard in Appendix 1 for an organisational overview.

Workforce

Vacancies and Recruitment	Registered Nursing and Midwifery staff	Unregistered Nursing and Midwifery staff
Latest number of vacancies NB: This is an overall figure	14.9 WTE (reduction from 31.08 WTE)	- 43.01 (reduction from -60.62)
Latest vacancy %	1.43%	-
Recruitment pipeline	131.16 WTE and of this number, 43.12 WTE have start dates	29.62 WTE and of this number, 11.83 WTE
Maternity leave	2.4%	-
Sickness absence	5.1%	-

Please see the graphs below for a trend over time.





Ward information – top 3 clinical areas with the highest number of Registered Nurse and Midwife vacancies

Division	Highest number of vacancies (WTE) for RNs & Midwives based on establishment	Action – In addition to ongoing adverts.
Division 3	Planned care 11.33 WTE	Promotion of internal transfer scheme, promotional recruitment activities in place.
Division 3	Health Visitors 15.52 WTE	5 posts ringfenced for commissioned places dues to qualify Autumn. Increased training places commissioned.
Division 1	Hilton Main 11.62 WTE	Promotional recruitment activities in place. Review of accommodation opportunities in the Cannock area to facilitate further Clinical Fellowship opportunity.

Other key headlines

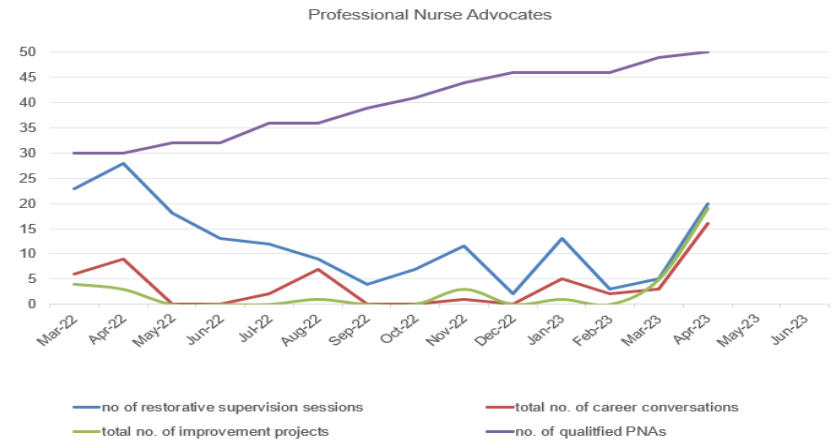
- Local and international recruitment continues, with 30 International Nurses planned to arrive each month from April 2023 to November 2023.The Nursing Clinical Fellowship Team have an in-country recruitment event planned in the Philippines May/June 2023.
- The Prince's Trust initiative, inclusive of a monthly rolling advert for the temporary staffing (Bank).
- In April 2023, we were awarded the NHS Pastoral Care Quality Award for our International Nurse Pastoral service.
- The Stay Together all Year (STaY) event was held on 21st April 2023. This is a targeted retention intervention for staff who have worked at the Trust for 12 months or less, providing opportunities for a two-way conversation with senior colleagues and signposting to Trust opportunities.
- The Legacy Mentor pilot, aimed at supporting our newly qualified staff, has recruited 3 out of 6 legacy mentors so far. We aim to provide a service evaluation of the role after 12 months.
- The NMC has raised a national issue with their Test of Competence process for International Nurses. This relates to a step in the process called the Computer Based Test (CBT) which is undertaken before entry to the United Kingdom. The NMC has advised there is no action for Providers at this point, we await further information and guidance.
- Care Hours Per Patient Day (CHPPD) – please see information contained within this month's IQPR.

Education

Key updates for nursing and midwifery education and staff development include:

- We have submitted our application for the Interim Quality Mark Scheme (IQMS) for the Preceptorship program and await outcome.
- On the 19th April 2023, we held a development workshop for our Professional Nurse Advocates (PNA) and the data on the graph below has shown an increase in all recorded activity since this event.

	Total number of registered nursing staff (patient facing) with a PNA qualification (headcount)	Total number of restorative supervision sessions conducted by a PNA (total in month)	Total number of career conversations delivered by a PNA (total in month)	Total number of improvement projects/programmes supported by PNAs (rolling total)
Mar-22	30	23	6	4
Apr-22	30	28	9	3
May-22	32	18	0	0
Jun-22	32	13	0	0
Jul-22	36	12	2	0
Aug-22	36	9	7	1
Sep-22	39	4	0	0
Oct-22	41	7	0	0
Nov-22	44	11.5	1	3
Dec-22	46	2	0	0
Jan-23	46	13	5	1
Feb-23	46	3	2	0
Mar-23	49	5	3	5
Apr-23	50	20	16	19
May-23				



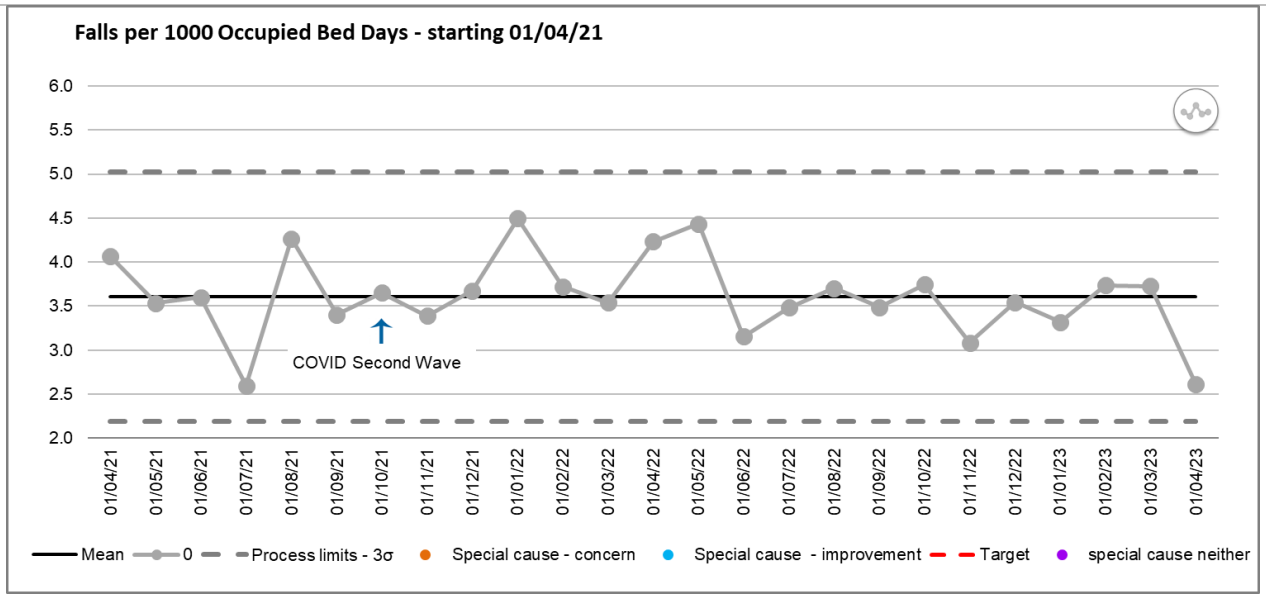
Excellence in care

Quality

Falls

Please see information contained within this month's IQPR demonstrating a reduction in month as per the graph below. A Falls Quality Improvement Plan was approved at the Falls Steering Group in April 2023. Ongoing themes from incidents relate to falls in patients with cognitive conditions and review of risk assessments. The Quality team are working with Frailty and Mental Health colleagues to improve this. In addition, a sample of 50 audits pertaining to Enhanced Care Scores has commenced and they will be completed monthly.

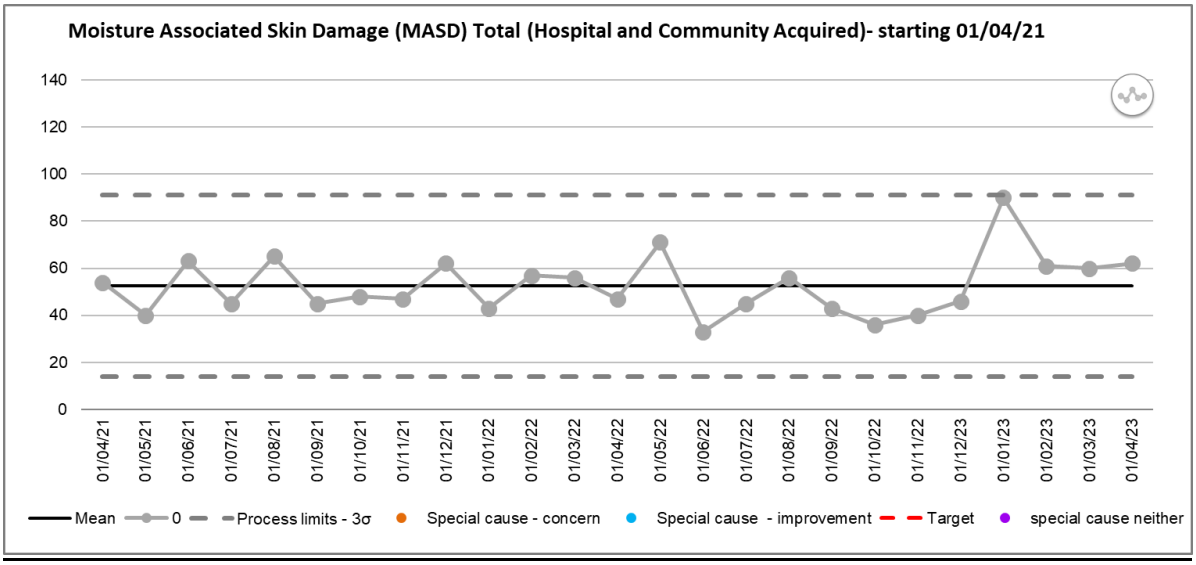
The graphs below illustrate the latest falls data (rate):



Pressure ulcers (PUs) and moisture associated skin damage (MASD)

Pressure Ulcers
Please see information contained within this month's IQPR demonstrating an overall static position in month.

Moisture Associated Skin Damage (MASD)
The MASD data remains static at 62 for the 3rd consecutive month as per graph below. A pilot for MASD assessment tool will commence from June 2023 and will be overseen via the Tissue Viability Steering Group.



Ongoing improvement interventions include:

- Sharing of improvement tips for leaders related to PU and MASD prevention
- Use of safety crosses to promote 'knowing how you are doing' and to celebrate ongoing 'pressure ulcer free' days
- Focus on reporting of faulty mattresses
- E-Learning modules on the prevention, recognition and wound assessment are now live
- Assessment training on using Purpose T via Microsoft Teams is available weekly

Patient Observations
Please see information contained within this month's IQPR.

Wider quality activities

Clinical accreditation
Clinical Accreditation has now launched as planned in April 2023. In total,10 wards have been assessed to date and their accreditation levels will be confirmed at the Clinical Accreditation Board meeting in May 2023. Staff voted that the levels of accreditation are named after gemstones and as follows: Ruby, Emerald, Sapphire and Diamond being the highest level. Wards not yet accredited will be known as 'Working towards accreditation'.

Nutrition and Hydration
The Supportive Mealtimes Policy has been circulated clinical areas in April 2023 to encourage a carer or family member present at mealtimes, if desired, to promote nutrition and hydration. Key professionals such as Dieticians and Speech and Language Therapists are encouraged to be on the ward/department at mealtimes. An assessment against the National Standards for Healthcare Food and Drink is currently being undertaken and outcomes will be reported via the established governance process and in this report.

Audit
An options appraisal for the review of quality audits is scheduled for May 2023. In preparation, a survey will be circulated to colleagues for collective decisions. Trend reports continue not to be available due to updates to the reporting tables.

Patient Experience
Please see information contained within this month's IQPR and Patient Experience Annual Report

Maternity
Please see the separate Maternity Services report

Adult and Children Safeguarding
Please see the separate Safeguarding report

Infection Prevention and Control (IPC)

The position update for April 2023 is as follows:

Methicillin Resistant *Staph. aureus* (MRSA) bacteraemia = 0
0/0 cases year to date
External annual trajectory zero for all NHS organisations

Methicillin Sensitive *Staph. aureus* (MSSA) bacteraemia = 1
01/24 cases year to date
Internal annual trajectory 24

MRSA Acquisition = 5
05/24 cases year to date.
Internal annual trajectory 24.

Actions
Wards supported with targeted education for MRSA screening and decolonisation.

Advise – Infection Prevention team (IPT) are supporting wards and the Capacity team to prioritise side room requirements according to the Isolation matrix in IP Policy 10. MRSA focus week facilitated by the IPT for wards that have an MRSA screening period of increased incidence.

***Clostridioides difficile* (*C. diff*) = 6**
06/58 cases year to date.
2022/23 External annual trajectory 58.

Actions
C diff action plan updated following external review.
Targeted education continues across all in patient areas.
Decant plan under review with the aim to recommence Summer 2023
QI support convened.

Assure
Patient equipment cleaning centre (PECC) continues to support the routine cleaning of equipment and support the patient flow.
Environmental audits are completed monthly.
Weekly *C. diff* ward rounds with Microbiologist.
Weekly antimicrobial ward rounds with Microbiologist and Antimicrobial Pharmacist.

Advise
National Health Service England (NHSE) undertook an invited visit on 31st January 2023 and written feedback has now been received with the actions added to the Trust *C. diff* action plan.
Awaiting plan and date to commence the installation of Ultraviolet decontamination ceiling mounted units in all doored cubicles in the Acute Medical Unit and the Emergency Department.

Gram Negative bacteraemia
***Escherichia coli (E coli)* = 6**
06/103 cases year to date.
2022/23 External annual trajectory 103.
(Awaiting confirmation of external trajectory for 2023/24).

***Klebsiella* = 4**
04/35 cases year to date.
2022/23 External annual trajectory 35.
(Awaiting confirmation of external trajectory for 2023/24).

***Pseudomonas aeruginosa* = 1**
01/18 cases year to date.
2022/23 External annual trajectory 18.
(Awaiting confirmation of external trajectory for 2023/24).

Actions
Involved in Gram Negative collaborative work with NHSE.
Catheter Working Group meet monthly, plans to trial catheter pack and catheter passport in 2023.

Device Related Hospital Acquired Bacteraemias (DRHABs) = 3
03/48 cases year to date.
Internal annual trajectory 48.

Actions
Urinary catheter and Cannula dashboards have been developed and being tested to support audit of devices.

COVID
As of 25th May, there are 8 positive cases in the Trust.

Influenza
As of 21th May, there are 1 positive cases in the Trust.

Advise – NHS England COVID-19 testing policy update - changes to NHS use cases document was published on 31st March 2023.The joint Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare Trust (WHT) risk assessment has been updated and following executive agreement the changes have been implemented.

Norovirus
19 positive samples processed in April 2023.
Invasive Group A Strep (iGAS)
4 cases in April – 2 with cellulitis, 1 foot abscess, 1 pneumonia.

Outbreaks:

- COVID-19 = 5
- C diff = 2 outbreaks
- Norovirus = 1

Infection Prevention Trajectories received for 2023/24 are as follows:
CDI = 53
E coli = 94
Pseudomonas a = 15
Klebsiella = 29

2022/23 actuals/objective:
CDI = 72/58
E coli = 96/103
Pseudomonas a = 17/18
Klebsiella = 32/35

The Quality Framework

The Quality Framework has been launched in April 2023. This enables the strategic vision for Nursing, Midwifery and Allied Health Professionals (AHPs) to be translated into an open and transparent plan which can be replicated over timeframes. It is built on the above listed foundation blocks which overlap and are integrated to one another. We have specific milestone plans for Maternity, Adult Acute, Paediatrics, Community and AHPs for the next 2 years and are developing a quarterly reporting structure.

Research and innovation

- Rachael Williams, Haematology Research Nurse at RWT has been successful in her application and interview to serve as a member of a Health Research Authority Ethics Committee. Rachael received confirmation of her appointment last month.
- The Professional Nurse Advocate (PNA) research study team at RWT have capitalised on opportunities to report progress with their research at local and national events organised by NHSE. This included presentation at a PNA webinar hosted by NHS England's National PNA Nursing Team.

Digital

- Work continues with the Group Technology Director overseeing digital services to support convergence in terms of support to Nursing and AHP staff for both systems, devices, and future application of technology in particular around the implementation of a modular System C Electronic Patient record (EPR).
- We have recruited 2 out of 6 Digital Nurses to support EPR implementation.

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.

(Updated and downloaded on 18 May 2023)

		Nursing Workforce										Patient Voice		Pressure Ulcer		Falls	Deteriorating Patient	Infection Prevention	Medication
		Annual Leave 11-17%	Budget WTE	CHPPD (Care Hours Per Patient Day)	Combined sickness %	Mandatory Training % - trend from last month	Maternity leave %	Registered Nurse Midwife WTE Vacancies	Registered Nurse Midwife WTE Vacancies %	Unregistered WTE Vacancies	Unregistered WTE Vacancies %	Number of Formal Complaints	Would Recommend	Number of Moisture Associated Skin Damage (approved by line manager)	Number of Pressure Ulcers (Datix reported)	Number of patient falls	% of observations achieved	Number of C-Diff	Number of Medication Errors (reported) Exc. OPD.
Royal Wolverhampton NHS Trust	This Period	14.05	2,513.82	8.6	5.61	92.0	2.44	14.90	1.43	-43.01	-4.77	28		62	34	77	83.1%	7	41
	Previous Period	18.00	2,450.08	8.1	5.76	92.3	2.42	31.68	1.09	-60.62	-12.43	37	84	65	34	116	81.3%	11	65

		Nursing Workforce										Patient Voice		Pressure Ulcer		Falls	Deteriorating Patient	Infection Prevention	Medication
		Annual Leave 11-17%	Budget WTE	CHPPD (Care Hours Per Patient Day)	Combined sickness %	Mandatory Training % - trend from last month	Maternity leave %	Registered Nurse Midwife WTE Vacancies	Registered Nurse Midwife WTE Vacancies %	Unregistered WTE Vacancies	Unregistered WTE Vacancies %	Number of Formal Complaints	Would Recommend	Number of Moisture Associated Skin Damage (approved by line manager)	Number of Pressure Ulcers (Datix reported)	Number of patient falls	% of observations achieved	Number of C-Diff	Number of Medication Errors (reported) Exc. OPD.
Division 1 (Surgical)	This Period	13.84	1,259.67	11.2	5.81	91.4	3.86	4.63	5.73	-1.01	-0.06	9		19	2	14	84.9%	2	14
B14 Cardiology ward	This Period	13.83	69.62	7.5	5.35	94.5	4.24	-1.37	-2.61	3.11	18.03	0		2	0	3	87.3%	0	1
B15 Cath Labs and Day Ward	This Period	17.14	30.24	~	2.39	95.0	3.77	3.14	12.88	0.19	3.30	0		0	0	0		0	0
B8 Cardiothoracic ward	This Period	12.67	43.34	8.0	8.13	89.4	5.45	-0.83	-2.32	-1.04	-13.47	0		0	1	1	81.9%	0	0
ICCU	This Period	14.13	204.01	33.3	3.26	95.1	2.65	2.06	1.14	0.83	3.56	0	~	3	1	0	~	0	1
A12 General Surgery	This Period	12.36	35.23	6.7	9.52	87.7	2.73	-2.35	10.51	1.84	14.28	0		0	0	0	88.5%	0	0
A14 General Surgery	This Period	13.45	35.23	7.4	1.53	95.4	1.42	-2.74	-12.28	1.91	14.79	1		2	0	2	84.5%	0	1
SEU	This Period	14.48	78.50	9.9	4.20	92.2	2.70	-2.18	-4.49	2.27	7.60	1		0	0	1	85.7%	1	2
D7 Gynae ward	This Period	12.12	40.62	6.5	10.19	92.8	7.84	-2.66	-9.94	-1.84	-13.27	0		0	0	0	0.0%	0	0
B7 Head and Neck	This Period	15.90	43.27	10.5	3.25	85.9	1.92	5.76	19.01	-0.63	-4.88	0		2	0	1	85.5%	0	0
Neonatal Unit	This Period	13.86	123.57	30.1	15.06	86.5	0.00	-8.24	12.85	-1.03	13.50	0		0	0	0	~	0	5
Transitional Care	This Period	11.05	20.49	~	9.74	86.5	7.48	7.90	54.10	-0.24	-4.08	0		0	0	0	~	0	0
D10 Maternity Ward	This Period	12.65	44.15	10.7	7.73	84.4	5.14	-2.81	-9.59	-5.55	-37.38	0		0	0	0	~	0	0
Delivery Suite	This Period	13.30	89.59	~	3.77	92.3	6.10	-5.98	-8.36	0.72	4.01	0		0	0	0	~	0	0
Hilton main CCH	This Period	15.15	46.70	5.3	12.60	96.0	3.03	11.67	37.08	0.36	2.39	0		2	0	0	82.9%	0	0
A5 T & O ward	This Period	16.70	40.77	7.1	2.75	90.9	2.37	0.89	3.91	1.85	10.30	1		1	0	0	85.7%	0	1
A6 T & O ward	This Period	12.22	40.73	7.6	6.31	89.1	4.03	2.06	9.08	0.13	0.74	1		1	0	3	81.2%	0	1
Theatres	This Period	14.25	273.61	~	6.62	92.0	2.55	0.29	0.19	-3.91	-3.21	0	~	0	0	0	~	0	0

		Nursing Workforce										Patient Voice		Pressure Ulcer		Falls	Deteriorating Patient	Infection Prevention	Medication
		Annual Leave 11-17%	Budget WTE	CHPPD (Care Hours Per Patient Day)	Combined sickness %	Mandatory Training % - trend from last month	Maternity leave %	Registered Nurse Midwife WTE Vacancies	Registered Nurse Midwife WTE Vacancies %	Unregistered WTE Vacancies	Unregistered WTE Vacancies %	Number of Formal Complaints	Would Recommend	Number of Moisture Associated Skin Damage (approved by line manager)	Number of Pressure Ulcers (Datix reported)	Number of patient falls	% of observations achieved	Number of C-Diff	Number of Medication Errors (reported) Exc. OPD.
Division 2 (EMS)	This Period	11.92	724.18	6.7	5.50	90.5	3.53	-5.95	-0.53	-1.33	-3.51	14		30	25	59	82.6%	5	17
AMU	This Period	13.45	89.29	7.7	3.43		6.45	-0.36	-0.01	4.38	0.20	1		0	0	4	84.7%	0	1
C15 Diabetes	This Period	9.60	26.90	5.7	1.80	91.1	13.65	-5.71	-29.72	-2.46	-31.95	0		3	2	4	75.2%	0	0
C16 Diabetes	This Period	7.28	33.53	5.6	6.22	91.1	2.67	-1.65	-7.58	-1.30	-11.05	0		4	2	6	76.3%	0	2
C17	This Period	16.26	30.50	6.8	7.31	94.6	2.40	-0.27		5.26		0		1	2	2	83.6%	0	0
ED	This Period	11.19	154.71	~	7.14	90.2	3.05	-1.63	-1.34	-6.18	-18.93	7		0	0	5	~	0	3
A7 Gastroenterology	This Period	12.09	40.28	6.2	0.25	91.5	4.21	2.68	10.79	3.11	20.12	0		0	1	0	0.0%	0	0
A8 Gastroenterology	This Period	11.31	40.28	5.8	10.78	95.2	0.00	5.15	20.72	0.60	3.89	1		0	2	4	91.7%	0	2
Clinical Haematology Unit	This Period	17.46	41.70	6.9	3.17	91.3	4.84	1.37	4.74	2.53	19.90	0		1	2	4	83.7%	0	0
C39 ward	This Period	16.40	0.00	7.5	29.29	91.0	0.00	-2.15		-2.20		1		0	0	3	82.6%	0	0
Fairoak	This Period	15.31	32.00	5.4	0.20	86.5	4.40	0.84	5.06	1.69	11.00	0		0	1	0	85.2%	0	0
C18 Elderly Care	This Period	16.91	37.80	7.2	7.09		2.69	0.47	2.08	0.61	3.98	0		1	0	0	91.4%	2	1
C19 Elderly Care	This Period	11.56	37.80	6.8	4.38	85.8	3.88	-0.36	-1.61	-0.59	3.85	0		2	2	1	93.0%	0	0
C35 Deansley Ward	This Period	11.25	29.00	7.9	2.07	87.3	2.62	1.75	9.10	-2.32	-23.67	0		1	0	2	71.0%	2	0
Durnall	This Period	11.19	19.81	~	9.49	94.7	3.84	-2.06	-13.01	-1.43	-35.67	0		0	0	0	95.9%	0	0
NRU West Park	This Period	5.99	21.80	10.8	14.77	97.5	0.00	-0.26	-2.26	-1.31	-12.75	0		0	0	0	94.4%	0	0
Ward 1 West Park	This Period	9.49	29.60	5.6	4.68	97.2	8.89	-1.85	-11.12	-1.41	-10.85	0		2	0	0	94.7%	0	0
Ward 2 West Park	This Period	14.40	31.20	5.8	8.90	93.4	0.00	1.08	7.66	0.38	2.22	0		0	0	3	87.2%	0	1
C22 Renal	This Period	9.55	27.10	6.6	2.80	86.4	1.42	-1.16	-7.25	-1.50	-13.51	0		5	2	5	75.3%	0	1
C24 Renal Ward	This Period	9.05	34.54	5.8	6.18	91.9	2.34	2.66	11.67	0.27	2.33	0		2	1	1	83.9%	0	0
C25 Renal Ward	This Period	10.22	34.54	5.6	4.96	89.2	5.63	0.39	1.73	-1.10	-9.37	1		4	1	3	76.8%	0	0
C14 Respiratory	This Period	12.66	40.10	6.5	6.36	82.3	1.56	-0.95	-4.12	1.71	10.02	2		1	3	6	81.0%	0	0
C26 Respiratory	This Period	11.09	46.41	8.7	5.11	89.9	5.00	-6.84	-23.33	-1.77	-10.34	0		0	1	1	83.2%	0	0
C21 Acute Stroke Unit	This Period	10.61	62.69	7.9	6.06	88.8	0.00	2.90	7.35	1.69	7.24	0		3	3	2	72.4%	0	5

			Nursing Workforce											Patient Voice		Pressure Ulcer		Falls	Deteriorating Patient	Infection Prevention	Medication
		Number of C-Diff	Annual Leave 11-17%	Budget WTE	CHPPD (Care Hours Per Patient Day)	Combined sickness %	Mandatory Training % - trend from last month	Maternity leave %	Registered Nurse Midwife WTE Vacancies	Registered Nurse Midwife WTE Vacancies %	Unregistered WTE Vacancies	Unregistered WTE Vacancies %	Number of Formal Complaints	Would Recommend	Number of Moisture Associated Skin Damage (approved by line manager)	Number of Pressure Ulcers (Datix reported)	Number of patient falls	% of observations achieved	Number of C-Diff	Number of Medication Errors (reported) Exc. OPD.
Division 3 (CCSS)	This Period	~	16.39	529.97	7.3	5.41	95.3	1.34	16.22	-0.91	-40.67	-36.45	5		12	7	3	78	0	10
A21	This Period	0	15.89	59.28	8.8	3.41	95.9	7.25	-0.64	-1.29	-3.51	-36.68	0		0	0	1	78.33	~	3
A21/PAU	This Period	~	~	~	~	~	~	~	~	~	~	~	~	~	~	~	~	~	~	~
Clinical Nurse Specialist	This Period	~		4.98	~	0.00	91.3	0.00	-6.69	-134.27	0.00				0	0	0	~		0
Community Children's Nursing Team - Generic Team	This Period	~		28.28	~	0.64	95.8	2.95	3.99	19.71	-2.78	-34.55			0	0	0	~	0	0
PAU	This Period	0	14.76	17.81	5.9	8.36	97.2	9.40	-0.53	-4.21	-1.23	-23.50	0		0	0	0	78.95	~	0
Planned Care	This Period	~	13.00	101.36	~	5.59	94.0	1.97	11.33	15.28	1.80	6.59	3		12	7	0	~	0	6
Urgent Care	This Period	~	15.40	78.27	~	7.29	94.7	3.51	4.41	8.02	-8.75	-37.60			0	0	0	~	0	0
Intermediate Care	This Period	~	9.42	3.20	~	1.06	93.2	0.00	0.00		-8.60	-268.75			0	0	0	~		0
Dermatology	This Period	~	10.00	12.77	~	8.76	97.0	0.00	0.18	2.19	-1.05	-23.08	0		0	0	0	~	0	0
Physio & OT	This Period	~	~		~	~	~	~	~	~	~	~	0	~	0	0	0	~	~	0
Primary Care Services	This Period	~		25.75	~	12.43	91.5	2.21	-3.22	-15.87	-1.80	-33.09	1		0	0	0	~	~	0
Radiology	This Period	~	17.20	8.40	~	8.95	93.7	0.00	0.60	9.38	-1.91	-95.33	0		0	0	2	~	0	0
Rheumatology	This Period	~	17.90	14.41	~	6.96	93.6	0.00	0.71	8.96	-1.32	-20.52	1		0	0	0	~	0	0
Sexual Health	This Period	~	18.72	4.29	~	7.17	95.4	2.53	-8.05	0.00	-6.80	0.00	0		0	0	0	~	0	0
Ambulatory Care	This Period	~	11.45	20.50	~	8.05	96.5	2.41	-2.74	-16.02	-0.20	-5.88			0	0	0	~	~	0

KEY				Green	Amber	Red
	Budget	Total nursing and HCSW funded establishment for clinical location - Band 2-7		**Not applicable**		
	Total Vacancies	The total vacancies at the time of report = number recruited added with open vacancies	wte = whole time	**ncies: trend arrow v. previous month: bar graph % over v. under recr**		
	Number in recruitment	All known appointments made through recruitment - these staff are not yet in post	equivalents	**0-3 wte**	**3-5 wte**	**>5 wte**
	Combined Absence	Combined absence average per ward area		**<3.85%**	**3.86 - 4.23%**	**>4.24%**
	CHHD	An equation for the cost of patient care per (total hours of care delivery/bed occupied)		**>6**	**5-6**	**<5**
	Mandatory Training	**Percentage of all training mandatory requirements completed for each clinical location**		**>95%**	**90% - 95%**	**<90%**
	FFT - Recommendations	Friends and Family Test - from the patient response rates, how many would recommend care at RWT		**>90%**	**80% - 90%**	**<80%**
	Complaints	Total number of complaint received for the clinical location/ward (Formal & Pals)		**0**	**Not applicable**	**≥1**
	Pressure Ulcers	Number of pressure injuries as reported on Datix (sample date - circa 10th day of new month)		**0**	**Not applicable**	**≥1**
	Falls	Number of falls as reported on Datix (sample date - circa 10th day of new month)		**0 - 1**	**2**	**≥3**
	Medication Administration Errors	Number of Administration errors reported on Datix (sample data - circa 10th of new month)		**0**	**Not applicable**	**>1**
	Missed dose % of all medications given	% of missed doses during a month		**<5%**	**Not applicable**	**>5%**
	Late Observations	% of observations completed from Care Flow Vitals		**<5%**	**Not applicable**	**>5%**
	Cardiac Arrests	Total number of cardiac arrest calls to clinical location: not including other 2222 calls for non-cardiac arrest		**0**	**Not applicable**	**≥1**
	C-diff	Number of clostridium difficile incidences (as reported by Infection Prevention)		**0**	**Not applicable**	**≥1**
	MRSA	Number of MRSA acquisitions per month (as reported by Infection Prevention)		**0**	**Not applicable**	**≥1**

The Royal Wolverhampton NHS Trust

Trust Board		
Meeting Date:	6th June 2023	
Title of Report	Maternity Services Report	
Action Requested:	**To note**	
For the attention of the Board		
Assure	• A successful recruitment event has taken place with 26 conditional offers made to Student Midwives due to qualify this Autumn. • In March and April data form the Birth Rate Plus Acuity tool demonstrates that One to One Care Rate in labour were 100% therefore meeting national standards.	
Advise	• The 3-year Single Delivery Plan for Maternity and Neonatal Services has now been received by Trusts. There are 4 High level key themes that Services will be required to focus on over the next 3 years. • The report provides an update for Maternity and Neonatal Services from The Perinatal Services Clinical Directors on some of the Quality Improvement Programmes the service is involved in. • Maternity health inequalities data demonstrates higher that over 50% of booked women are from higher levels of deprivation. Levels of smoking and obesity are also higher in our populations.	
Alert	• Birth Rate Acuity Tool demonstrates in improvement in shifts staffed to acuity 43% in March and 72% in April, this still falls below Royal College of Midwives recommendation that services should aim to achieve positive acuity 85% of touchpoints.	
Author and Responsible Director Contact Details:	Tracy Palmer – Director of Midwifery and Neonatal Services The Royal Wolverhampton NHS Trust. Tel 01902 307999 Ext. 85162 Email Tracypalmer@nhs.net Quality impact (QI) Service Lead updates: Dr Richard Heaver, Clinical Director Neonatal Services Dr Nina Johns, Clinical Director Obstetrics	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement.
	Support our Colleagues	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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequality strategy. b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities

	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:	Capital: Workforce:	
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		
Risks: BAF/ TRR		
Risk: Appetite		
Public or Private:	Public	
Other formal bodies involved:		
References and Appendices	Appendix 1: : B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk) Appendix 2: Single Delivery Plan: Improvement template	
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:	Maternity Services Report
Item/paragraph	**<u>The Royal Wolverhampton Midwifery Workforce Update</u>** The report outlines the present position for Midwifery and Maternity Support Worker (MSW) deficit related to vacancy and Maternity leave. Ongoing recruitment has proved successful with 26 Students being given conditional offers. The workforce trajectory for both turnover and maternity leave has been forecasted and indicates a positive picture moving forwards into Autumn when it is estimated that all vacancy and maternity leave in both midwifery and MSW workforce will be filled. This reflects the proactive approach to recruit substantively into maternity leave and expected leavers hours.

	The report provides One to One Care Rate in labour and Midwifery staffing based on acuity compliance for March and April. **Three-year Single Delivery Plan for Maternity and Neonatal Services** The Three Year Single Delivery Plan (SDP) for Maternity and Neonatal Services published by NHSE in March 2023 has been received. The plan (Appendix 1) summarises responsibilities for each part of the NHS including Trusts, Integrated Care Boards and Systems including Local Maternity and Neonatal Systems and Operational Delivery Networks, and NHS England The report outlines the four Key high-level themes that services are expected to implement. An improvement template has also been provided by NHSE (Appendix 2) outlining the fundamental recommendations with timescales for Maternity and Neonatal providers, 0-19 services, Integrated Care Boards and NHSE. **Health Inequalities data for Women booking for birth at RWT.** Wolverhampton is recognised as having high areas of deprivation. The number of women who smoke or are obese at booking, is well above the national average. Data has been provided over a 5-year period which indicates that smoking and obesity in pregnancy is prevalent in Wolverhampton and that minimum progress has been made to improve healthy lifestyles over the last five years. Funding has been secured to support smoking cessation and promote healthy lifestyles during pregnancy to support the public health agenda in Wolverhampton. **Updates for Clinical Directors in Neonates and Obstetric Services** An update has been provided from Dr Richard Heaver Clinical Director for Neonatal Services and Dr Nina Johns Clinical Director for Obstetric Services; updates provide an overview of some of the Quality Improvement work that The Perinatal Service are involved with and leading on in line with The National Transformation Programme for Maternity and Neonatal services.

Detailed Report – Maternity Services Report 6th June 2023

Growing and Retaining our Workforce

The Royal Wolverhampton Midwifery Workforce Update

Table 1 indicates Vacancy rates for Midwifery and Maternity Support Worker (MSW) roles. The present position indicates that there is a deficit of 12.83 WTE Midwifery posts and 1.42 WTE MSW posts within the Directorate. In April Maternity leave for Midwifery was 9.36 WTE and 2.03 MSW. Long term sickness within both workforces is minimal and is just over 4 WTE.

The highest deficit for Midwifery vacancy is within the Community Midwifery Service.

Table 1

Area	RM Vacancy	MSW Vacancy	RM Mat leave	MSW Mat Leave	RM LTS	MSW LTS
ANC/FAU	0	0.5	1	0.8	0	0
Delivery suite	0	0.92	4.64	0	1.17	0.64
Midwife Led Unit	1.95	0.92	4.64	0	0	0.96
Community	5.69	0	1.8	0	0	1
Maternity Wards D!0 D9	2.99	0	1.28	1.23	0.96	0
Sonography	2.2	0	0	0	0	0
Total	**12.83**	**1.42**	**9.36**	**2.03**	**2.13**	**2.6**

A successful recruitment day was held on the 3rd May 2023 and hosted by the Local Maternity and Neonatal Systems (LMNS).

26 Student Midwives have been given conditional offers of appointment. The Midwifery workforce lead is working on a forecast of when the students will commence into posts, considering that some students may require resits and to make up clinical hours, but also some students may not want full time hours. The forecast will include projected l turnover and maternity leave from the summer onwards; these figures will be considered when offers are made to ensure minimum vacancy rates by Autumn 2023.

Table 2: One to One Care rates in Established Labour

The national ambition and recommendation in NHSR CNST Maternity Incentive Scheme (MIS) safety action 5: *Can you demonstrate an effective system of midwifery workforce planning to the required standard*? Recommends that 100% of women receive 1:1 care in established labour.

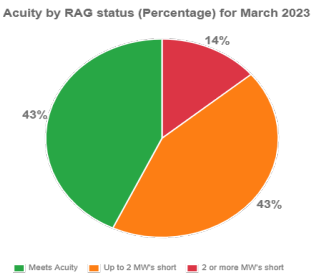
Table 2

Activity	Previous Year Average	March 2023	April 2023
1:1 Care rate in labour	99.5%	100%	100%

One to One Care rates in established labour continue to be maintained at 100% for March and April 2023. This has been challenging due to the deficit in the midwifery workforce because of vacancy, maternity leave and sickness absence as detailed in table 1.

Table 3: Acuity by RAG Status (%) March / April 2023

The Birth Rate Plus Acuity Tool provides data for the overall Midwifery Deficit for March and April.



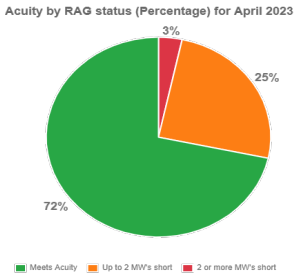


Table3

Month	Met Acuity	Up 2 Midwives Short per shift	Up to 2 Midwives > per shift
March	43%	43%	14%
April	72%	25%	3%

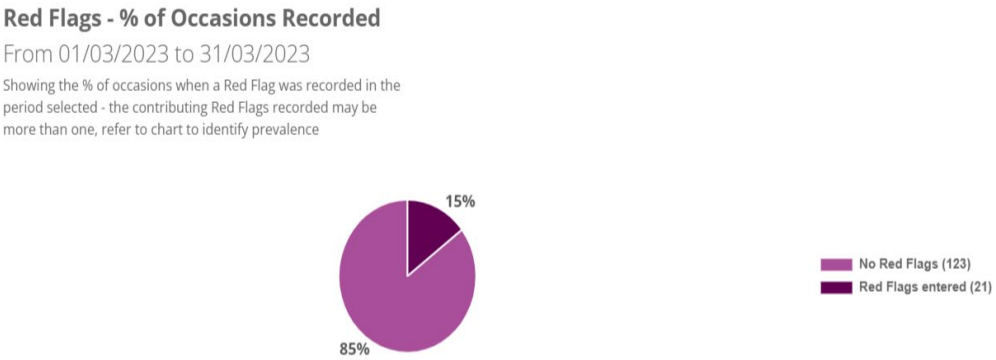
Guidance from the Royal College of Midwives recommends that services should aim to achieve positive acuity 85% of the time, recognising that maternity activity does fluctuate and staffing plans do need to include escalation for period of increased activity. Improvements have been seen in month and the local escalation plans mitigate risk when acuity exceeds staffing, this includes the now established duty manager 7 days per week.

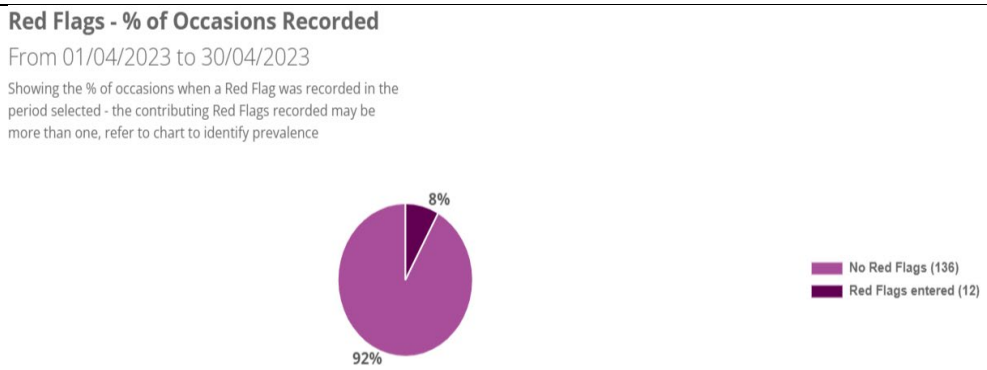
There have been no Serious incidents directly related to midwifery staffing.

Red Flags number /Percentage March-April 2023

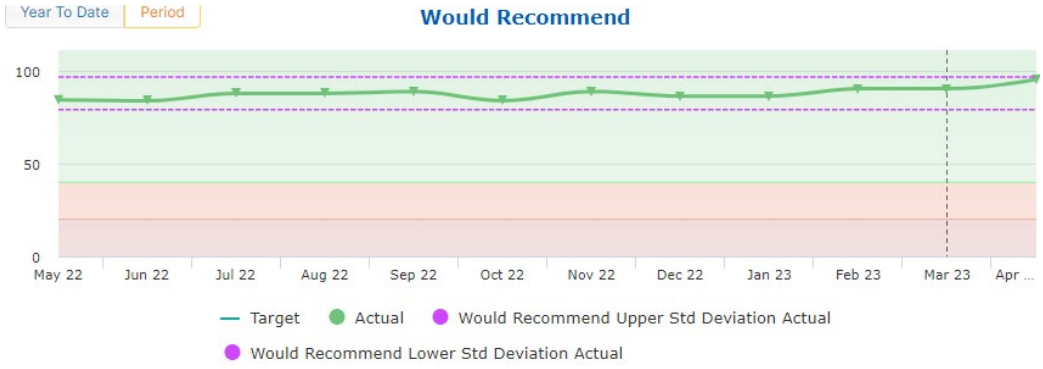
Red flag events are delays in providing care to a woman that is specifically attributed to Midwifery staffing deficit. There is guidance from the Royal College of Midwives in terms of what should be considered a red flag event.

Month	Number of .Red Flags reported
March 2023	21 (15%)
April 2023	12 (8%)





There were no adverse outcomes because of Red Flag events in both March and April 2023 and no rise in complaints has been seen and Friends and Family Test results remain within the upper and lower bounds.



Listening to, and working with, women and families with compassion

Three-year Single Delivery Plan for Maternity and Neonatal Services

On March 30th 2023 Three Year Single Delivery Plan (SDP) for Maternity and Neonatal Services was published by NHS England (NHSE) (Appendix1).

The plan was developed for Trust Boards, Senior leaders, and frontline staff to focus on key themes that emerged from the recent reports.

NHSE has stated that the plan aims to deliver change rather than set out new policy. It seeks to help each part of the NHS to plan and prioritise actions by bringing together learning and action from a range of national reports and plans into this one document.

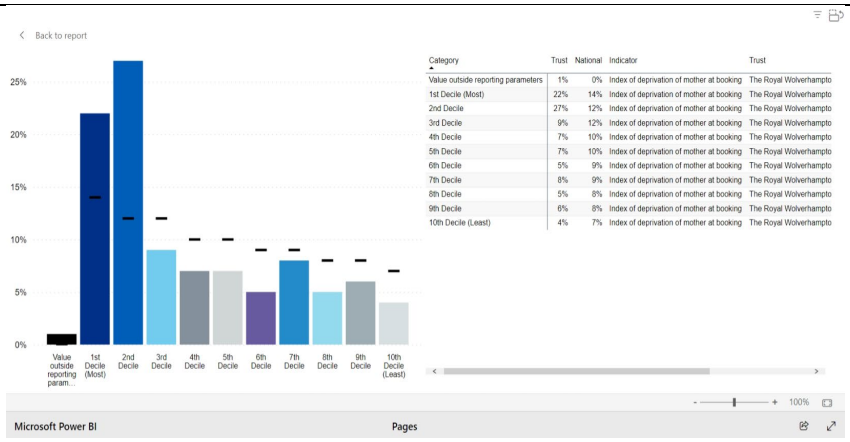
The plan summarises responsibilities for each part of the NHS including Trusts, Integrated Care Boards and Systems including Local Maternity and Neonatal Systems and Operational Delivery Networks, and NHS England

The four Key high-level themes are:

1. Listening to, and working with, women and families with compassion.
We want to ensure care is personalised and that service users have informed choice. Voices of all women including those from diverse backgrounds must be heard, and services should work closely with all service users to collaboratively plan, design and improve care.

2. Growing, retaining, and supporting our workforce with the resources and teams they need to excel.
We want to ensure there are sufficient highly skilled staff across the whole maternity and neonatal team whilst combatting workforce inequalities. Staff

	should feel valued, with plentiful opportunity for skills and career development to facilitate a lifelong career in the NHS. **3. Developing and sustaining a culture of safety, learning, and support.** There should be a positive safety culture in every maternity and neonatal service, where everyone takes responsibility for safer care and learning, and leaders understand, and act based on how it feels for their teams to work at their organisation. **4. Standards and structures that underpin safer, more personalised, and more equitable care.** Best practice should be consistently implemented across the country, with timely, accurate data available to support learning and early identification of emerging safety issues. Women can access their records and interact with their plans and information to support informed decision-making. An Improvement template (Appendix 2) has been provided from NHSE with the key recommendations for Trusts with timescales for to implementation. Monitoring of progress with the key recommendations will be undertaken by Local Maternity and Neonatal Systems and Integrated Care Boards. The Directorate is working through the document to benchmark where the service is presently. Action plans will be developed to ensure that the Directorate remains focused on the recommendations and ambition from the three-year Single Delivery Plan. The Single Delivery Plan will also align with the Directorates Perinatal Strategy. Regular updates and progress reports will be presented to Trust Board by the Director of Midwifery and also go to directorate governance, divisional governance, QSAG and QCAC. In addition updates will be monitored by the Local Maternity and Neonatal System. **<u>Standards and structures that underpin safer, more personalised, and more equitable care.</u>** <u>Health Inequalities data for Pregnant Women booked for birth in Wolverhampton 2018/23.</u> <u>Deprivation</u> Women with a low socio-economic status with social risk factors are at a disproportionate risk of poor birth outcomes. Mothers booking at RWT score well above the national average for the 1st and 2nd decile categories which indicate high deprivation for those catchment areas. Graph 1: Demonstrates % of women that book with RWT for birth are from the highest deprived catchment areas within Wolverhampton. (Data extracted from The National Maternity Dashboard).



The graph demonstrates that over 50% of women that book for birth live within the highest areas of deprivation in Wolverhampton (decile 1 and 2).

Smoking in Pregnancy

Smoking in pregnancy remains a key public health concern and is the single most modifiable risk factor for poor pregnancy and birth outcomes. There is a high prevalence of smoking in Wolverhampton.

As part of the National Transformation Programme for Maternity Services NHSE has set the aspirational target to reduce smoking at time of birth to 6% by 2024-25.

National birth outcome data demonstrates that pregnant women who smoke are more likely to experience a premature birth, perinatal death and / or low birth weight babies.

Table 4: Demonstrates that within Wolverhampton over a five-year period an average of 16.5% of pregnant women smoked at the time of booking.

The data demonstrates that referral to Smoking Cessation Referral Services has remained consistent over a four-year period (2019/23) since the Maternity Smoking Cessation Service was introduced permanently in 2019.

CO monitoring over the 5-year period has remained consistent with exception to year 2020/21 when CO monitoring was paused due to the COVID 19 Pandemic.

Table 4: Smokers at booking data 2018/23

Data Source: Badgernet

Indicators	2018 2019	2019 2020	2020 2021	2021 2022	YTD 2022-23
Total Bookings	4568	4624	4629	5113	1959
Smoking at Booking	737	715	796	803	357
% Smokers at Booking	**16%**	**15%**	**17%**	**16%**	**18%**
% CO Level Offered	85%	88%	13%	77%	89%
% Smokers Referral Offered & Accepted	30%	47%	48%	41%	41%
% Care Plan at Booking	99%	99%	98%	99%	98%
% Overweight Women at Booking	52%	53%	54%	55%	56%
% Obese Women at Booking	24%	23%	25%	25%	26%
% Severely Obese Women at Booking	**4%**	**5%**	**5%**	**5%**	**5%**

Table 5: Teenage Pregnancy: Smoking at Booking

Indicators	2018 2019	2019 2020	2020 2021	2021 2022	YTD 2022-23
Total Bookings	84	69	54	71	26
Smoking at Booking	23	20	17	17	6
% Smokers at Booking	27%	29%	31%	24%	23%
% CO Level Offered	86%	87%	11%	73%	92%
% Smokers Referral Offered & Accepted	17%	20%	53%	41%	33%

Table 5 indicates total bookings for teenage pregnancies (women booking under the age of 19) and demonstrates the percentage of teenagers that smoked at booking. There has been a very gradual decline in teenage pregnancy smokers at booking over a five-year period. Targeted work continues with these groups of teenage women to aim at improving healthy lifestyles.

The plan in the future is to include teenage pregnant mothers on a continuity of care pathway. Presently further introduction of continuity teams is not possible until the Midwifery workforce is in line with Birth Rate Plus and Midwives are trained and up skilled in delivering care in intrapartum environments.

This plan part of the 3-year Continuity of Care plan that will align with the Single Delivery Plan to make Standards and Structures of care safe, personalised and more equitable.

Funding has been secured from Wolverhampton Public Health as part of the long-term plan for RWT to become a smoke free hospital. This will include the provision of smoking cessation services to those pregnant women who smoke and book for birth at RWT.

Further funding has been secured for 2 whole time equivalent (WTE) Band 4 Healthy Pregnancy Advisors and 2 WTE Band 4 Smoking Cessation support workers. These key new roles will provide advice and support to pregnant women who reside in Wolverhampton catchment areas with high deprivation. The aim is to reduce smoking at time of birth in line with national trajectories and promote healthier lifestyles to reduce obesity and improve outcomes for women and babies. This sits as part of the Trustwide vision for health inequalities and Smokefree Hospital aligning with the NHS Long Term Plan.

Developing and sustaining a culture of safety, learning, and support.

Neonatal Services

The Neonatal Service is currently launching 'PeriPREM' which is an evidence-based approach to improving mortality and morbidity in extreme preterm infants. The project is initially aimed at reducing term admissions to Neonatal Unit specifically with respiratory problems; the project has been presented at national conferences winning several awards and attracting interest from other Trusts who would like to us to share our approach.

In 2021 RWT were an outlier for hypothermia in the neonate on admission to the neonatal unit. There has been focused work from the multidisciplinary team to improve on this standard and, data is indicating that these improvements will be reflected in the 2022 data therefore RWT will not be an outlier for this standard in 2022 when the data is published.

	Mortality data continues to show neonatal and extended perinatal mortality as an outlier >5% above expected national data. There is a robust mortality review process in place with obstetric and neonatal leads. External reviewers are invited when possible. There are various Quality Improvement programmes which RWT are engaging with to improve outcomes for babies. • Saving Babies Lives Care Bundle • Avoiding Term Admissions into Neonatal Unit (ATAIN) • PeriPREM a package of care which has proven to improve outcomes for the premature neonate. • Standardisation of the 27-week pathway for Preterm infants. As part of the Ockenden review RWT Neonatal Unit are supporting staff from Dudley Group Hospitals and Walsall Health Care Trust to attend working sessions on RWT's level 3 Neonatal Unit in order to maintain their skills and knowledge. Ideally these sessions should occur more frequently, however challenges with staffing within the two Trusts have meant that departments have had to limit allocated sessions for this. Obstetrics The Obstetric service is engaging in the MatNeoSIP National Regional Quality Improvement Programme 'Improving Clinical Escalation in Maternity'. The aim of the programme I; • Reduce delays in escalation. • Standardise the use of safety critical language. • To promote a culture of respect, kindness, and civility • Creating a supportive environment by reducing hierarchical structures. The directorate is introducing the Each baby counts learn and support toolkit for clinical escalation led by Dr Nina Johns.

Three Year Delivery Plan for Maternity and Neonatal Services - March 2023

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Under 21 servces	GPs	Success Measures
			All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5.					**NHSE outcome measure for this theme will be** 1. indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation. **Relevant regulation and incentivisation includes:** 2. The CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections. 3. The NHS Resolution CNST Maternity incentive scheme which encourages the use of MNVPs.
				Commission for and monitor implementation of personalised care for every woman.				Evidence which ICBs can use includes: – Feedback on personalised care gathered via MNVPs from a wide range of service users. – Local evidence of working with women and families to improve services, including co-production.
		NHSE 2025			Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.			
			The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.					
			Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women.					
			Women receive care that has the best start in life for babies.					
			NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers.					
			Evidence-based information about screening.					
			Evidence-based information about vaccination.					
			Women have clear choices, supported by unbiased information and evidence□based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Re:Birth report, and is co-produced.					
					Work with service users and other partners to produce standardised information to aid decision-making, focusing on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour, and pain relief.			
			All women have equitable access to specialist care, including perinatal mental health services.					We will use these progress measures: 1. perinatal mental health services are in place. 2. The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard
				Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care.				
	sed	Trusts 2024	All women have equitable access to specialist care, including , perinatal pelvic health services.					We will use these progress measures: – Perinatal pelvic health services are in place.

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Under 21 servces	GPs	Success Measures
stening to and working with d families with compassion	Objective 1: Care that is personalis			Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.				
		NHSE Spring 2023			In Spring 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.			
			All women have equitable access to specialist care, including maternal and medicine networks.					
			All women have equitable access to specialist care, including fetal medicine networks.					
			All women have equitable access to specialist care, including neonatal care, when needed.					
		NHSE Spring 2023	Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 10 | Three Year Delivery Plan for Maternity and Neonatal Services weeks after birth.					
					Publish national postnatal care guidance by the end of 2023, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.			
						Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services.		
							Women experience personalised, joined-up, high-quality care right through to the postnatal period with a GP check 6-8 weeks after birth.	
			Women are provided with practical support and information that reflects how they choose to feed their babies.					
						Women are provided with practical support and information that reflects how they choose to feed their babies.		
			Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.					
		NHSE 2023/24	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.					

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Under 21 servces	GPs	Success Measures
Theme 1: Lis women and					Invest to ensure availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.			
			Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.					
		01/03/2027	Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.					The proportion of maternity and neonatal services with UNICEF BFI accreditation.
					Extend the national support offer to the 38 maternity services yet to achieve UNICEF BFI accreditation or an equivalent initiative.			
		Mar-24			By March 2024, act on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report.			
	nprove equity for mothers and babies		Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities.					
			Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes ensuring access to interpreter services.					
			Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes adhering to the Accessible Information Standard in maternity and neonatal settings.					
			Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.					
		During 23/24		During 2023/24, continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries.				
					Provide regional and national support for the implementation of LMNS equity and equality action plans.			
				Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.				

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Under 21 servces	GPs	Success Measures
	Objective 2: Ir	NHSE From 2023			Pilot and evaluate new service models designed to reduce inequalities including from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas.			
					Continue to work with the Maternity Disparities Taskforce to explore disparities in maternity care and identify how to improve outcomes.			
		NHSE Spring 2023			In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services.			
	Objective 3: Work with service users to improve care		Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.					
				Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.				
				Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.				
				Ensure service user representatives are members of the local maternity and neonatal system board.				
					Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.			
					Through operational delivery networks, support parent representation in the governance of neonatal services.			
					Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement.			

Three Year Delivery Plan for Maternity and Neonatal Services - March 2023

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
	Objective 4: Grow our workforce	by 2027/28	Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birth-rate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28			Relevant regulation and incentivisation includes: 1. The CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development. 2. The NHS Resolution CNST maternity incentive scheme incentivises trusts to evidence that training in accordance with the core competency framework is in place
			Develop and implement a local plan to 1. fill vacancies 2. include support for newly qualified staff 3. include support for clinicians who wish to return to practice			
			Provide administrative support to free up pressured clinical time.			
				Commission and fund safe staffing across their system		Evidence that ICBs can use includes: 1. Progress against workforce, retention, succession, and training plans. 2. Local staff feedback mechanisms. 3. Progress against the nursing and midwifery high impact retention interventions.
				Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels for example, 1. guidelines for the provision of anaesthesia services for an obstetric population 2. implementing the recommendations of the neonatal critical care transformation review		
				Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity.		
		24/25		It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.		
				Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements		
					Assist trusts and **regions** with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing	1. Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data. 2. In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists. 3. To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.
					Boost midwifery workforce supply across 1. undergraduate training, 2. apprenticeships, 3. postgraduate conversion, 4. return to midwifery programmes, 5. international recruitment	
					Increase medical training places to expand the consultant workforce in maternity services across 1. obstetrics and gynaecology 2. anaesthetics	

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
Theme 2: Growing, retaining, and supporting our workforce		Across 2023/24.			Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care	
	Objective 5: Value and retain our workforce		Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan			
			Implement equity and equality plan actions to reduce workforce inequalities.			
			Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.			
			Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.			
			1. Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. 2. Newly appointed Band 7 and 8 midwives should be supported by a mentor.			
			Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.			
				Share best practice for retention and staff support.		
				Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach		
		From 24/25		Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter		
		23/24			Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter	
					Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.	
		23/24			In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance	
		23/24			In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead.	
					Continue to address workforce inequalities through the Workforce Race Equality Standard	
					Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local service	

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
		Jul-23			By July 2023, develop a safe clinical learning environment charter for trusts;	
		Apr-24			By April 2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students.	
	Objective 6: Invest in skills	Annual	Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework			
			Ensure junior, speciality and associate specialist obstetricians have appropriate clinical support and supervision in line with RCOG guidance			
			Ensure junior, speciality and associate specialist neonatal medical staff have appropriate clinical support and supervision in line with BAPM guidance			
			Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.			
		Jun-23			Refresh the curriculum for maternity support workers (MSWs) by June 2023.	
		Sep-23			Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.	
		Summer 2023			Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development.	
					Establish a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks	
					Work with royal colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.	
					Through action set out above to grow the workforce, help to address pressures on backfill for training.	

Three Year Delivery Plan for Maternity and Neonatal Services - March 2023

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
g and sustaining a culture rning, and support	Objective 7: Develop a positive safety culture		Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.			
		Apr-24	Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice			
			At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.			Relevant regulation includes: 1. The CQC will continue to consider whether a trust has a learning and responsive culture, strong leadership, and robust governance.
			Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.			
			Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways			
				Monitor the impact of work to improve culture and provide additional support when needed.		The evidence ICBs can use across maternity and neonatal services includes 1. Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture 2. Whether trust boards regularly share and act on learning. 3. Staff feedback on how incidents and issues of concern are managed.
				Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other		
		Apr-24			By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.	Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups
	tive 8: Learning and improving		Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust			
			Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.			
			Respond effectively and openly to patient safety incidents using PSIRF			
			Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.			
			Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale			
			Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).			
				Share learning and good practice across all trusts in the ICS.		
		23/24		Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place		

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
Theme 3: Developin of safety, lea	Objec	Through 2023			Throughout 2023, support the transition to PSIRF through national learning events	
					Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity	
	Objective 9: Support and oversight		Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.			
			Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard			
			Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.			
			Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends			
			At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.			
				Commission services that enable safe, equitable, and personalised maternity care for the local population		
				Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.		
				Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.		
					Through our regional teams, listen to the local NHS and through our national governance listen to frontline staff voices and continue to work RCOG, RCM, BAPM, and others.	We will primarily determine overall success by listening to the people who use and work in frontline services.
					Continue to work closely with national bodies, ICBs, and trusts to address issues escalated to national level.	
					Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).	
					Work to align the MSSP with the NHS oversight framework, improve alignment with the recovery support programme, and evaluate the programme by March 2024.	
		During 23/24			During 2023/24, test the extent to which the PQSM has been effectively implemented.	
		Mar-24			By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.	

Three Year Delivery Plan for Maternity and Neonatal Services - March 2023

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
hat d more	Objective 10: Standards to ensure best practice	Mar-24	Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024			1. Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool. 2. Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care. 3. Three Year Delivery Plan for Maternity and Neonatal Services 4. The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme
		Mar-25	Adopt the national MEWS tools by March 2025.			Relevant regulation and incentivisation includes: 1. The NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions. 2. The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.
		Mar-25	Adopt the national NEWTT-2 tools by March 2025.			
			Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.			Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. We will monitor these measures nationally by ethnicity and deprivation
			Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.			
			Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.			
				Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.		1.Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle. 2. An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible. 3. Progress against locally planned improvements
				Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme		
				Monitor and support trusts to implement national standards.		
				Commission care with due regard to NICE guidelines.		
					Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle	
					Keep best practice up to date through the MEWS tool	
					Keep best practice up to date through d NEWTT-2 tools,	
					Keep best practice up to date by developing tools to improve the detection and response to suspected intrapartum fetal deterioration.	
		Oct-24			Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.	
		23/24 AND 24/25			Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.	

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
Theme 4: Standards and structures t underpin safer, more personalised, anc equitable care		25/26			Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England.	
					Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the Futures platform	
	Objective 11: Data to inform learning		Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.			
			Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.			
				Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.		
					At a regional level, understand any variation in outcomes and support local providers to address identified issues.	
		Oct-24			Convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.	
		Aug-24			Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.	
	se of digital technology in onatal services		Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.			
			Procure an EPR system – where that is not already being managed by the ICB –that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop			
			Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set			
				Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.		

Theme	Objective	Delivery Date	Trust	ICB	NHSE	Success Measures
	Objective 12: Make better us maternity and ne			Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.		
				Support regional digital maternity leadership networks.		
		Mar-24			Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.	
		Mar-24			Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024	A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.
					Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership	
					Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app	
		Mar-25			Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.	

The Royal Wolverhampton NHS Trust

Trust Board

Meeting Date:	6th June 2023
Title of Report	Executive Summary Workforce Report
Action Requested:	To Receive and Note
For the attention of the Board	
Assure	The report provides assurance on key workforce metrics and areas or work, specifically: • Vacancy rates • Turnover and retention rates • Sickness absence rates • Training and appraisal compliance rates • Mandatory training rates
Advise	Vacancy rates are below Trust target at 3.40% against a target of 6%. Retention, which is now measured consistently with Black Country Providers as a 12 month figure is meeting the target. Mandatory training compliance is above the 85% target at 95.10%.
Alert	Turnover is elevated above the target, however has improved for the forth consecutive month. Sickness absence remains elevated and above the target. Appraisal compliance is not meeting the target and has worsened in month.
Author and Responsible Director Contact Details:	Adam Race, Interim Director of HR & OD Tel 01902 695430 Email: Adam.Race@nhs.net

Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
Excel in the delivery of Care	e) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations	
Support our Colleagues	a) Be in the top quartile for vacancy levels 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 Standards	
Effective Collaboration	d) Progress joint working across Wolverhampton and Walsall	

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	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
Risk: Appetite	The report seeks to provide assurance on actions taken to decrease the Workforce Risks within the Trust.
Other formal bodies involved:	**None**
References	**None**
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

Executive Summary

This report provides the Board with information and assurance on key workforce metrics and an update on key workforce matters.

Three of the six workforce indicators are meeting the agreed targets/ thresholds mandatory training, vacancy rates and 12 month retention. Appraisal compliance, turnover and sickness absence are rated amber.

- Normalised turnover is 10.95%, improving slightly in month and for the the forth consecutive month. The retention rate is now reported as 12 month retention and is meeting the agreed standard.

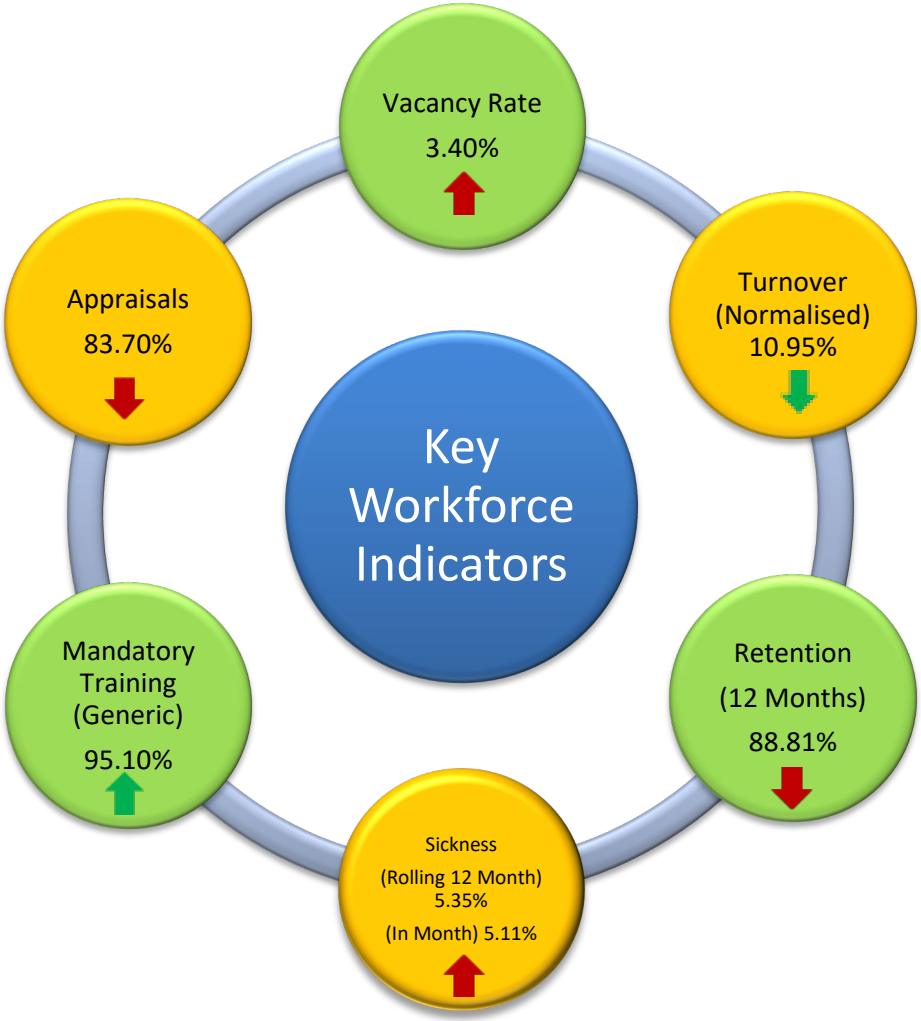
- The vacancy rate has worsened slightly in month, however, continues to meet the target at 3.40%. Over the last month the number of staff employed has remains largely stable with an increase of 2.80WTE over the month. The vacancy rate has increased as the number of established posts has been increased by almost 59WTE. Recruitment continues to outpace turnover. There are 111.60WTE newly qualified/ international nurses working towards their pin.

- Attendance levels have worsened in month over March. The in month performance for this indicator is above the target at 5.11%. Levels of absence as a result of COVID-19 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 5.35%.

- Performance in relation to generic Mandatory Training continues to meet the external target of 85%. Current performance is unchanged at 95.10%. Role specific mandatory training compliance also remains unchanged at 94.30% and above the target. In relation to appraisal, compliance rates have worsened slightly over the last month to 83.70%. This indicator is again rated amber and below the target of 90%.

- The fill rate through the bank in April was 70% for registered nursing staff and 84% for healthcare assistants. The medical bank fill rate was 85% exceeding the new target of 70%.

Key Workforce Metrics



Three of the six workforce indicators are meeting the agreed targets / thresholds; vacancy rate, retention rate and mandatory training compliance. Sickness absence, turnover and appraisal compliance are rated amber.

Turnover has improved slightly to 10.95%. Turnover performance is now meeting the standard only for Medical and Dental staff groups with elevated levels particularly in AHP and Healthcare Scientist staff groups.

The vacancy level has worsened in month, however, continues to meet the target. It is above target for medical staff only as the establishment has increased to a greater extent than the number of staff in post, with almost 4 additional doctors were in post at the end of April when compared with the end of March.

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 rates have improved, and continues to exceed the 85% target.

Appraisal compliance has worsened slightly and is not meeting the Trust target of 90%.

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	6th June 2023
Title:	Learning from Deaths
Executive Summary:	Mortality Data – SHMI, Crude Mortality and Alerting Diagnosis Groups The paper presents the Trust's mortality data as at April 2023 and the work being undertaken to scrutinise and continually improve. The SHMI value published for the period December 2021 to November 2022 is 0.9249. The Trust is now ranked 25th out of 121 Trusts across the country and remains within the expected range. The crude mortality rate for the last four months has been as follows: • December 2022 – 1.99% • January 2023 – 2.15% • February 2023 – 2.06% • March 2023 – 1.82% Medical Examiner Service The percentage of deaths reviewed by the Medical Examiner (ME) over the last three months is as follows: • December 2022 – 95% • January 2023 – 96% • February 2023 – 95% • March 2023 – 98% The percentage of cases that had an ME assessment which included discussions with bereaved families/carers is consistently reaching over 95%. The roll-out of the current Medical Examiner Service out into the community has been successfully implemented to all Wolverhampton GP Practices and Compton Hospice. The statutory date for this service has changed to April 2024. There are a remaining 4 Primary Care Networks to come on board from the South Staffs area and it is planned for all to come on board by September 2023. The Medical Examiner Service has reviewed the following number of community deaths December 2022 to March 2023: Mortality Reviews As of 19th May 2023, outstanding SJRS for in hospital deaths is as follows: • 62 SJR1s outstanding of which 24 are allocated to a mortality reviewer and 38 which are unallocated but will be allocated shortly. • 4 SJR2s outstanding of which 3 are allocated to a mortality reviewer and 1 which is unallocated but will be allocated shortly. The Mortality Review SJR process has now been rolled out into RWT PCN practices. The outcome of the reviews was presented to the Mortality Review

	Group in February 2023, there were no cases rated as poor care. A further thematic analysis of the cases will be undertaken. As of 19th May 2023, outstanding RWT PCN SJRs is as follows: • 9 SJR1s outstanding of which 6 are allocated to mortality reviewers and 3 which are due to be allocated shortly.
Action Requested:	Receive and note
For the attention of the Board	To note the SHMI of 0.9249, 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 and 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 (December 2021 to November 2022) have been listed below with details of actions being taken to investigate these further: 1. Chronic ulcer of skin – A coding audit has been completed with no issues identified. An assessment of the pathway and case note review is due to be undertaken. Once this has been completed the outcomes will be presented to the Clinical Pathway Meeting and the Mortality Review Group. 2. Pneumonia – The Pneumonia Lead presented at the Clinical Pathway meeting in February 2023 to provide an update on this workstream which has been detailed in the Clinical Pathway section in Appendix A. A further meeting has taken place with the Chief Medical Officers and Deputy Chief Medical Officers to agree an action plan and the Pneumonia alerting primary diagnosis group has been added onto the Respiratory risk register. 3. Acute Cerebrovascular Disease – A coding review has identified no issues. The Clinical Director presented at the Clinical Pathway meeting in April 2023. An update presented at the May 2023 Mortality Review Group identified that there is an improving SHMI trend with a reduction in hospital deaths with relatively stable admission numbers. This diagnosis group is continuing to be monitored.
Author + Contact Details:	Karenjit Sahota - Head of Chief Medical Officer Portfolios Email: Karenjit.Sahota@nhs.net on behalf of Dr Brian McKaig 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

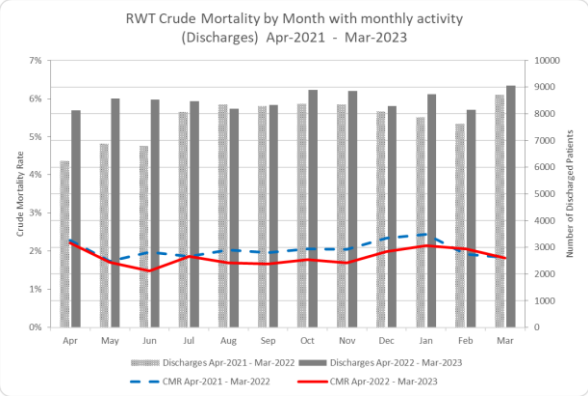
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, 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

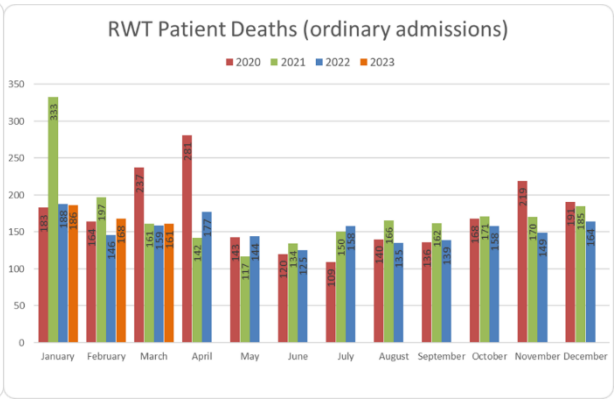
The Royal Wolverhampton NHS Trust

Learning from Deaths Update of monthly activity for April 2023

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

1.1 Crude mortality



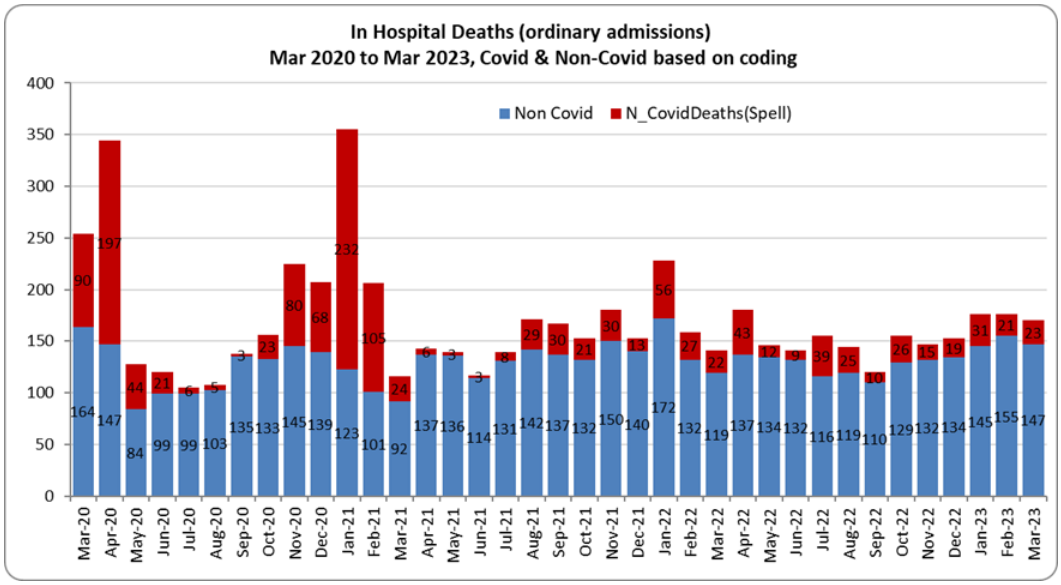


The crude mortality rate for the last four months has been as follows:

- December 2022 – 1.99%
- January 2023 – 2.15%
- February 2023 – 2.06%
- March 2023 – 1.82%

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

- December 2022 – 164 deaths of which 19 of these deaths were Covid related based on parts 1 or 2 of the death certificate
- January 2023 – 186 deaths of which 31 of these deaths were Covid related based on parts 1 or 2 of the death certificate
- February 2023 – 168 deaths of which 20 of these deaths were Covid related based on parts 1 or 2 of the death certificate.
- March 2023 – 161 deaths in March, of which 11 of these deaths were Covid related based on parts 1 or 2 of the death certificate.



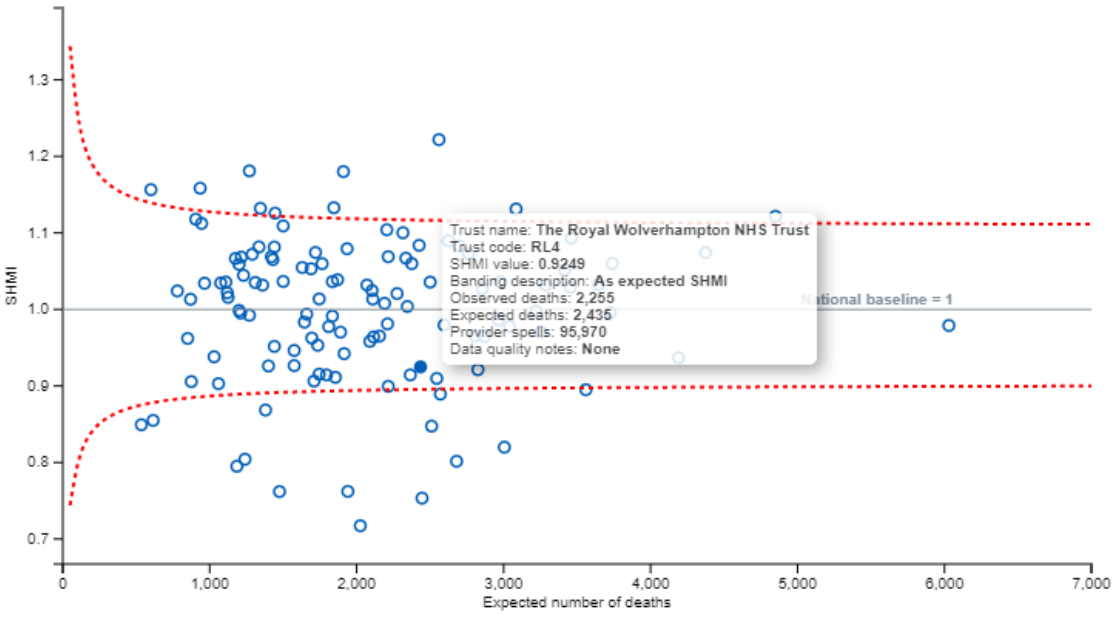
If any of the episodes within a provider spell have a COVID-19 diagnosis code, then the spell is excluded from the SHMI. Additionally, if COVID-19 is recorded anywhere on the death certificate, then the death and the spell it is linked to are excluded from the SHMI.

The following table shows in-hospital deaths and crude mortality for March 2023 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 (Dec-21-Nov 22)	Alerting Group in most recent HSMR
Pneumonia (excluding TB/STD)	23	161	12.5%		
Septicaemia (except in labour), Shock	16	65	19.8%		
Acute cerebrovascular disease	15	79	16.0%		
Acute myocardial infarction	7	120	5.5%		
Congestive heart failure; nonhypertensive	7	97	6.7%		
Acute and unspecified renal failure	5	38	11.6%		
Fluid and electrolyte disorders	5	45	10.0%		
Fracture of neck of femur (hip)	5	39	11.4%		
Gastrointestinal hemorrhage	5	50	9.1%		
Intracranial injury	4	9	30.8%		
Cystic fibrosis, Other lower respiratory disease	4	57	6.6%		
Secondary malignancies	4	25	13.8%		
Liver disease; alcohol-related	3	15	16.7%		
Organic mental disorders	3	49	5.8%		
Other gastrointestinal disorders	3	90	3.2%		
Allergic reactions, aftercare & screening, R codes	3	166	1.8%		
Complication of device; implant; or graft	3	60	4.8%		
Others (32 Groups, 2 or less per group)	46	1710	2.6%		
ALL	**161**	**8860**	**1.78%**		

1.2 SHMI (Inpatient deaths plus 30 days post discharge)

The SHMI value published for the period December 2021 to November 2022 is 0.9249. The Trust is now ranked 25th 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 %
Jul-21 to Jun-22	0.964	2.48%
Aug-21 to Jul-22	0.949	2.43%
Sep-21 to Aug-22	0.938	2.40%
Oct-21 to Sep-22	0.935	2.40%
Nov-21 to Oct-22	0.928	2.36%
Dec-21 to Nov-22	0.925	2.35%
Jan-22 to Dec-22*	0.900	2.31%

*NHS Digital Previewer 26th April 2023

1.4 SHMI in comparison with neighbouring Trusts

Trust	December 2021 to November 2022
The Royal Wolverhampton NHS Trust	0.925
The Dudley Group NHS Foundation Trust	1.133
Walsall Healthcare NHS Trust	1.069
Shrewsbury And Telford Hospital NHS Trust	1.021
University Hospitals Of North Midlands NHS Trust	1.052
Sandwell And West Birmingham Hospitals NHS Trust	1.053

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
199 - Chronic ulcer of skin	233.01	7	133.1	16	11	164	69%
122 - Pneumonia (excluding TB/STD)	119.92	271	107.2	325	247	1525	76%
109 - Acute cerebrovascular disease	115.86	158	99.7	183	143	990	78%

* Dec-21-Nov 22, 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 ulcer of skin – A coding audit has been completed with no significant issues identified. An assessment of the pathway and case note review is due to be undertaken. Once this has been completed the outcomes will be presented to the Clinical Pathway Meeting and the Mortality Review Group.
- Pneumonia – The Pneumonia Lead presented at the Clinical Pathway meeting in February 2023 to provide an update on this workstream which has been detailed in the Clinical Pathway section of this report. A further meeting has taken place with the Chief Medical Officers and Deputy Chief Medical Officers to agree an action plan and the Pneumonia diagnosis group has been added onto the Respiratory risk register.
- Acute Cerebrovascular Disease – A coding review has identified no issues. The Clinical Director presented at the Clinical Pathway meeting in April 2023. An update presented at the May 2023 Mortality Review Group identified that there is an improving SHMI trend with a

reduction in hospital deaths with relatively stable admission numbers. This diagnosis group is continuing to be monitored.

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

2. Directorate Learning / Feedback

At the Mortality Review Group meetings in February, March and April 2023 the following Directorate Learning and Feedback has been presented:

Cardiology

The Cardiology directorate presented one case which went through a Root Cause Analysis (RCA) and following discussion of this at the directorate meeting the following learning and recommendations were identified:

- Roll out of Human Factor Training to all Cardiologists. Aim for all Cardiology staff to undergo the training by the end of March 2023.
- Review of the shift pattern process to ensure there is direct verbal handover to the Clinical Fellow responsible for reviewing the patients at night. A dedicated Junior Doctor for Cardiology is required.
- Doctors to undertake personal reflection involved in this case to consider escalation and handover of care with further discussion with education supervisors.
- The learning from this RCA is to be circulated with junior doctors and middle grade medical staff covering Cardiology on-call with the available guidelines regarding management of GI bleeding and dual antiplatelets and anticoagulants from Gastroenterology and Acute Coronary Syndromes.

The lessons learned from this case are to be shared across the organisation through the Learning from Deaths and Risky Business newsletter/communications. It was also requested that an update is sent to directorates informing them of the importance of focusing on the fall in haemoglobin.

Acute Medicine

Acute Medicine presented one case in relation to a patient which had Chronic Obstructive Pulmonary Disease and the condition was deteriorating. The Structured Judgement Review (SJR) recognised a number of areas of good care, however, the rating of poor care was due to a missed opportunity to repeat blood gas and the issues of getting a non-invasive ventilation bed. A Datix incident was raised for this case following discussion at the directorate mortality and morbidity meeting, however, it has been downgraded since the patient did not need non-invasive ventilation. The key learning from this case is that a new oxygen requirement or increasing oxygen requirement must prompt a medical review. The learning has been shared with the nursing team and this case will be discussed at the next mortality teaching session. Wider actions from this case have been discussed at the Mortality Review Group and information has been disseminated trust wide around the issue of patients with a new or increased oxygen requirement to have a medical review. Following presentation of this case at the Mortality Review Group it was agreed that the case would be presented to the Respiratory management team also to obtain reassurance of the ring-fencing of non-invasive ventilation beds to ensure that if these beds are not available the patient goes to a high-dependency facility. However, in this case it is not clear if the non-invasive ventilation bed would have changed the outcome. The learning is to be shared across the organisation through the Risky Business communications.

Renal

The Renal directorate presented three cases. The first case was reviewed by a mortality reviewer with an overall care rating as poor due to the delay in corticosteroids for Covid-19. There was also a concern about an inappropriate dose for this treatment of DVT and the fluid balance was poorly documented in the notes. The case was discussed at the department mortality and morbidity meeting with the team feeling the grading of poor care was harsh, however, it was acknowledged that the there were lessons to be learned for DVT management. The directorate recognised the opportunity to discharge patient when medically fit and neurology review could have been done via an outpatient's appointment. The learning around documentation has been raised with the consultant on duty and will be relayed to the junior doctors also.

The second case presented had been through an SJR2 process and was rated an overall care score as poor. The case was discussed at the departmental mortality and morbidity team. The department acknowledged the delay in treatment of the pressure ulcer but agreed this would not have changed the overall outcome, however, the decision to palliate the patient should have been made sooner. The learning from this case was a proactive approach when making decisions around palliation and the Trust Mortality Lead and MRG chair highlighted the use of the huddle tool which would enable teams to have these discussions. An action point from MRG was to determine how learning can be shared trust wide around the use of the huddle and to determine when the Palliative Care Team can support advanced care planning.

The third case presented was scored with an overall care rating as poor by a mortality reviewer due to the fall resulting in a catastrophic intracranial bleed. The directorate noted that it wasn't made clear from the notes whether the falls risk assessment was accurate, and the case was referred to the coroner. The case is currently going through an RCA process and therefore the learning from this case will be presented following the completion of this.

Emergency Department

The Emergency Department presented one case whereby the mortality review process identified concerns regarding the time to treatment for the patient due to delays in the Emergency Department. The directorate confirmed that this incident happened during a very difficult winter for the NHS and the patient had a sudden and unexpected deterioration leading to cardiac arrest that may have still been the case even if the patient was seen sooner. However, the directorate presented that due to the new ambulance receiving centre there is no longer such a delay in patients being held with crew. The case has been discussed at the directorate mortality and morbidity meeting and the learning has been captured with changes within the Emergency Department to ensure a more efficient flow process, with appropriate prioritisation and escalation where required.

3. Clinical Pathway Meeting

During the report period there were two Clinical Pathway Meetings with presentations from the following:

3.1 Epilepsy and Convulsions

The Clinical Pathway Meeting on 26th January 2023 focussed on Epilepsy and Convulsions. Dr Francesco Manfredonia Consultant Neurologist and Clinical Lead for Neurology and Phil Tittensor Consultant Nurse for Epilepsies presented this update:

This diagnosis group was alerting therefore a case note review was undertaken which identified issues relating to monitoring of seizure (using seizure charts), management of status epilepticus, escalation to critical care, involvement of the neurology team, management of non-convulsive status and appropriate use of EEG (Electroencephalogram). In addition, there was limited documented evidence that deaths due to status epilepticus were linked to SUDEP (Sudden Unexpected Death in Epilepsy) actions.

Following this review the lessons learned and changes implemented were as follows:

- Review of status epilepticus guideline completed.
    - Dissemination
    - Grand round – departmental educational meeting
    - Education of stakeholders
- Patient with diagnosed first seizure or epilepsy accessing ED – can be respectively referred to first seizure clinic and epilepsy nurse team.
    - Inbox available
    - Prompt review
- Use of seizure chart to facilitate review and optimize management.
- Easy flow chart for review of status epilepticus guidance.
- Epilepsy nurse team – referred to the nurses by nurse box.
- A first seizure referral form document is now available.
- Active Neurology involvement and seek advice.
    - RWT Team
    - Regional tertiary centre for out of hours (QE)
- Low threshold to request EEG in patient admitted with seizures who do not regain consciousness as at risk of non-convulsive status epilepticus (NCSE)
- Need to develop an action plan with acute physicians regarding the implication of NASH 3 and NCEPOD recommendations.
- Mortality review captured people dying with seizures in hospital and mostly symptomatic status epilepticus in people without a previous diagnosis of epilepsy – this is only a fraction of people dying from epilepsy related causes such as sudden unexpected death in epilepsy (SUDEP) or death due to epilepsy related injury. Further work to be undertaken looking at community notification.

It was agreed the CMO Office would support development of an action plan following this presentation and further presented to the Clinical Pathway meeting of the action plan and updates.

3.2 Acute Myocardial Infarction (AMI)

The Clinical Pathway Meeting on 26th January 2023 focussed on Acute Myocardial Infarction which was presented by Dr Saqib Ahmad.

- A case note review identified that comorbidities were not consistently documented in the notes leading to inadequate coding during the hospital spell.
- Locally an audit was undertaken, and this did not reveal any issues related to care provision. A significant proportion of the deaths reviewed were out of hospital cardiac arrests.

<u>AMI Action Plan</u>

1. The outcomes following the presentation was for further work to be undertaken to improve the recording of co-morbidities' in record for the hospital spell.

3.3 Sepsis
The Trust Sepsis Clinical Lead Dr Saibal Ganguly presented an update at the Clinical Pathway meeting on 23rd February 2023.

- Screening and antibiotic delivery is more than 80% consistently. The sepsis screening performance has been over 90% from July 2022 to December 2022 and antibiotic administration within an hour has been over 90% from August 2022 to December 2022. Although the compliance in ED for antibiotic delivery is not consistent, a action plan is being developed to mitigate this risk.
- The Intensive Care National Audit and Research Centre (ICNARC) data shows that high-risk sepsis admissions have been low, and it has been green for the past two years which reflects good sepsis practices within the organisation.
- SHMI for Sepsis has remained within the expected range for the period October 2021 to September 2022 at 1.0372.
- Neutropenic sepsis door to needle time for the Durnell Unit compliance has been 100% for 12 months.
- For Haematology / Oncology the following measures have been introduced to ensure patients are treated within one hour of arriving on the unit including: sepsis trolley with all the equipment needed, stopwatch and data collection to show staff improvement in times, all registered nurses are trained in collecting samples from all lines, peripheral blood cultures and trained on using PGD for IV Meropenem and IV Tazobactam to use suspected for suspected high-risk neutropenic sepsis.
- A mortality audit was completed in February 2023 for 30 random patients from 1st January 2022 to 31st January 2022. The findings of the sepsis audit were:
    - Screening for sepsis – 100%
    - Antibiotic administration within an hour – 96.7%
    - Of the 30 patients reviewed, 21 were medical patients, and 9 were surgical patients.
    - NCEPOD scoring – there is 1 case which requires improvement and 29 which were good/adequate care.
    - Reasons other than sepsis documented on the death certificate – 17 patients.

<u>Sepsis Action Plan</u>

- Sepsis in Emergency Department is an area of focus with an action plan being developed to improve antibiotic delivery within the expected timescales set especially for high-risk sepsis patients.
- On-going sepsis education and awareness teaching sessions for nurses and doctors.
- Daily “sepsis ward rounds” in clinical areas to improve sepsis recognition and management.
- Use of Datix if significant delays in sepsis care or delivery of antibiotics.
- Improve documentation of suspected sepsis for screening and antibiotic delivery.
- Plans to implement newly published NICE sepsis recommendations due to be released in June 2023.

3.3 Pneumonia
The Trust Pneumonia Clinical Lead Dr Stanley Ejiofor presented an update at the Clinical Pathway meeting on 23rd February 2023, the following update was provided:

- In February 2023, the SHMI for the period September 2021 to August 2022 remained elevated at 129, there was a peak during the pandemic, however, the SHMI has continued to remain higher than it should be. The SHMI has been actively reviewed and the recent SHMI has improved to 114.5 for the period January 2022 to December 2022.
- A Quality Improvement Project is in progress to review the data to assess compliance with the British Thoracic Society pneumonia care bundle and proposed Black Country and West Birmingham Community Acquired Pneumonia (CAP) pathway. The methodology was looking at retrospective data collection of patients that were seen in hospital and the clinician coded with a diagnosis of Pneumonia. All patients admitted with CAP during this period were reviewed. The results from the reviews show improvements in front door metrics related to Pneumonia management including chest x-ray within 4 hours, oxygen prescription and antibiotic prescriptions as per standard guidelines and this is being monitored on a monthly basis as part of the quality improvement project.

A number of quality improvement actions have taken place including events specific for Pneumonia, launch of the new pathway with trust wide communication, dedicated teaching and education sessions focusing specifically on pneumonia as well as posters and dedicated sessions with the Acute Medical Unit and Emergency Department. Additional teaching sessions are underway, and

these are sent out monthly to encourage uptake. A pathway is being developed to support managing patients that present with breathlessness.

A few areas of improvement have been identified in relation to triage and diagnostic testing and therefore a further meeting with the Chief Medical Officers is being set up to agree next steps and an action plan.

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:

- December 2022 – 95%
- January 2023 – 96%
- February 2023 – 95%
- March 2023 – 98%

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

Community Deaths

The roll-out of the current Medical Examiner Service out into the community is progressing on target. The statutory date has been postponed to April 2024. All GP practices in Wolverhampton and Compton Hospice are referring into the RWT Medical Examiner service and initial meetings are continuing with wider PCNs to expand the rollout further. There are a further four Primary Care Networks which are outside of Wolverhampton and form part of South Staffs area which are to come on board and join the RWT Medical Examiner Service and work is ongoing to bring these practices on board by September 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:

	December 2022	January 2023	February 2023	March 2023
Community Deaths - ME Scrutiny undertaken	**111**	**102**	**80**	**70**
% of community deaths scrutinised by an ME that have had a discussion with bereaved families/carers	**86%**	**92%**	**94%**	**93%**

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.

5. Mortality Reviews - Structured Judgement Reviews (SJRs)

As at 19th May 2023, outstanding SJRS for in hospital deaths is as follows:

- 62 SJR1s outstanding of which 24 are allocated to a mortality reviewer and 38 which are unallocated but will be allocated shortly.
- 4 SJR2s outstanding of which 3 are allocated to a mortality reviewer and 1 which is unallocated but will be allocated shortly.

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 undertaken up to January 2023 were presented to MRG in February 2023. No cases were identified as having poor care. Due to the number of reviews undertaken, a further thematic analysis will be undertaken to identify any problems in care across the entire pathway.

As at 19th May 2023, outstanding RWT PCN SJRs is as follows:

- 9 SJR1s outstanding of which 6 are allocated to mortality reviewers and 3 which are due to be allocated shortly.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	6th June 2023
Title:	Integrated Quality and Performance Report – April 2023
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

Executive Summary

Obs on time: further improvement seen during April 23. Progress and additional interventions are discussed at the Deteriorating Patient Group and other relevant forums. Quality improvement work continues with wards and this includes focus on the use of NEWS2 Scale 2.
C.diff: 6 cases in month against a target of 4. The new target for 2022/23 is 53 cases in the year. An action plan is in place for Clostridioides difficile which includes, increased education for staff.
MRSA: no cases during April 23.
CHPPD (total nursing): The second return scheduled rostering confirm and challenge meetings are underway to ensure best rostering practice and these are scheduled for every clinical area across the year.
Smoking at delivery: although we have seen some improvement this month, this remains above target. Additional funding has been agreed to increase support for stopping smoking and healthy living in pregnancy.

RTT incomplete pathway: slight increase in month but in line with the trajectory expected for a continued rise throughout 2023/24 as demand from the pandemic restores.

RTT 78+ week wait: the trend of increasing breaches has been reversed with a fall of two breaches in month. Additional weekend activity is planned to reduce the number of 78 week waits further ahead of the end of June target. This indicator has been impacted by the Junior Doctor Industrial Action in March/April 23 and subsequent cancellations. A total of 2,988 patients were affected (373 admitted & 2,615 outpatients) were cancelled or rescheduled.

Diagnostics: performance has remained relatively static during April 23 with the biggest waits in endoscopy, echocardiography and ultrasound - all driven by staffing challenges. Remedial action plans are in place with an expectation that performance improves throughout 2023/24.
ED 4 hour: Performance improved in month, exceeding the new national standard of 76%. The Streaming/Navigation pilot has been extended with an evaluation of its effectiveness planned. We continue to benchmark well both locally and nationally.
Cancer 2ww: we continue to see high volumes of 2ww referrals and is driving our underperformance. Mutual aid is being sought where available and likewise, RWT is continuing to offer mutual aid support to Walsall within the Skin specialty.
Cancer 62 day: the referral numbers above, combined with delays within histopathology and some specialty specific constraints continue to impact on our 62 day performance. Additional capacity has been procured outside of the system to support with the transfer of some urology patients.

RIT referrals/patients accepted and seen: there has been a marked reduction in the number of referrals over the last 3 month period, this is currently being investigated to understand the reasons why.
Virtual ward: is currently performing and managing its referrals within the current pathways.

Care Coordination: this centre streamlines all referrals into Adult Community Nursing Services. They are there to help patients, relatives and other professionals ensure they access the right services they need. Once the referral has been accepted the patients are streamed to alternative/appropriate pathways more suitable for the patient, thereby reducing ambulance conveyancing, ED attendance and aiding admission avoidance.

Executive Summary (continued)

Trust vacancy rate: very slight deterioration seen during April 23, however, this indicator remains above target.
Turnover (normalised): this target has shown some slight improvement when compared with the previous month, this continues to exceed the target.
Retention (24 months): this remains below target. This has been very consistent over the past 7 months.
Appraisals: this is seeing an overall improving trajectory, however, this remains below target. This performance has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.
Sickness (monthly): deterioration seen in month, taking this indicator back above target. Considerable work has been undertaken to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	6 June 2023	
Title of Report	Chief Executive's Report	
Action Requested:	**To 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 and Responsible Director Contact Details:	Tel: 01902 695950 Email: gayle.nightingale@nhs.net	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	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 community and populations
	Support our Colleagues	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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
	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:	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	**Responsive: Well-led:**	
Equality and Diversity Impact	None in this report.	
Risks: BAF/ TRR	None in this report.	
Risk: Appetite	None in this report.	
Public or Private:	Public	
Other formal bodies involved:	As detailed in the report.	

References	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

Brief/Executive Report Details	
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 twelve Consultant Appointments since I last reported: **Palliative** Dr Sophie Taylor **Trauma and Orthopaedics** Dr Varun Dewan Dr Shanaka Senevirathna **Gatroenerology** Dr Muhamad A Jasim **Rheumatology** Dr Muhammad Raheel Anjum **Diabetes** Dr Albana Sykja **Respiratory** Dr Anna Mowat Dr Elin Roddy Dr Parminder Bhomra **Acute Medicine** Dr Harjinder Kainth **Cellular Pathology** Dr Conrad Hayes **Urology (Pelvic and Robotic)** Dr Nemeka Eli

3.0	**Policies and Strategies**
	Policies for April 2023 • Policies, Procedures, Guidelines and Strategies Update for March 2023 Report • HR16 - Freedom to Speak Up Policy (previously Raising Concerns at Work Policy and Procedure) • HR24 - Secondment Policy • HS33 - Driving for Work Policy • OP39 - Patient Access Policy • OP102 - Non-Elective Surgery Policy • GDL10 - New Guidance and Statement of Intent for Transgender Inclusion • PRT0 - New Respiratory Illness Protocol **Policies for May 2023** • Policies, Procedures, Guidelines and Strategies Update for April 2023 Report • HR17 - Implementation of Working Time Regulations Policy • HS06 - Laser, UV and Optical Radiation Protection Policy • OP62 - Breaking Bad News Policy
4.0	**Visits and Events**
	• Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since 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 • 20 March 2023 – participated in an NHS Providers Integration virtual workshop • 21 March 2023 – chaired the virtual West Midlands Cancer Alliance Board • 22 March 2023 - chaired the virtual Joint Staff Briefing • 23 March 2023 – participated in a virtual quarterly Black Country System Review meeting • 24 March 2023 – chaired a virtual Trust Management Committee (TMC) • 28 March 2023 – opened the Career Wellbeing conference • 31 March 2023 – presented Simon Parton, Head of ICT Systems and Applications Services with the NDL Community commendable second place award for our Learning From Deaths project for the innovative way he led the implementation of digital services within the community • 3 April 2023 - participated in the virtual Black Country Collaborative Executive Group meeting • 14 April 2023 – virtually met with Becky Wilkinson - Director of Adult Services, Wolverhampton City Council • 17 April 2023 - virtually met with Mark Axcell, Chief Executive – Integrated Care System (ICS) • 18 April 2023 – attended a ICS Financial 2023/24 Planning meeting • 19 April 2023 – attended Amanda Pritchard's – Chief Executive, NHS Leadership event • 20 April 2023 – participated in an ICS Financial 2023/24 Planning meeting • 21 April 2023 – attended an NHS Urology Clinical Senate meeting for RWT/ WHT • 26 April 2023 – participated in the virtual Health and Wellbeing Together Committee 27 April 2023 – attended the Institute of Health and Social Care Management (IHSCM) National Conference • 28 April 2023 – undertook a site visit at the newly renovated Compton Hospice, Wolverhampton and chaired the Trust Management Committee (TMC) 3 May 2023 – attended a West Midlands Cancer Alliance – Cancer Priorities and Future Delivery in the West Midlands Workshop • 4 May 2023 – attended a RWT/WHT – Joint Strategy Research Development session

	• 5 May 2023 – as part of the King's Coronation - 'Big Help Out' I presented the volunteers with certificates and badges in recognition of their support to the Trust • 9 May 2023 – participated in the Local Estates Forum • 10 May 2023 – met with John Raftery, Interim Vice Chancellor – University of Wolverhampton and met with Dr Elisa McAlindon, new Chair of the Senior Medical Committee • 12 May 2023 – hosted a visit from Lord Patrick Carter • 16 May 2023 – participated in the Joint RWT and WHT Oversight and Assurance meeting with NHS England's Regional Team and the ICS • 17 May 2023 – jointly presented with Sir David Nicholson KCB CBE the staff Long Service Awards • 19 May 2023 – hosted a visit from Matthew Taylor, Chief Executive – NHS Confederation
5.0	**Board Matters**
	Mr Junior Hemans, Non-Executive Director, term of office came to an end on 31 May 2023.

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	6 June 2023	
Title of Report	Chair's report of the Trust Management Committee (TMC) held on 28 April 2023 – to note this was a virtual meeting	
Action Requested:	**To 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 and Responsible Director Contact Details:	Tel: 01902 695950 Email: gayle.nightingale@nhs.net	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	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 community and populations
	Support our Colleagues	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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
	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:	As per the agenda item.	
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 identified.	
Risks: BAF/ TRR	None identified.	
Risk: Appetite	None identified.	
Public or Private:	Public	

The Royal Wolverhampton NHS Trust

Other formal bodies involved:	Executive Team Meetings, Staff Briefing
References	As per the agenda 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		
Executive Summary Title:		Chair's report of the Trust Management Committee (TMC) held on 28 April 2023 – to note this was a virtual meeting
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)/ Director of Nursing Report • Finance Position Report – Months 12 • Financial Recovery Board Update Report • Capital Programme Update 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. • Integrated Care System (ICS) Development Report • Financial Planning 2023/23 Proposals - revised Report • Capital Programme 2023/ 24 – 5 Year Plan Update Report • Contracting and Business Development Update Report	
5	**Business Cases approved - Division 1** • Business Case for a Replacement Blood Fridge at Cannock Chase Hospital.	
6	**Business Cases approved - Division 2** • There were none this month.	
7	**Business Cases approved - Division 3** • Business Case to fund NICE approved TA605 Xeomin (botulinum neurotoxin type A) for the Treatment of Chronic Sialorrhoea	
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 March 2023 Report • HR16 - Freedom to Speak Up Policy (previously Raising Concerns at Work Policy and Procedure) • HR24 - Secondment Policy • HS33 - Driving for Work Policy • OP39 - Patient Access Policy • OP102 - Non-Elective Surgery Policy • GDL10 - New Guidance and Statement of Intent for Transgender Inclusion • PRT0 - New Respiratory Illness Protocol
11	**Other items discussed:** • There were none this month.

The Royal Wolverhampton NHS Trust

Trust Board Report

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For the attention of the Board		
Assure	• None in this report.	
Advise	• Matters discussed and reviewed at the most recent TMC.	
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Author and Responsible Director Contact Details:	Tel: 01902 695950 Email: gayle.nightingale@nhs.net	
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	Support our Colleagues	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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
	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:	As per the agenda item.	
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 identified.	
Risks: BAF/ TRR	None identified.	
Risk: Appetite	None identified.	
Public or Private:	Public	

Other formal bodies involved:	Executive Team Meetings, Staff Briefing
References	As per the agenda 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

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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)/ Director of Nursing Report • Finance Position Report – Month 2 • Financial Recovery Board Update Report • Capital Programme Update Report • Operational Finance Group Minutes • Black Country Provider Collaboration Update	
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. • Safeguarding – Adult and Childrens Report • Nursing and Midwifery deferred from April 2023 Report • Quality Account Report • Learning from Deaths Report • Property Management Report • Trust Risk Register (TRR)/ Board Assurance Framework (BAF) Report • Midwifery Services Report • Patient Experience Report • Contracting and Business Development Update Report • Sustainability Report • Care Quality Commission (CQC) Fundamental Standards of Care Compliance Report • Emergency Planning Report • Fire Safety Annual Report • Quality Improvement Report • The Royal Wolverhampton and Wolverhampton Place Winter 2022/23 Plan • Infection Prevention and Control Annual 2022/23 Report	

5	**Business Cases approved - Division 1**

	• Business Case for a Replacement and Upgraded Morcellator • Business Case for Elective and Emergency Maternity Theatres Staffing • Business Case for a Band 8a Advanced Practitioner Physiotherapist
6	**Business Cases approved - Division 2** • There were none this month.
7	**Business Cases approved - Division 3** Business Case to fund TA735 Tofacitinib for the Treatment of Juvenile Idiopathic Arthritis Business Case to fund TA861 Upadacitinib for the Treatment of Active Non-Radiographic Axial Spondyloarthritis
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 April 2023 Report • HR17 - Implementation of Working Time Regulations Policy • HS06 - Laser, UV and Optical Radiation Protection Policy • OP62 - Breaking Bad News Policy
11	**Other items discussed:** • There were none this month.

Strategic Delivery Plan 2023/24

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

Care Colleagues
Collaboration Communities

Context

In 2022, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust signed off our five-year strategy. The strategy set out a clear vision, to work together to improve the health and wellbeing of the populations we serve. In doing so, it focused on four strategic aims (collectively known as the 'Four C's):

1. **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. **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. **Communities** - we will positively contribute to the health and wellbeing of the communities we serve.
4. **Collaboration** - we will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.

The Four C's are underpinned by a set of strategic objectives – more specific, time bound measures detailing how we will measure our achievement of our strategic aims. These objectives may change over the length of this strategy in line with changes within the environment in which we are operating.

The strategy was launched towards the end of the 2022 calendar year alongside the reinforcement of each individual Trust's values and the new collective vision.

Since launching the strategy, we have:

- Developed and launched the enabling Quality and Patient Safety Strategy and are developing the People and Organisational Development Enabling strategy (both joint strategies between the two Trusts)
- Met the ambition to clear 104 week waits by the end of 2022/23 and on course to achieve the 78-week target by the end of June 2023.
- Maintained the best ambulance handover times in the region in Walsall and significantly improved those in Wolverhampton.
- Continued to explore opportunities for collaborative working between our two Trusts including with the transfer of Urology staff to RWT.
- Maximised our community offer with increasing numbers of patients being referral to virtual wards and ultimately avoiding admission.

Whilst we are making progress, we still have much work to do:

- We are faced with an unprecedented financial challenge as the NHS works to restore productivity levels to and beyond pre-pandemic levels whilst dealing with high inflation.

- Our waiting lists remain high and our capacity is limited.
- We need to deliver more services in a preventive manner if we are to change the future demands on our services and improve life chances for our population.
- There are areas within the Trusts where recruitment remains a challenge.

Annual Objectives for 2023/24

This annual plan sets out what we need to deliver in the next 12 months to continue to improve and ultimately achieve our vision.

The table below sets out the annual objectives to be achieved by 1 April 2024. Alongside our own internal aspirations, these objectives align to:

- NHS England operational planning guidance 2023/24. This guidance sets out the national priorities (and specific targets) across the NHS to improve quality and access. We have prioritised the metrics that will have the biggest impact for patients. We have strived to be ambitious whilst remaining credible in what we are saying we can deliver.
- Care Quality Commission (CQC). The Care Quality Commission quality standards are the basis on which our CQC rating is given, and it is this rating that many use to assess the quality of service we offer.
- NHS Staff Survey and People Plan. Our emphasis on Colleagues comes from the NHS People Plan and NHS Staff Survey with direct alignment between these and our Colleague strategic objectives.
- As with our strategy, we have considered other national strategies and guidance in setting the below objectives, e.g., the NHS Long Term Plan and the emerging Five-Year Joint Forward View in our Black Country Integrated Care System.

In setting these objectives we have considered those that will have the biggest impact on the populations we serve and the colleagues who work with us. Whilst we expect our strategic aims to remain unchanged over the next five years, we recognise that the environment in which we are working is constantly changing and that our strategic objectives may need refreshing from time to time. These changes will be considered through the annual planning process.

Strategic Aim	Strategic Objective	Board Level Metric	Method of reporting	Receiving Committee
Care	- We will embed a culture of learning and continuous improvement at all levels of the organisation	- 5% increase on previous year in the percentage of staff responding positively in the annual staff survey when asked if they are able to suggest and make improvements in their area.	CQI Board Report	QGAC
	- We will prioritise the treatment of cancer patients, focused on improving the outcome of those diagnosed with the disease	- Reduce the 62 day backlog to 195 in RWT and 61 in Urology by the end of March 2024.	F&P Report and IQPR	QGAC & P&F
	- We will deliver safe and responsive urgent and emergency care in the community and in hospital	- Delivery of the 70% 2 hour Urgent Community Response standard - Delivery of the 76% 4 hour A&E target	IQPR	QGAC & P&F
	- We will deliver the priorities within the National Elective Care Strategy	- Eliminate 78 weeks by the end of June 2023 and 65 weeks by the end of March 24 (excluding patient choice)	IQPR and Elective Recovery Report	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	- Delivery of the agreed financial plan	Finance Report	P&F
Colleagues	- Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff	- Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff by March 2024.	Workforce Report	WOD
	- Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing	- Deliver an improvement on 2022/23 in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing by March 2024.	Workforce Report	WOD
	- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged	- Improve overall staff engagement on the level achieved in 2022/23, by March 24, addressing identified areas for improvement where groups are less well engaged	Workforce Report	WOD
	- Deliver year on year improvement in Workforce Equality Standard performance	- Deliver an improvement on 2022/23 in Workforce Equality Standard performance by March 2024.	Workforce Report	WOD
Collaboration	- Work as part of the provider collaborative to improve population health outcomes	- Identify, implement and report on a agreed set of outcome measures for each of the projects within the provider colloborative programme	Provider colloborative project plan	Joint Committee
	- Improve clinical service sustainability by implementing new models of care through the provider collaborative		Provider colloborative project plan	Joint Committee
	- Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital	- Increase from March 23 in the number of pathways being offered through virtual wards by March 2024.	IQPR	Performance and Finance Committee
	- Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes	- Reduce the growth in the Urology waiting list across both Trusts by March 24 compared to the trend seen in 2022/23.	Integration Plan Update	Joint Committee
	- Facilitate research that establishes new knowledge and improves the quality of care of patients	- Increase the number of researchers and participant numbers beyond the level of achieved in 2019/20 by March 24	Innovation, Research and Improvement Joint Committee	Research and Innovation Committee
Communities	- Develop a strategy to understand and deliver action on health inequalities	Develop and implement a Health Inequalities Strategy with measurable outcomes in 2023/24.	Update from health inequalities group	QGAC
	- Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025	Achieve a 5% reduction in the carbon footprint at WHT and a 15% reduction in RWT by the end of March 24 compared to 2020/21.	Sustainability P&F Report	P&F
	- Work together with PLACE based partners to deliver improvements to the health of our immediate communities	A reduction in the average number of medically fit for discharge patients from 2022/23 at RWT by March 2024.	PBP Monthly Board Report	Trust Board

Key Projects

It is important that the objectives above are reflected in our 'business as usual'. Notwithstanding this, there are some key projects of note that support their delivery.

CARE

Whilst it is a collective responsibility of all that work at the Trusts to embed a culture, our Quality Improvement programme will be intrinsic to the achievement of this. The programme focuses on how we will embed quality improvement at all areas of both organisations and includes targeted actions to increase training levels in Quality Improvement (QI) as well as the introduction of a quality management system.

Regular performance forums are in place that oversee cancer and long waiting performance – intrinsic to this, and the delivery of our financial plan, will be our ability to deliver the maximum amount of activity possible. The plans submitted are based on a combination of core capacity as well schemes targeting improved productivity or additional activity. Progress against these is reported through our elective recovery forums and ultimately, to Performance Finance Committee. The challenges vary by Trust – Wolverhampton has a greater challenge over long waiting patients with a reliance on capacity outside of the Trust. Therefore, the collaborative work taking place between the respective Trusts, as well as across the provider collaborative, is vital in making best use of capacity.

Timeliness of urgent care is a symptom of the effectiveness of the entire system. The delivery of schemes within the community, such as virtual wards or RITs, that avoid admission or expedite discharge are therefore critical to the timely admission and flow of patients presenting at A&E. Alongside this are the internal programmes within the Trusts focused on ensuring the timely flow of patients throughout our hospitals.

The delivery of our financial plan will be heavily dependent on the effectiveness of our Cost Improvement Plan. Our Financial Recovery Group's oversee this programme which focuses on identifying opportunities for improved productivity such as our theatre efficiency and opportunities for more effective working. Tools such as GIRFT and Model Health System are used to identify where this opportunity exists.

COLLEAGUES

We will launch our Joint People and Organisational Development Enabling Strategy in 2023/24 – the first joint strategy between our organisations that covers our approach to meeting our Colleague related objectives. Our key focus being on retaining our workforce by strengthening the compassionate and inclusive culture necessary to deliver outstanding care.

In response to the results of the staff survey, action plans are being developed at Trust, Division and Directorate level that focus on the actions tailored to the results of those areas. We know that there are different challenges across different areas within the Trusts, with some posts being particularly hard to fill. Working alongside operational colleagues in these areas, we will work together to attract staff using a tailored approach to the challenge in question.

At Trust level, we will continue to develop and promote our health and wellbeing offer, expanding on initiatives already in place such as the foodbank. We expect to recruit and train additional mental health first aid trainers in 2023/24 and review the wellbeing calendar of events.

COLLOBORATION

Our collaboration efforts take a dual focus – the collaboration opportunities between our respective organisations and those of the Black Country Provider Collaborative. The common theme across both programmes is in identifying services who could be made more sustainable and deliver improved outcomes for patients through joint working.

A corporate work programme is underway within the Black Provider Collaborative to identify opportunities for collaborative work in corporate areas. Options appraisals are due for consideration in the early part of the year of the initial priority areas as well as scoping due to commence on other potential areas of opportunity. In addition to this, the introduction of the Joint Committee across the four Trusts should support decision making.

The opportunities for collaboration between our respective Trusts continue to grow. In 2023/24, the shared urology service will hit a new milestone with the transfer of the waiting list at WHT to RWT as we continue to track the benefits of the service against the business case. Equally the transition of the Community Diagnostic Centre from mobile provision to static facilities which see capacity shared across both Trusts to support timely diagnosis of patients, including those with cancer.

Finally, whilst not due to go live until 2025, work continues to progress the business case for the additional theatre activity at Cannock – offering the opportunity to consolidate orthopaedic activity at an Elective Hub and increasing the elective capacity remaining at New Cross and Walsall Manor sites.

Further opportunities for collaborative working, both in clinical services and non-clinical, will continue to be scoped and progressed.

COMMUNITIES

In 2023/24, we will launch our first health inequalities strategy that detailing the work we continue to take in understanding health inequalities and ultimately, reducing them. The strategy will cover our priorities, progress so far and the measures we seek to achieve going forward.

We also continue the implementation of our green plan to reduce the carbon footprint of our organisations. Some of the key initiatives to support this ambition are the continued reduction of anaesthetic gases, the reduced prescribing of metered dose inhalers, an increase in the level of recycling and the implementation of the NHS Net Zero Building Standards.

The respective PLACE partnerships across both organisations are integral to the achievement of our communities related objectives as we focus on initiatives to reduce the number of patients in hospitals, either by expediting discharge or avoiding admission in the first place.

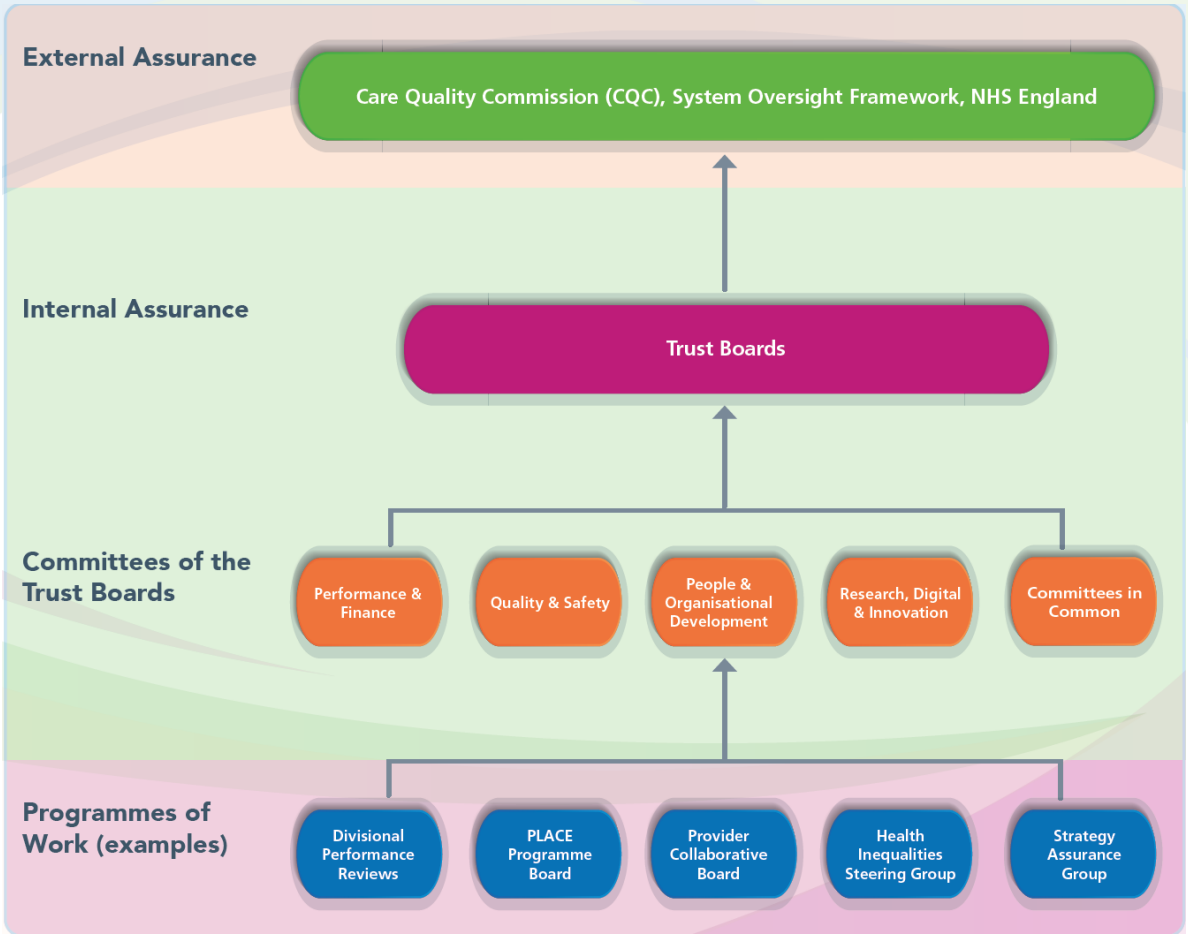
Reporting to Board

In making clear our areas of focus for 2023/24, we must also ensure that we embed this focus throughout the organisation. Our governance structure detailed within Appendix 1 demonstrates how we report into Board and the image above demonstrates how objectives align to these committees.

The sub-committees of the Board are responsible for monitoring the achievement of the metrics aligned to their area of responsibility. Our report and agenda templates will be updated to make it clearer how content relates to our areas of priority.

Over the last two years we have consolidated the information that we take to Board – focusing on those indicators of most significance. Alongside this, we have developed an Integrated Quality and Performance Report (IQPR) that provides the key performance information across various disciplines within the Trust, e.g., Finance, Quality, Performance and HR.

Appendix 1 – Governance Structure



The Royal Wolverhampton NHS Trust

The Royal Wolverhampton Trust Board Meeting	
Meeting Date:	Tuesday 6th June 2023
Title of Report:	Black Country Provider Collaborative – Update Report
Action Requested:	Note the report
For the attention of the Board	
Assure	• A number of the executives (including the CEO) participated in the discussions around the next steps for the Provider Collaborative.
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	• Detailed work is underway to develop proposals for the corporate work programme
Author and Responsible Director Contact Details:	Simon Evans simon.evans8@nhs.net Group Chief Strategy Officer
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Prioritise the treatment of cancer patients b) Safe and responsive urgent and emergency care c) Deliver the priorities within the National Elective Care Strategy
Support our Colleagues	a) Improve overall staff engagement
Improve the Healthcare of our Communities	a) Develop a health inequalities strategy
Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Implement technological solutions that improve patient experience
Resource Implications:	None as a result of this report
CQC Domains	Safe: patients, staff and the public are protected from abuse and avoidable harm. Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. Caring: staff involve and treat everyone with compassion, kindness, dignity and respect. Responsive: services are organised so that they meet people's needs. Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	Health Equalities are considered are considered within the draft proposals.
Risks: BAF/ TRR	N/A
Risk: Appetite	N/A
Public or Private:	Public
Other formal bodies involved:	

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:	Black Country Provider Collaborative – Update Report

The following are the key messages from the BC Provider Collaborative meeting May 2023.

1) New Collaborative work priorities (Outline Briefs)

The Collaborative Executive received Outline Briefs for a number of new work priority areas which include the following:

- BC Networked Service Solutions – *a general Outline Brief embracing all clinical fragile services for consideration in a phased way*
- BC Breast Radiology Alliance
- BC Reconstructive Plastics Surgery Unit
- Breast Unit Consolidation
- Centres of Excellence
- CQC
- Shared Consent Forms

Further discussions were held around assessment of fragile services and understanding the impact.

The Collaborative Executive were asked to discuss within their respective organisations and provide feedback to the BCPC Managing Director on the following:

- Provide feedback and comment on all of the Outline Briefs, and if appropriate how they may be strengthened
- Endorse the pursuit of all Outline Briefs
- Identify / confirm (nominate) leadership from the Collaborative Executive for each of the proposed priority areas (Outline Briefs)

An updated paper taking into account all feedback will be presented to the June Collaborative Executive meeting.

2) Colorectal – review of recent NBOCAP benchmarking

The Clinical Lead for the Colorectal Network recently presented a benchmark review of key clinical performance indicators from NBOCAP data. In short it highlighted no change (and at best very little movement) from a similar report conducted the year before. Some quality concerns have been identified and raised, with the BCPC CMO escalating the issue for discussion with all partner CMO's shortly.
The output of that discussion and resulting actions will be reported at the next Collaborative Executive in June.

3) Corporate Improvement Programme

The SRO for the Corporate Improvement Programme updated the Collaborative Executive (CE) on progress with the first three reviewed priorities as follows:

- HR – an Options Appraisal and updated position is scheduled to be brought forward to the June meeting of the CE
- Payroll – engagement with all partners is about to commence, with an Options Appraisal due to be presented at the June meeting of the CE
- Procurement – Further work is being finalised to bring a plan for agreement & execution to the June meeting of the Collaborative Executive.

As these three priority areas are well underway, and options being presented, it was suggested (and agreed in principle) that the next tranche of services for review be commenced. These are to include:

- Communications & Engagement
- Data, Digital & Technology
- Estates & Facilities

It is proposed that these commence imminently with an Options Appraisal for each of these three areas be presented in the early autumn (Sept / Oct time) with a final tranche (Legal & Governance, and Finance) commencing in early winter (around December / January time).

4) Governance (Collaboration Agreement & 'Joint Provider Committee')

The BCPC Managing Director gave an overview of work being undertaken to strengthen collaborative working across the four partners of the BCPC, through work on developing and establishing a 'Joint Provider Committee'.

A draft of two key documents has been shared with all four NHS Trust partners. They are:

- **Draft Collaboration Agreement (CA)** - This document is an agreement that sets out the 'legal framework' and various provisions that enable the establishment of the 'Joint Provider Committee'.
- Draft '**Joint Provider Committee'** (JPC) terms of reference. This sets out the specific details (Scope, membership, focus etc) for the JPC.

Both documents are 'work in progress' and all partners were asked to review and provide comment back to the BCPC Managing Director.

All comments will be reviewed and discussed with the Legal team, and a further (and hopefully) final draft of both documents will be presented to all organisation (with a cover Board paper) for review approval / sign off by early June.

5) Workforce – Bank rates

The workforce lead provided an update on the activities of the workforce, HR & OD workstream.

Agreement from the CE centred on the work around Bank Rates (aligning standard rates and aligning the rate for exceptional time limited enhancements). It was agreed to park the alignment of the standard bank rates, however, it was agreed to support/align a £5 per hour for exceptional time limited enhancements.

Further work will continue in aligning Bank Rates for other bandings, and the issue of full implementation (as intended) will be revisited as the opportunity allows.

6) Surgical Robotics – update

The BCPC CMO provided a brief update on implementing the RAS. Both DGFT and SWBH have now received their Surgical Robots, with both sites now having undertaken clinical procedures successfully. Consequently, this stage of the work is now almost at a completion stage, with on-going training & education, together with the formal development of the 'Centres of Excellence' model now likely to be picked up in a subsequent stage.

7) NHS Partners – update from WM NHSE

The Deputy Director of Strategic Transformation, NHSE West Midlands shared some brief updates as follows:

- Maturity Matrix for Provider Collaboratives is now available. This is optional and not mandated but may provide some useful insights to support the BCPC in its on-going development / and strategic endeavours.
- The formal process of ICB to Provider delegations has been put on hold to 24/25. It was noted however, that in moving to the operating model scoping work will be commencing in the Black Country to support the development of a plan across the financial year of 23-24.

8) Presentation to NHS Providers

The BCPC Managing Director, CMO and SRO have been invited to present the Black Country Provider Collaborative experience at a number of national and regional events. This includes:

- The NHS Providers Workshop series. This has been recorded at available at the following link (shortly to be connected to the BCPC website)

  https://www.youtube.com/watch?v=w6A_uw76bTs&t=245s
- The NHS Confederation provider Collaborative workshop series
- Southwest Peninsula UAN
- Derbyshire ICB / Provider Collaborative
- BC ICS Health & Housing Training programme

Minutes of the Performance & Finance Committee

Date	Wednesday 22nd March 2023
Venue	via MSTeams
Time	08.30am

Present:	
John Dunn	Non-Executive Director (Chair)
Lisa Cowley	Non-Executive Director
Gwen Nuttall	Chief Operating Officer
Martin Levermore	Non-Executive Director
Kevin Stringer	Group Chief Finance Officer & Deputy Chief Executive
Alan Duffell	Group Chief People Officer
Simon Evans	Group Chief Strategy Officer

In Attendance:	
Tim Shayes	Deputy Group Chief Strategy Officer
Adam Race	Interim Director of Human Resources & Organisational Development
James Green	Interim Chief Finance Officer
Mark Greene	Deputy Chief Finance Officer
Stew Watson	Director of Estates development (Part Attendance)
Claire Richards	Executive PA to Group Chief Strategy Officer (Minutes)

022/2023	**Apologies for Absence** Apologies were received from Lord Carter, K Wilshere and D Gritton.	
023/2023	**Declarations of Interest** There were no declarations of interest.	
024/2023	**Minutes of Meeting Held on 22nd February 2023** The minutes of the meeting from 22nd February 2023 were agreed.	
025/2024	**Action Points from the Previous Meetings**	
025.01	1063 Winter Plan Progress Column – G Nuttall confirmed that there will be a full review of the Winter Plan by the Place Urgent Care Group next week and that a full review of the Winter Plan will be discussed at the April Performance & Finance Meeting (action column will be included). **Action closed.** L Cowley queried if there were any areas of funding that were likely to come to an end at the end of the financial year which required highlighting. G Nuttall confirmed that a meeting was taking place with D Loughton, G Nuttall and the Local Authority to have discussions regarding funding. G Nuttall stated that additional funding was available via the Better Care Fund which need to be triangulated and some staff incentive schemes which have made a difference are due to end. G Nuttall informed the Committee that the criteria to reside numbers are benchmarking at 80 per month and most of the improvement is in Wolverhampton. G Nuttall highlighted that there is risk. **Chairs Report: Agreed to do review of winter plan at next meeting.**	
025.02	1064 Movement of Patients (Timing) – G Nuttall confirmed that deaths are not included within the discharge information. **Action closed.**	

025.03	1065 Financial Information (IQPR Format) – J Dunn met with M Greene to discuss the financial report and will circulate a copy of the proposal. **Repeat action.**	**M Greene**
025.04	1067 Financial Briefing (EDs and NEDs) – M Greene to arrange a 1 hour financial briefing session with Executive Directors and NEDs. **Repeat action.**	**M Greene**
026/2023	**Performance**	
026.01	Elective Recovery Programme – J Dunn thanked T Shayes for the revised format of the report. The paper provided the following highlights: Advise • The Trust achieved the ERF target (on a clock stop basis) in month, achieving 111.6%. • The waiting list has started to plateau. It remains to be seen whether this will continue. • The Trust's draft planning trajectories for 2023/24 have been submitted and are included within the report to the Committee. Further discussions are ongoing within the ICB before they're submitted to NHS England at the end of March. Alert • The Trust has had to cancel or rearrange 1,670 patients (230 admitted and 1,440 non-admitted) in March as a result of the industrial action taken by Junior Doctors. The activity is being re-arranged but to the detriment of other patients who would have otherwise utilised the capacity. • The activity plan for next year, at 106.9% by value falls slightly short of the 108% Trust target. The opportunity to increase activity further is constrained both by staffing availability and funding. • The Trust will not achieve the 78 week target for the end of March as a result of the impact of the junior doctor strike, combined with pre-existing challenges. The target has been revised to the end of April, however, this remains a risk given the size of the waiting list tail. • The Trust will not achieve its target to reduce its 62 day backlog to 140. This is primarily as a result of increased referrals (beyond normal levels). A revised target of 195 has been set for next year which takes into account the increased referrals being seen. Assure • NHS England have tiered providers according to their perceived risk – Tier 1 being the highest risk and Tier 3 the lowest. RWT remains within Tier 3. J Dunn queried how the Trust would increase the capacity to meet the trajectories put forward. G Nuttall stated that the expectation is that the Trust delivers 108% and that the Trust needs to identify whether there is a need to achieve 120% to achieve everything and that an internal piece of work will take place to look into this further. G Nuttall stated that there is a need to look at capacity and productivity and confirmed that current capacity is at maximum and there are no delays, which is part of a theatre productivity programme which is in place. The Trust hasn't factored in any additional waiting list initiative capacity into planning assumptions and figures, which allows an opportunity for future gain if the Trust were able to recover and increase additional waiting list capacity. T Shayes confirmed that this was the case. J Dunn asked G Nuttall to provide an update on forecast activity plans at the next meeting, this item has been added to the work plan. L Cowley queried what the Trust would be able to achieve without ICB funding. T Shayes stated that current run rates to achieve existing ERF targets assume 3 forms of assistance i.e. Q4 assistance purchased from a private sector provider, mutual aid from other NHS providers and existing independent provider assistance. T Shayes clarified that the only assistance that has been removed 23/24 is the assistance from the independent sector. T Shayes stated that discussions regarding mutual aid are taking place at an earlier date by the end of the year. L Cowley stressed the need to know the reality of where the Trust will be in March. T Shayes stated that he will add some modelled scenarios within the report for the next meeting.	**G Nuttall** **T Shayes**

	L Cowley queried what plans were in place to support outpatients and diagnostics. T Shayes stated that the 3 most challenged areas are Endoscopy, Echo and Ultrasound. T Shayes informed the Committee that a plan is in place to continue with an independent provider for Endoscopy whilst recruitment takes place. T Shayes stated that Ultrasound performance has improved which should achieve 75% by the end of the year. T Shayes informed the Committee that Echo performance was a reflection on the lack of staffing of Echocardiographers across the region, however, an internal plan is being developed to improve performance. G Nuttall stated that there was a clinical gap in this area but informed the Committee that discussions have taken place with N Hobbs regarding a collective approach to outpatient recovery. G Nuttall stated that she would share a copy of the plan May/June 2023. The Committee noted the report.	
026.02	National & Contractual Standards (IQPR Extract) – G Nuttall provided an update to the Committee. G Nuttall referred to page 15 of the report and clarified that medically fit for discharge should read as 'criteria to reside'. G Nuttall informed the Committee that the performance figure of 65 excludes patients waiting for rehabilitation locally but that the performance has stabilised and there is an average of 80 patients. G Nuttall stated that Wolverhampton was making the most improvement and that the area most challenged at present is Dudley due to repatriation of patients to Dudley. There has been a significant increase in ambulance conveyances from Shropshire, particularly from SaTH which has led to delays in repatriation of patients to Shropshire. G Nuttall informed the Committee that there had been improvement in ED performance and ambulance handovers in February due to the utilisation of the Ambulance Receiving Centre (ARC). G Nuttall informed the Committee that the Trust had submitted a request for UEC pressure funding to continue to fund the ARC and that has not yet been agreed. G Nuttall reported that safety was maintained during the Junior Doctor Strike. G Nuttall informed the Committee that Cancer performance was red and that most are in Urology and surgical treatment of people with kidney tumours and that the Trust has flagged those patients as high risk. G Nuttall informed the Committee that an action plan has been put into place which is reliant on increasing capacity and throughput at RWT using our own surgeon, moving some benign work on waiting lists to Russells Hall and using the private sector and a consultant based at Stoke providing additional capacity at weekends and also mutual aid from Leeds Hospital. G Nuttall noted that the mutual aid from Leeds Hospital will involve patients travelling to Leeds and that patient engagement would be required regarding this. The transfer of patients will also result in transport costs and private sector costs. G Nuttall stated that she has had discussions with the Cancer Alliance regarding financial support due to the risk/harm to patients. G Nuttall informed the Committee that it was unlikely the Trust would clear the 78 week requirement by the end of April and that the Trust was likely to achieve the target by the end of June. J Dunn summarised that hospital flow has improved due to the reduction in medically fit patients, the ARC is working well, focus is on cancer performance and specialities which have any major issues such as Urology, Renal Surgery, Gynaecology and General Surgery. J Dunn stated that the Trust is achieving good, solid consistent performance. L Cowley queried how the patients would be transported to Leeds. G Nuttall confirmed that the hospital would arrange this.	

L Cowley stated that the number of 78 week patients had increased from 50 to 96 and queried what the reasons were for the increase. G Nuttall clarified that the mutual aid support from the private sector company managed by Sandwell & West Birmingham did not materialise and a small amount were impacted due to the strike action.

M Levermore referred to page 16 of the report and queried whether there were any identifiable factors for improved performance against the targets for 62 day screening and first treatment in January and November. G Nuttall stated that performance reduces in December due to patient choice and there is less capacity due to the holiday period and October due to the half term. G Nuttall informed the Committee that there will be a reduction in age for bowel screening and both RWT and Dudley are working on adding additional capacity to help to improve the metric. RWT will have additional capacity in place from May and that improvements should show from June onwards.

The Committee noted the report.

027/2023 **Financial Performance for Period**

027.01.01 Monthly Financial Report – K Stringer provided an overview of the financial performance. The Trust is reporting an in month adjusted surplus of £2.4m, this is £1.2m favourable to plan. The year to date deficit of £2.2m is £1.4m adverse to plan. The Trust has enacted its recovery plan and is forecasting break-even but is reliant on system performance and support through the risk share arrangements. £9.5m of the year to date deficit relates to budget reduction CIP that was planned to be delivered by this point in the year, of which £2.3m is unidentified and £7.2m do not have budget or run rate related reductions as they relate to productivity and cost avoidance schemes.

K Stringer informed the Committee that West Midlands Ambulance Service did not achieve the £6m requirement for the risk/share agreement and were only able to offer £2m. The shortfalls has been distributed to the remaining organisations, which will result in an additional £0.9m requirement for RWT before year end.

027.01.02 Trust Income & Expenditure Position (within the report) –

	In Month Actual	YTD
Income	£'m	£'m
Block Payment	58.18	621.21
Other Income	17.72	157.12
Top-up Payment	0.43	4.30
Total	76.33	782.62
Expenditure	73.90	784.80
Surplus/(Deficit)	2.44	(2.17)
Planned Surplus/(Deficit)	1.19	(0.80)
Variance to Plan	1.25	(1.37)

027.01.03 Covid 19 Expenditure – In month 11 there was a total of £664k expenditure relating to Covid-19, of this amount £632k is reimbursed for testing.

027.01.04 Cash – The cash balance as at 28th February 2023 is £71.6m actual against £48.1m planned.

027.01.05 System Update – Following the enactment of System Risk Share arrangements the ICB continues to forecast a break even position for 2022/23, although some organisations are experiencing substantial pressure to deliver this. RWT will receive £3.8m of support from the Risk Share in 2022/23 and we remain committed to achieving break-even. The System (in line with guidance) is not forecasting a loss of ERF resources even though performance is substantially below the ERF target level.

	J Dunn summarised that the Trust will achieve the forecast year-end break-even. However, this will put pressure on next year's financial budget. The Committee thanked the financial and operations team for all the hard work to achieve the year-end result. The Committee received the report for assurance and noted the report.	
027.02	Financial Planning – K Stringer gave an update on the System CEOs Meeting. The meeting looked at a capped expenditure plan methodology and the report submitted to CEOs reported a £206m deficit plan next financial year, with a view to remove £41m to achieve £165m. K Stringer stated that he would share the list of suggestions of how this could be achieved (more CIP, further balance sheet release and constraining Service Development Funds). K Stringer informed the Committee if the deficit remains at £165m the Black Country is likely to be escalated regionally and nationally. K Stringer informed the Committee that the Trust will need to develop a 3 – 5 year recovery plan as Auditors will test the organisation against value for money. J Dunn stated that it is important to understand the pre/post covid costs-movement, CIP plans and queried the assumptions to achieve £165m. K Stringer agreed that there were a number of assumptions and a cash pressure for organisations in the next financial year. A discussion took place regarding the 4% CIP efficiency, a level which has never been achieved historically. G Nuttall clarified that work is taking place to identify service change and efficiencies but stressed that achieving the efficiency requirement is high risk. M Levermore queried what the Trust could put into place to address the cash shortfall for the Trust. K Stringer informed the Committee that the Trust would experience cash issues during Q3 on the current deficit plan. K Stringer clarified that sufficient cash is available within the system but that it would need to be collectively re-distributed to providers. M Levermore queried what areas the Trust were looking at regarding chargeable services. K Stringer stated that the Divisions activity flagged anything that was not on NHS tariff and that there was an area of commercial income for car parking and retail. K Stringer stated that there may need to be a requirement to look into PBR coding further to ensure all activity had been appropriately coded. J Greene provided a presentation which informed the Committee of the forecast deficit for 2023/24, which has improved from £82.8m to £72.9m as of 18th March 2023 (the figures include the latest income position from the ICB). J Greene outlined planning assumptions that had previously been reported and displayed the ICS Position Summary Forecast Plan 23/24. The expected ICS submission on 30th March is showing a system deficit of £165m. The ICS has undertaken analysis across all organisations to produce a breakdown of the key elements of financial pressure to explain the £165m forecast deficit, a breakdown of the analysis was included within the report. J Greene displayed a copy of the RWT 23/24 Plan and explained the expenditure cap methodology and outlined the route to achieving the expenditure cap and the next steps over the coming weeks, which includes: • Agreement across organisations to bridge the gap from current plans to the Expenditure Cap calculation. • Production of the Financial Plan Return – submission date of 30th March 2023. • Further investigation into productivity measures. • Investigation into potential CIP schemes that will bridge the current £24m unidentified challenge. • Preparation for external intervention.	**K Stringer**

	J Dunn summarised that the Board will need to understand the risks and discuss the risk appetite and understand what can be achieved. The Trust will likely experience some intervention from NHSE and J Dunn stressed the need to understand the pre/post covid figures before Trust Board. There is a need to present a realistic CIP plan. L Cowley queried that excess inflation has been removed as the costs are being covered separately. J Green stated that energy costs are reducing and that the Trust will benefit from that. J Green confirmed that there is also a challenge from organisations to go back to the centre to request funds for excess inflation above tariff funding. L Cowley expressed concerns regarding pay budget and that the Trust were paying a bank uplift and super enhanced payment for ED and queried if it had been planned into the budget. J Green stated that the bank uplift and super enhanced would be included from month 10. L Cowley queried if the 32.3% uplift in terms of cost base from pre to post covid is split by department to understand the increased cost base. M Greene stated that this information can be made available and that the majority is across the board but key areas are ED and surgical. M Greene stated that this information can be made available. K Stringer confirmed that this information was needed as soon as possible. L Cowley queried if options for Service Development Funds could be RAG rated. K Stringer stated that there needs to be absolute clarity that expenditure is income backed or not and therefore the ICB had to share their assumptions. L Cowley stated that a discussion took place at Charity Committee that there is a lot of funding which is not being utilised and queried if that could be used appropriately rather than funding via budget/business cases. J Green confirmed that this would be investigated. M Levermore queried whether there would be a need to explore staff cost reduction. J Green stated that service reduction would need to be considered before examining staff cost reduction. G Nuttall stated that if staff cost reduction needed to be considered it would be managed via redeployment across the ICB. A Race agreed with the summary. K Stringer informed the Committee that there is a need to understand the cost base, the driver for the investment and a need to benchmark and to look into the level of service which is provided compared against other Trusts and taking into consideration of impact on patients. K Stringer also confirmed that re-deployment of staff would be a consideration if services were reduced or ceased, rather than redundancies. L Cowley stressed that there is also a need to consider if the same service could be delivered by a non-NHS provider. J Dunn queried if pre-briefing plans could be shared prior to the update at the Extra-ordinary Trust Board Meeting on 29th March or if additional time can be granted for discussion. K Stringer and the Finance Team to examine the possibilities available. The Committee noted the report.	**M Greene** **K Stringer**
027.03	<u>Financial Recovery Group Update</u> – The Committee noted the report. <u>2022/23 CIP Target</u> – The 2022/23 CIP Target is £19.1m, £1.6m has been delivered in month 11 which sees an achievement of 77% of the monthly target. This equates to 87% of the year to date phased target and 77% against the full year delivery target. <u>2023/24 Pipeline</u> – The final CIP figure is yet to be confirmed but a 4% efficiency target has been set across the ICS. The report contained a list of schemes that had been identified totalling £1.9 – £3m (estimated values to be confirmed).	

027.04	Better Payment Practice Action Plan – The Committee noted the report. The Trust has made significant improvement this year, with the last 3 months achieving at least 95% value. The Trust is also seeing significant improvements for volume, also hitting 95% for the first time this year in February.	
028/2023	**Board/Pre-Board Approval Reports**	
028.01	EMR & PAS Implementation (EREAFS 634 & 637) – The paper on placing the contract with the preferred EMR/PAS provider was not discussed during the Committee Meeting as there was insufficient time to read through the paper prior to the meeting. K Stringer agreed to circulate the paper to the Committee by 12noon today (22nd March) for electronic comment/endorsement prior to submission to Trust Board. J Dunn stressed the need to give assurance to the Board regarding next steps and asked that ownership transfer to G Nuttall as the Lead Executive for this. G Nuttall confirmed that she would pick up SRO responsibility for implementation and would be supported by Dr McKaig. G Nuttall also stated that reports will be submitted to Performance & Finance Committee post implementation. G Nuttall confirmed that the programme lead will be Keely Evans.	**K Stringer**
028.02	Cannock Chase Hospital Theatres Programme (FBC Update) – S Watson provided an update to the Committee on the expression of interest that the Trust submitted under phase 2 of the Targeted Investment Fund (TIF) which was submitted by RWT to NHSEI West Midlands for consideration of a Northern Elective Hub. S Watson stated that the returned tenders exceed the project budget and extend the delivery timeline by 12 months. S Watson clarified that £32.5m was allocated for the project and the tenders are projecting £38.5m, a £6m shortfall. NHSEI are arranging a meeting to discuss delivery of the project and have asked that a review be completed. The timetable will be reviewed once there is a full understanding of the revised costs. G Nuttall confirmed that she will provide a verbal update at the Trust Board Meeting following the meeting with NHSEI regarding the ICB Project that is being led by RWT.	**G Nuttall**
028.03	Community Diagnostic Hub Contract Award – S Watson clarified that as the contract award needed to progress prior to the end of March to achieve NHS funding conditions approval was sought from the Performance & Finance Committee Chair, Executives and Trust Board Chair outside of the Committee cycle process in line with the Standing Financial Instructions. The Contract Award was approved outside of the meeting. The Committee noted the Contract Award endorsement and approval.	
028.04	PSDS Decarbonisation Update – S Watson provided an update on the Public Sector Decarbonisation Scheme Phase 3 Grant Funding. The Trust has been granted further additional funding. The funding forms part of the bid submitted on behalf of RWT, Walsall Healthcare NHS Trust, the West Midlands Ambulance Service and Sandwell & West Birmingham. The Grant Offer Letter confirms the gross value of £35.75M which includes the client contributions, now totalling at £4.36M. Following negotiations with the SALIX financial assessment team the capital injection from the 4 organisations has reduced by £1.49M. S Watson clarified that RWT would receive £6M from the funding and assured the Committee that his team continue to actively look for further external funding opportunities. The Committee noted the report. J Dunn asked S Watson to provide a paragraph regarding the funding achievement which could be included within the Chairs report. M Levermore requested further information regarding the resource challenges. S Watson clarified that delivery resources within the department had reduced by 30% and that the	**S Watson**

	work to procure additional funding was labour intensive. S Watson clarified that recruitment is taking place to address the shortfall. M Levermore queried if the organisation was looking at bidding for some of the £1.5b funding. S Watson confirmed that the team were aware of the funding and were looking into this further. J Dunn requested an update at a future meeting.	
029/2023	**Reports to Note**	
029.01	Capital Report – The report was noted.	
029.02	High Value Contract Report – The report was noted.	
029.03	Contracting & Business Development Report – The report was noted.	
029.04	Monthly Supplementary Finance Report – The report was noted.	
029.05	Temporary Staffing Dashboard – The report was noted.	
029.06	NHSI Monthly Return – The report was noted.	
030/2023	**Any Other Business/Meeting Reflection**	
030.01	Meeting Reflection – • The items to be included within the Chairs Report are included within the minutes. • The Committee reflected on the meeting and agreed that the meeting focus was on the important areas and that there had been a good balance of discussion and debate.	
030.02	Meeting Reflection/CEO Highlights – Nothing to note this month.	
031/2023	**Date and Time of Next Meeting**	
	The next meeting is scheduled to take place on Wednesday 26th April at 8.30am via MSTeams. Please ensure that all reports are emailed to claire.richards12@nhs.net in pdf format by 12noon on Friday 21st April.	

Minutes of the Performance & Finance Committee

Date	Wednesday 26th April 2023
Venue	via MSTeams
Time	08.30am

Present:	
Lisa Cowley	Non-Executive Director (Acting Chair)
Gwen Nuttall	Chief Operating Officer
Martin Levermore	Non-Executive Director
Kevin Stringer	Group Chief Finance Officer & Deputy Chief Executive
Lord Patrick Carter	Specialist Advisor to the Board

In Attendance:	
Tim Shayes	Deputy Group Chief Strategy Officer
James Green	Interim Chief Finance Officer
Mark Greene	Deputy Chief Finance Officer
Nathan Joy-Johnson	Group Director of Procurement (Part Attendance)
Adam Race	Director of Human Resources & Organisational Development (Part Attendance)
Stew Watson	Director of Estates Development (Part Attendance)
Claire Richards	Executive PA to Group Chief Strategy Officer (Minutes)

032/2023	**Apologies for Absence** Apologies were received from J Dunn, S Evans, A Duffell and D Gritton.	
033/2023	**Declarations of Interest** There were no declarations of interest.	
034/2023	**Minutes of Meeting Held on 22nd March 2023** The minutes of the meeting from 22nd March 2023 were agreed.	
035/2024	**Action Points from the Previous Meetings**	
035.01	1065 Financial Information (IQPR Format) – M Greene informed the Committee that he had discussions with J Dunn re the IQPR and that work is ongoing. **Repeat action.**	**M Greene**
035.02	1067 Financial Briefing (EDs and NEDs) – M Greene confirmed that discussion meetings have taken place, work continues to take place and that Executive Directors and NEDs will be briefed as soon as possible. **Repeat action.**	**M Greene**
035.03	1142 Forecast Activity Plans – This item has been added to the agenda. G Nuttall will provide an update at the meeting. **Action closed.**	
035.04	1143 Elective Recovery Report (Model Scenarios) – T Shayes confirmed that model scenarios will be included in future reports. **Action closed.**	
035.05	1144 System CEO Meeting (Deficit Suggestions) – K Stringer circulated the list of suggestions for tackling the deficit which were discussed at the System CEO Meeting. **Action closed.**	

035.06	1145 Cost Base Split by Department – M Greene confirmed that the uplift in terms of cost base is split by division and area. **Action closed.**	
035.07	1146 Financial Pre-Briefing for Extraordinary Trust Board 29th March – The meeting has taken place. **Action closed.**	
035.08	1147 Circulate EREAF 634 and 637 – K Stringer circulated the EREAF. **Action closed.**	
035.09	1148 Verbal Update to Trust Board re CCH Hospital Theatres Programme – G Nuttall provided a verbal update to Trust Board as requested. **Action closed.**	
035.10	1149 PSDS Update – S Watson provided J Dunn with a paragraph regarding the funding achievements for inclusion within the Chairs Report. **Action closed.**	
036/2023	**Performance**	
036.01	Elective Recovery Programme – T Shayes provided an update on the paper and provided the following highlights: Advise • The Trust's waiting list had started to plateau in March, however, there will be a slight increase in April following Industrial Action. • The Trust's draft planning trajectories for 2023/24 have been submitted and are included within the report pack. The performance elements have been accepted however the activity remains an ongoing discussion given its impact on the Trust's financial plans. Alert • The Trust has been alerted to the likelihood of it being escalated to the tiering system owing to the current 62 day backlog. • The Trust has had to cancel or rearrange 2,988 patients (373 admitted and 2,615 non-admitted) in March and April as a result of the industrial action taken by Junior Doctors. This activity is being re-arranged but to the detriment of other patients who would have otherwise utilised this capacity. • The activity plan for next year, at 106.9% falls slightly short of the 108% Trust target. The opportunity to increase activity further is constrained both by staffing availability and funding. T Shayes and G Nuttall are discussing any potential revisions to the activity plan by week ending 28th April 2023. • The Trust will not achieve the 78 week target for the end of March as a result of the impact of the junior doctor strike, combined with pre-existing challenges. The target has been revised to the end of May, however, this remains a risk given the size of the Trust's waiting list tail. T Shayes stated that challenges lie in 3 specialities; general surgery, gynaecology and urology due to a lack of capacity within the system. The Trust is reliant on mutual aid to bridge the gap and none of the other NHS providers within the region have capacity to be able to provide a material difference. The independent sector are only able to assist with routine cases which has been exhausted. • The Trust will not achieve its target to reduce its 62 day backlog to 140. This is primarily as a result of increased referrals (beyond normal levels). A revised target of 195 has been set for next year which considers the increased referrals being seen. Assure • The Trust achieved the ERF target (on a clock stop basis) in month, achieving 111.6%. M Levermore queried the length of time theatres are available and asked if they could be rented out to the independent sector. T Shayes stated that exploratory discussions are taking place as to whether the independent sector can utilise the theatres on weekends.	

	M Levermore queried if the targets that were not met last financial year were likely not to be met this financial year and whether this could be challenged and re-balanced. T Shayes confirmed that the Trust had revised the trajectory this year, which was accepted by NHSE at a system level and despite that the Trust has received a notification for escalation. G Nuttall provided a brief update on the Outpatient Transformation Project. The Project consists of reducing follow ups for patients and moving toward Patient Initiated Follow Up (PIFU). G Nuttall stated that the Trust has a project plan and proposals in place to work towards PIFU. G Nuttall confirmed that a clinical lead was not yet in place for the project at present but a lead will be in place within the next 2 months, the project is moving forward via Divisions and Service Improvement Team with clinical support via Dr Brian McKaig in the interim. Progress will be reported monthly through the Financial Recovery Group (FRG). G Nuttall clarified that the activity forecast in the FRG papers is to increase productivity around additional potential income but activity numbers submitted and agreed do not deliver the full ERF value at RWT. L Cowley asked for an update on the Outpatient Transformation Project at the Committee Meeting. G Nuttall agreed to provide quarterly updates as part of the FRG report. The workplan has been updated accordingly. L Cowley queried if PODC were looking into the impact of diagnostics on waiting times. G Nuttall confirmed that hard to fill areas had been identified. A Race confirmed that this was correct and that plans were in place to address the recruitment for the hard to fill positions. G Nuttall stated that some were nationally difficult to recruit to, in particular Sonographers and Echo Physiologists in Cardiology. G Nuttall informed the Committee that the Trust have individuals booked on Sonographer training and is looking at using alternative workforce and training staff internally. L Cowley asked if PODC could explore this in further detail. A Race to feedback to PODC. **Action closed.** M Levermore expressed concerns regarding potential recruitment freeze impact on diagnostic performance and queried if a finance impact assessment was required. G Nuttall confirmed that there will be an impact and informed the Committee that the Trust has submitted a trajectory plan based on forecast, throughput, activity and referrals of all diagnostics to the ICB. There has been no discussion regarding recruitment freezes on clinical posts at this time. L Cowley felt that there was a need for key targets need to be RAG rated against key risk factors going forwards. The Committee noted the report.	
036.02	<u>Forecast Activity Plan (Verbal Update)</u> – G Nuttall stated that there is a need to have further discussions regarding the proposed budget and actions. G Nuttall clarified that proposals are aimed at becoming more productive, more efficient and utilising GIRFT metrics and high volume/low complexity metrics and ensuring the risks are including within the Trust BAF. L Cowley felt that there needed to be leadership discussions regarding staff engagement going forwards.	
036.03	<u>National & Contractual Standards (IQPR Extract)</u> – G Nuttall provided highlights from the report. G Nuttall highlighted that there had been a slight deterioration in the number of cancelled operations on day of surgery for non-medical reasons and that this was due to a spike in in consultant sickness in theatres. There had been a spike in covid cases during March which saw an increase in delays to medically fit for discharge due to clinical reasons. G Nuttall clarified medically fit is averaging around 60 – 70 in April. Time spent in ED metrics have shown some deterioration at the beginning of March due to spikes in covid and an increase in ambulance conveyances, however, this improved from the middle of March onwards.	

	G Nuttall highlighted 62 day wait for treatment and 78 week performance. G Nuttall explained how the cancer metrics are being measured and stated that the Trust has not yet received formal notification that it has been escalated into tier 2 but that it will happen. G Nuttall stated that this has been included on the Trust Risk Register and BAF. G Nuttall informed the Committee that patients waiting for neurological treatments and kidney/tumour sites equate to 50% and that a recovery plan is in place to address with 2 organisations providing mutual aid (Leeds and Frimley Park) from May and that a percentage of patients have agreed to travel for the treatment. G Nuttall also stated that The Dudley Group will also assist with mutual aid following robot training. The Trust is forecasting recovery end of September/beginning of October. L Cowley queried the breakdown of the waiting list. G Nuttall confirmed that the remaining 2 from the top 3 are Gynaecology and Colorectal, both of which are national issues and mutual aid is not available at this time. L Cowley requested an update on the ED Streaming Pilot. G Nuttall stated that a review has taken place after a 2 week period, the pilot has continued however further information is required for a more in-depth review. A review will be taking place of the pilot at the May Non-Elective Flow Group Meeting. G Nuttall stated that she would provide an update in next month's IQPR. The Committee noted the report.	
036.04	Winter Plan Review (Verbal Update) – G Nuttall informed the Committee that a One Wolverhampton Urgent & Emergency Care Meeting took place on 25th April where there was a draft review of Winter schemes, which have been pulled together, which include third sector and Compton. G Nuttall will provide the Committee with a review at the next meeting. The workplan has been updated, **action closed**. G Nuttall stated that some Place schemes were funded until the end of March which have ceased and that this needs to be risk assessed and reviewed. G Nuttall stated that Service Development Funds totalling £2.4m were supposed to roll forward into the new financial year, however, due to the current cost pressures the funding will be reduced which will result in cost pressures for any schemes that have been carried forward. G Nuttall agreed to ensure that the list of the 7 schemes would be included within the review of the Winter Plan to the Committee next month and that the schemes would be circulated for pre-reading. L Cowley informed the Committee of a potential funding issue from the Local Authority regarding social care uplift for Walsall patients. M Levermore queried the impact on young adults/paediatrics following cost pressures on the virtual ward. G Nuttall stated that discussions need to take place regarding occupancy and at present the virtual ward for paediatrics can support 20 children but the Trust has never reached that occupancy.	**G Nuttall**
037/2023	**Financial Performance for Period**	
037.01.01	Monthly Financial Report – K Stringer provided an overview of the financial performance. The Trust reported an in month adjusted surplus of £2.3m, £1.5m favourable to plan and year end surplus £0.09m. This had been achieved through non-recurrent support of £8m and ICB risk share arrangement for £2.7m (a reduction of £1.1m due to deterioration elsewhere in the ICB), as well as a significant level of releases of provisions and accruals no longer required of £29.1m (£5.7m income related, £14.4m pay related and £9m non-pay related). £8.9m (adverse) of the year end position related to budget reduction CIP that was planned to be delivered, of which £7.9m did not have budget or run rate related reductions as they related to productivity and cost avoidance schemes. There were year-	

end reported overspends on pay of £4.6m net of £14.4m release of accruals, and drugs of £3.5m related to activity and the application of block contract arrangements to costs previously passed through to CCGs. Non-pay was £1.4m underspent at the year-end after £9m release of accruals. £10.6m of reserves remained not drawn down.

037.01.02 Trust Income & Expenditure Position (within the report) –

	In Month Actual	YTD
Income	£'m	£'m
Block Payment	100.44	721.65
Other Income	17.38	174.50
Top-up Payment	0.44	4.74
Total	118.27	900.89
Expenditure	116.01	900.80
Surplus/(Deficit)	2.26	0.09
Planned Surplus/(Deficit)	0.80	(0.00)
Variance to Plan	1.46	0.09

037.01.03 Covid 19 Expenditure – In month 12 there was a total of £589k expenditure relating to Covid-19, of this amount £554k is reimbursed for testing.

037.01.04 Cash – The cash balance as at 31st March 2023 was £69.3m actual against £69.1m planned.

037.01.05 CIP – YTD CIP achievement was £18.16m against a target of £19.09m

037.01.06 Capital – The Trust had spent £73.8m of capital YTD to 31st March 23. Of this £73.8m, £19.7m related to the capital spend target (CRL) which the ICS was measured against. The trust reported a small underspend of £16k against agreed Full Year ICS CRL of £19.7m.

Of the remaining YTD balance of capital of £54.1m this related to capital spend on grant funded items of £28.5m, made up of £5.5m PSDS Phase 2, £21.9m PSDS Phase 3 and £1.0m ERDF Grant; £5.2m for new leases for BCPS which are capitalised under IFRS 16 (offset by £0.8m of Linac Lease which has been transferred using PDC monies to owned asset); £19.8m of PDC monies; £0.5m PFI additions; and £0.8m of donated assets. The planned gross capital expenditure had moved from a prior month forecast of £89.4m due to additional PDC monies £0.8m; reduction in IFRIC 12 related capital spend of £4.7m; reduction in IFRS 16 leases of £0.9m due to leases not beginning in 22/23 as previously planned; and deferral of grant spend of £10.0m into 23/24.

K Stringer stated that the accounts were subject to audit. The Committee thanked everyone for all their hard work in achieving the year-end budget.

L Cowley highlighted an audit risk around the changes to accrual releases, which is a change in financial process from the ICS. The Trust had already highlighted this with auditors. K Stringer confirmed discussions had taken place with Auditors regarding this.

L Cowley noted PFI has increased, which is related to RPI and is a risk factor going forward as an unfunded inflation.

L Cowley asked if there had been an update on utilities for the new financial year. K Stringer stated that this would be reported in next year's reporting but that this was being investigated.

L Cowley queried if the Trust was able to identify where the drug overspend had arisen. G Nuttall confirmed that this can be tracked and that Medicines Management Committee have oversight of drug management. G Nuttall stated that there are options to make drug savings going forwards and that this is being tracked via FRG. K Stringer confirmed that

	Finance are currently scrutinising the information which will be shared with G Nuttall and then the Committee. The Committee received and noted the report.	
037.02	Financial Planning – K Stringer informed the Committee that the ICB are in national escalation today so a formal budget is yet to be agreed and numbers may change within the next 48 hours. As a result of methodology used the ICB are predicting a £30m surplus which should be allocated to deficit Trusts so RWT's position on allocation should improve. K Stringer informed the Committee that one of the Trusts within the system will run out of cash in July even with the surplus distribution and that this will need to be resolved. J Green presented a paper that had been updated within 24 hours of the meeting. J Green outlined the revised proposal and highlighted the following amendments since the Trust Board Meeting on 29th March 2023: • Further improvements had been identified by the system partner organisations. • There was a stretch challenge of £17.1m additional efficiency for RWT. • There was an improvement in the ICS wide deficit from £145.8m to £73.9m. • The RWT revised deficit plan was now £42.1m. Start point efficiency levels have been set at 4.0%, which equated to c£28m for RWT. £6.6m of CIP had been identified to date. The target had been indicatively split across pay and non-pay on a proportional basis, £19.8m on pay and £8.2m on non-pay. Currently in line with the ICB, these targets had been phased equally over the year. Additional stretch requirements leading up to 30th March 2023 submission have resulted in further efficiency being required of each organisation, which for RWT was £4.6m excluding balance sheet items. Further requirements had been agreed over the past week amounting to £7.5m (again excluding non-recurrent measures – a further £3m), taking the total recurrent efficiency target to £43.1m. The revised cumulative impact across organisations were efficiency levels ranging from 2.7% (WMAS) to 7.1% (DIHC). RWT was 6.2%. J Green outlined the risks, challenges, mitigations and proposed next steps which included: • Production of the final Financial Plan Return – submission date of 4th May 2023. • Further investigation into productivity measures. • Investigation into potential CIP schemes that will bridge the current £22.7m unidentified gap. • Preparation for external intervention. The Committee requested that time be allocated at the Board Development Session on 3rd May to discuss approval of the revised planning submission for 4th May 2023 and agree the budget for the first quarter of the financial year 2023/24 based on the deficit plan proposal. L Cowley stressed that if the budget is agreed by Trust Board there is a very high level of uncertainty regarding the proposed funding. L Cowley confirmed that she would email D Loughton and K Wilshere regarding the additional meetings. L Cowley highlighted that ICS have been asked to reduce workforce by £10m and that RWT have been asked to reduce workforce by £3.5m. There is a need to cross-reference staffing against performance where increases had occurred. A Race confirmed that the Trust is in the process of reviewing the movement on the workforce plan and triangulating growth against business cases that have been submitted. G Nuttall clarified that this was the equivalent workforce growth of 143 posts. G Nuttall queried how income backed workforce growth would be taken forward.	**L Cowley**

	L Cowley asked A Race if he could identify where growth is directly linked to income but would have a potential impact on performance/quality for discussion by the Trust Board at the Board Development Session on 3rd May along with the overall budget discussion. K Stringer confirmed there was a need to highlight those income funded protected posts. The Committee strongly felt that there was also a need to consider the staff experience mix alongside vacancy considerations. L Cowley informed the Committee that K Stringer and his team were going to examine the understanding of the clinical negligence percentage inflation increase as the Trust percentage is higher than the average. M Levermore asked J Green for clarification regarding the impact of triple lock. J Green confirmed that this would not alter the figures, it would restrict expenditure authorisation. M Levermore queried the impact on RWT if one of the providers ran out of cash. J Green stated that a discussion would take place across the whole system and what the possibilities are in terms of re-distribution of cash. If the system has a cash problem discussions would take place with NHSE to obtain cash loans to underpin the deficit. L Cowley queried if RWT was likely to run out of cash this financial year. J Green stated that RWT would not run out of cash as long as the deficit is lower than the cash balance and spend is reduced with lower revenue spend rather than non-recurrent balance sheet measures. L Cowley asked that this be highlighted as a risk as the Trust would be in month 3 before working towards a revised budget which would take time to embed. P Carter acknowledged the excellent process and supporting documentation against the uncomfortable position for the Committee and Board. P Carter recognised that the hospital was operating well against a challenging national position and queried if a bridge could be provided on workforce covid costs from 19/20 to date. J Green confirmed that workforce analysis has taken place from 19/20 to date and 1,770 WTE have increased since the end of 19/20 to the end of 22/23 and a there are a further 146 planned increases into 2023/24, which will reduce Bank by 80 WTE also. Further work is progressing to understand those movements, why they've occurred and has it delivered what was required (clinical issues, safety issue, activity growth, acuity, income backed development etc). L Cowley stated that there was also a need to identify posts that had been added due to a statutory requirement, due to key quality impact etc. L Cowley asked for papers for consideration at the Board Development Session to be circulated by close of play on Friday 28th April. The Committee noted the report.	**A Race** **J Green**
037.03	<u>Financial Recovery Group Update</u> – The Committee noted the report. <u>2022/23 CIP Summary</u> – Against an in-month target of £2.12m, the Trust has achieved £3.45m. Full year effect of £18.16m achieved against a target of £19.09m. £7.97m of this has been achieved through the rebasing exercise. Recurrent savings are £9.2m, of which £8.3m are from the revised reporting. There are approved PIDs of £8.295m, £2.235m recurrent and £6.06m non-recurrent with, £825k of schemes in progress. <u>2023/24 Pipeline</u> – The final CIP figure for 2023-24 has not yet been confirmed, but a 4% baseline efficiency target has been agreed across the ICS. Schemes for 2023-24 have been added to the pipeline. Where a financial value has been agreed as part of the PID development process this has been detailed within the pipeline. Other schemes remain as estimate with upper and lower values until details are finalised (this includes the Model Health system workstreams and the outcomes of the Corporate Self-Assessment Review Meetings which are in progress).	

	G Nuttall assured the Committee that further operational work is taking place to identify the re-occurring/non-reoccurring split and that she would endeavour to ensure the corporate/operational updates are available within the FRG for Friday circulation. L Cowley thanked G Nuttall for the report and progress being made and the CIP savings achieved this financial year. L Cowley stated that the GIRFT update is very useful and that an update would be helpful for Friday. L Cowley asked that Sensyne scheme be removed as the Committee decided at previous meetings as there are no financial savings there is no need to provide an update. L Cowley informed the Committee that the Health Inequalities Group have a funded project exploring DNAs in Ophthalmology which is due to report at the end of May, this could potentially provide some learning and funding. P Carter asked if K Stringer could provide him with a breakdown of the total salary/wage/labour cost for each year ending 19/20 to the budget for next year so that he could see the aggregate money spent and the inflation settlement that has driven it.	**K Stringer**
037.04	Annual PFI Contract Update – S Watson informed the Committee that the Trust has one PFI contract which covers the Radiology Building at New Cross Hospital and some elements of radiology equipment throughout the Trust. The contract runs for a term of 30 years and ends March 2032. The contract is between the Trust and Wolverhampton Radiology Limited (WRL). WRL have appointed a Management Company (currently Semperian Asset Management) to manage the contract on their behalf. In turn WRL also appointed Ergea (formerly known as Impregilio and then Medipass) to carry out the facilities management and to manage the medical equipment services. The current contract cost (Unitary Charge) is £7,749,384.72 per annum including VAT [22/23 figures]. S Watson assured the Committee that the contract was performing within its contractual requirements and advised that the levels of support expected from the external parties is appropriate to the needs of the contract and that positive working relations exist between all parties. S Watson also alerted the Committee that in times of extreme weather there remains occasions where the operation of the Radiology building can be affected. The Committee noted the report.	
038/2023	**Financial Planning**	
038.01	Supplies & Procurement Quarterly Update – N Joy-Johnson provided an update on the key workstreams currently undertaken by the North Midlands & Black Country Procurement Group (NMBC) including: • The final 2022-23 total Procurement related savings position of £5.6m. The RWT 2023-24 forecast Trust Procurement related bottom line savings position of £2.39m. • An update on the existing North Midlands and Black Country Procurement Group (NMBC) model, which consists of five organisations as part of the fully integrated model (UHNM, RWT, WHT, North Staffordshire Combined Healthcare NSCHC and BCPS) primarily operating over 2 ICS's was detailed and the Committee were briefed on the change of name from the ISPD to NMBC and subsequent branding change. • Wider Procurement collaboration/consolidation across the Staffordshire & Stoke-on-Trent and Black Country Integrated Care Systems (ICS's), including a key update on the outcome of the recent review of the future Procurement target operating model in the Black Country ICS led by the Black Country ICB/Provider Collaborative Executive. L Cowley queried if the workforce challenges have eased or exacerbated by the revised structure. N Joy-Johnson stated that the revised structure was a positive step which would	

	increase resilience, responsibility and the ability to invest in roles and provide further career opportunities. M Levermore queried how supply chain resilience is being communicated to suppliers. N Joy-Johnson stated that the supply chain resilience model has improved capability and that this helps with the sharing of resolutions as well as sharing problems and also provides the ability to assist each other with mutual aid. Due to the enhanced clinical procurement resource NMBC are better able to respond to clinical changes in terms of supply chain resilience. P Carter queried what catalogue system was in use and if it was the same system at RWT and other Trusts. P Carter also asked what the adherence/compliance rate for the use of the supplier base within the catalogue. N Joy-Johnson stated that e-catalogue system was in use across RWT and UHNM and that other systems are being migrated across the group, which is taking a little time. A central systems team works across the systems to drive compliance which is currently 92.4% (0.24% above the Lord Carter national target). The Committee recognised the work undertaken and noted the report.	
039/2023	**Board/Pre-Board Approval Reports**	
039.01 039.01.01	Renal Satellite Unit Bilston (REAF 611) – The business case outlined the contract for the provision of a renal haemodialysis satellite service (in Bilston). The paper sought retrospective approval for the service for a 10 year period at an estimated value of £16,004,298. The tender was run in March 2022 but was delayed by several months due to a bidder challenge which is why it is now being submitted for retrospective approval. Year One costs equate to £1,789, 973 with subsequent price increases in line with RPIX but no higher than 2.7% per annum. The Committed noted the retrospective request to approve the award of the contract for the supply of an adult renal haemodialysis Satellite service (Satellite Unit) to Renal Services Ltd for a 10-year period commencing 6th February 2023 at an estimated cost of £1,789,972.83 per annum. **The Committee noted the business case to go to Trust Board for further noting. The Committee are unable to approve the business case as it has been submitted retrospectively and are confident that it meets value for money and an appropriate supplier has been appointed. However, an investigation has been requested to understand why the business case was not approved by the Board before commencement of the service and any lessons learnt for business cases going forwards.** An in-depth wider discussion took place regarding the length of time it had taken for the business case to be submitted for approval. G Nuttall assured the Committee that Executive Directors have stressed that retrospective business cases will not be tolerated. The Committee stressed that it has been raised on numerous occasions that retrospective businesses cases are outside of policy and are not acceptable. The committee requested a detailed investigation into the case present with a documented report provided for the May committee meeting detailing how this situation had arisen and a detailed action plan to address the non-compliance in relation to this issue and prevent reoccurrence. L Cowley asked that the High Value Contract Report include a list of business cases that are in the pipeline to pre-inform the Committee ahead of review and to seek pre-approval where needed. P Carter queried how the contract could have been signed without Board approval, if it was valid and if any finances had been paid. N Joy-Johnson stated that the Supplier has commenced service without formal authority, no service or product should be delivered until a Purchase Order has been supplied. N Joy-Johnson stated that this will be investigated and a formal letter will be issued to all suppliers as part of the investigation and retrospective action. The contract has satisfied value for money	**J Green** **N Joy-Johnson**

	requirements, it is a compliant route to market and has satisfied commercial risk. N Joy-Johnson stated that there is a need to ensure Managers understand that even if a business case or budget has been approved a business case should not progress outside of the procurement process.	
040/2023	**Reports to Note**	
040.01	Capital Report – The report was noted.	
040.02	High Value Contract Report – The report was noted.	
040.03	Monthly Supplementary Finance Report – The report was noted.	
040.04	12 Month Capital Report – The report was noted.	
040.05	Temporary Staffing Dashboard – L Cowley expressed concerns regarding Industrial Action and queried the impact on financial costs and performance following further action. A Race briefed the Committee on the impact of potential medical and non-medical Industrial Action (IA). Agenda For Change/Non-Medical Staff IA – AFC voted not to have mandatory IA at RWT. RCN members have voted to reject the pay deal, a meeting is taking place on 2nd May as to whether the Trade Unions accept/reject the deal. Medical IA – No planned dates for Junior Doctor action, however, further IA is likely which would have financial/performance impact. The Committee noted the report.	
040.06	Committee Work Plan – The report was noted.	
041/2023	**Any Other Business/Meeting Reflection**	
041.01	Meeting Reflection – The following areas will be included within the Chairs Report: • Procurement. • Finance. • 78 week wait. • The Trust has been alerted to the likelihood of it being escalated to the tiering system owing to the current 62 day backlog. • L Cowley will email D Loughton and K Wilshere requesting additional Board Meetings next week for financial submission approval. Papers to be made available by Friday 28th April.	
041.02	CEO Highlights – The Committee asked for the following bullet point to be listed for the CEO Highlights: • Finance	
042/2023	**Date and Time of Next Meeting**	
	The next meeting is scheduled to take place on Wednesday 24th May at 8.30am via MSTeams. Please ensure that all reports are emailed to claire.richards12@nhs.net in pdf format by 12noon on Friday 19th May.	

The Royal Wolverhampton NHS Trust

Minutes of the People and Organisational Development Committee

Date	**Friday, 24th March 2023**
Venue	**Via MS Teams**
Time	**10:30am**

Present:	**Name**	**Role**
	Alan Duffell	Group Chief People officer
	Chrissla Davis	Deputy Director of Nursing
	Sally Evans	Group Director of Communications and Stakeholder Engagement
	Lyndsey Ibbs-George	Divisional Manager, Estates & Facilities
	Catherine Lisseman	Head of Corporate Learning Services
	Alvina Nisbet	Associate Director of Digital Innovation
	Mark Ondrak	Staffside Lead
	Gail Parry	Acting Head of OD
	Adam Race	Interim Director of HR & OD
	Sue Rawlings (Chair)	Associate Non-Executive Director
	Priyanka Nar	Service Lead, OH & Wellbeing
	Sian Thomas	Deputy COO, Division 3
	Cath Wilson	Deputy Director of Nursing
In Attendance:	Maria Dent	PA to Group Chief People Officer
	Tracey King	Acting Head of Resourcing
	Nick Price	HR Manager, Division 3
	Glen Whitehouse	Group Manager, Radiology
Apologies:	Junior Hemans	Non-Executive Director
	Allison Heseltine	Associate Non-Executive Director
	Claire Young	Group Deputy Director of Education and Training

Agenda Item No		Action
1.	**STANDING ITEMS**	
1.1	**Apologies for Absence and Welcome to the Meeting** Apologies were noted and recorded as above.	

Agenda Item No		Action
	S Rawlings chaired the meeting on behalf of J Hemans. It was noted that as A Heseltine may not be able to join the meeting due to travelling commitments, and no other Non-Executive had been able to attend, therefore the Committee was not quorate. However S Rawlings advised that A Heseltine had forwarded on her comments and queries ahead of the meeting.	
1.2	**Declarations of Interest** A Duffell reconfirmed that currently he was the Interim Chief People Office at Dudley Group Foundation Trust as well as his role at RWT and WHC and attended the equivalent committees.	
1.2.1	**Acknowledgement to Junior Hemans** S Rawlings advised that J Hemans's term at RWT would be coming to an end during May and therefore, he had chaired his final PODC meeting at RWT. She formerly noted the Committee's thanks to J Hemans for all the work and support given to PODC and indeed the Trust, over the past few years.	
1.3	**Confirmation of the Minutes from the Last Meeting, 24th February 2023** The minutes from the 24th February 2023 were reviewed and agreed as a true record of the meeting.	
1.4	**Review of Action Log and Matters Arising:** **Action 2023/001 – Exploration of QR Code for Staff who were thinking of leaving** T King advised that a QR code with questions could be created and she would work with IT and the Communications teams on the best way to promote and alert staff to it. However, she queried the direction and focus of the questions within, was it to try and generate more knowledge as to why staff were leaving or whether to deter staff from leaving, given that the stay conversations would be utilised widely. S Rawlings understood that this proposal was to enable a different route for staff to provide information and data for monitoring purposes. A Race advised that the prompt had come from J Hemans to explore this facility to capture staff as they were leaving. C Davis commented that it was propose as an additional option for staff who felt that they could not articulate themselves at the exit interview. A Race advised that this been discussed in various forums such as the Nursing Workforce Forum and the Attract and Retain group under the broader retention plan and further work was required to establish the best methodology for gathering data and intelligence. A Duffell commented that as the joint HR Strategy was currently under review and recruitment and retention would be one of the key areas of work, he proposed that this was put on hold for the time being until the strategy had been developed and the key actions identified; S Rawlings agreed to this proposal. Action closed.	
1.4.1	**Retention and Turnover Update Report (Action 2023/002)** A Race advised that the Committee had been considering a BAF risk around retention and he had prepared the update report to provide benchmarking data on a number of people indicators from Model Hospital and had brought forward a review of the strategic objectives for the Committee to review and consider. He reported that comparatively speaking, RWT was in the best quartile in the country	

Agenda Item No		Action
	for retention across staffing groups although there were some areas of challenge and he provided a brief update against the strategic objectives. S Rawlings commented that there were a number of positive areas and the Trust was performing well against the average, however, the question was whether the committee needed to consider a BAF against retention to increase awareness and monitoring of this position. A Duffell proposed that the Committee consider this further later in the meeting after taking into account the internal workforce reports.	
2.	**Key Updates and Workforce Performance s**	
2.1	**Key Updates**	
2.1.1	**Revised Joint People Strategy** A Duffell reported that the Joint People Strategy covering both RWT and WHC was currently under review and progressing.	
2.1.2	**National Pay Offer** A Duffell reported that an offer for agenda for change staff had been made, but this had not yet been formerly accepted as the Unions had to take this offer back to their members. He advised that the BMA were in negotiation discussions around the junior doctors pay, however, four days of industrial action had been announced and would take place immediately after the Easter Bank Holiday.	
2.1.3	**Black Country ICS – Finance, Workforce and Activity Data** A Duffell reported that the Trust was due to submit the triangulated data on finance, workforce and activity for the year ahead to the ICB.	
2.1.4	**National Workforce Plan** A Duffell informed that NHS England were working on a national workforce plan which he understood would be due in May.	
2.2	**Executive Workforce Report** A Duffell reported that the Trust vacancy rate was below 3% which was an incredible position and although the Trust was in a good position nationally for retention, it was not meeting the internal target set. He advised that there continued to be more starters than leavers and there had been some improvements in mandatory training and appraisals even though the past three to four months had been very difficult from an operational perspective. In response to a question by S Rawlings on the attendance and engagement during the Race Equality Week, A Race advised that there had been a marked improvement on the previous year's event and B Everitt, Head of EDI, had been very positive, given the operational pressures within the organisation and the difficulty in staff being released to join events. He informed that the Communications Team had widely supported during the week but acknowledged that there was always more work to be done to engage with our staff.	

Agenda Item No		Action
2.3	**Key Updates from the Operational Workforce Group (OWG)** A Race reported that at the last meeting, the OWG had received and considered the Hard to Fill report and this would be brought to each meeting in order to assess and align against any challenging vacancies reported within the Trust risk register by the Deputy COOs and colleagues. He advised that as a subset of that report, data on hard to fill posts was shared with colleagues across the System as part of the Provider Collaborative work, in order to consider any possible shared solutions. A Race advised that the Group also received the Resourcing report and there was some positive information on the time to hire reducing and an update on the recruitment event which saw 300 people attending and five qualified nurses offered positions.	
3.	**Formal Review / Sign Off**	
3.1	**PODC Work Plan for 2023-2024 and Joint PODC Terms of Reference 2023-2024** The Committee agreed to the proposed work plan and terms of reference for 2023-2024; S Rawlings advised that A Heseltine had provided written confirmation of her agreement. It was also agreed that the update on voluntary services was to be received on an annual basis unless the Committee requested an update by exception. It was agreed that, given the busy agenda and to allow for some flexibility, the Divisional Deep Dives would continue on an annual basis but the proposal to consider deep dives for the corporate areas would be parked unless any specific issue were identified and an update would be requested by exception.	
3.2	**Workforce Targets and Thresholds** A Race briefed the Committee on the proposals for the workforce targets and thresholds for the forthcoming financial year. Key points to note: • Sickness absence target continued to be challenging and proposed a stretching but improved target of 5%; • Appraisals – no change to target • Mandatory training – no change to current target • Vacancy rate – no change to current target • Turnover – proposed a slight increase to the current rate • 12 month retention – to remain the same target rate and proposal to remove the 24 month retention target as this was not benchmarked anywhere else • Bank fill rate for medical staff – following the implementation of the new system, proposal to increase to 70% • All others to remain unchanged S Rawlings queried whether the proposed bank fill for medical staff at 70% was sufficient to support continued improvement, given the recent rates. A Race commented that this seemed an acceptable level, given the newness of the system.	

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	A Duffell advised that the proposed bank fill rate at Dudley was 80% and queried whether a common target across the three Trusts would be beneficial for consistency. He agreed that he would be supportive of taking out the 24 month target for retention but queried whether the 18 month target would still be monitored as he understood that Walsall would be looking at this rate. He asked that A Race liaise with K Brogan at Dudley and C Bond at Walsall on these points. A Race advised that RWT had three target rates for the bank fill rates, 80% for nursing, 90% for unregistered nursing and 70% for doctors. The Committee agreed, that subject to the changes discussed and agreed action, the targets were approved.	**Action: 2023/015 A Race**
4.	**Strategic Focus Areas**	
4.1	**Deep Dive Report – Radiology, Division 3** G Whitehouse, Group Manager for Radiology, presented the deep dive report on Radiology which provided assurance on positive recruitment, retention development and trends over the past 12 months. Key points to note: • In order to support the extensive ambitions for growth and service development, which required a strong workforce profile, the directorate had appointed a dedicated workforce recruitment and development lead. This role was not a standard profile within Radiology departments and the appointment has had a real positive impact which has garnered interest from regional and national colleagues within Imaging. • Following this appointment, the number of staff members has increased over the past 12 months by 65. • Twenty substantive employees have been offered opportunities to progress into alternative or newly created posts within the department such as apprentice radiographers, patient flow coordinators and team leaders which has positively supported the retention of staff. • International recruitment of staff has seen 16 qualified radiographers appointed and one international nurse join the department. • Sickness absence within the department was in line with divisional standards. • There was a wide ethnic diversity within the department with 35% of staff members of an ethnic background. • During a recent recruitment drive for band 5 radiographers, the department received a high number of applications from all over the UK. • Two lead clinical educators, partially funded by HEE, have been appointed to support staff with opportunities for learning, career development and pastoral care. • Strong relationships developed with external stakeholders. • Opportunities for ‘step into health’ and the Princes Trust being recruited to and the lead educators would join the NHS Futures teams at school recruitment events. • Communication with leadership teams encouraged and drop-in sessions scheduled and an open door policy. • A departmental action plan devised in January 2022 outlined key targets around workforce growth, sustainability, equipment replacement and KPIs. An update on this was shared with colleagues and identified that key actions had been completed or event exceeded.	

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	• One of the actions was to develop a profile for radiology apprentices with Keele University and there was every confidence that this would continue going forward. • Future development plans include the expansion of RCT services in line with seven day services and continued overseas recruitment. G Whitehouse stated that it was recognised that the support offered for financial reimbursements and pastoral care for the CFP nurses and midwives differed to that offered to other professionals and requested for an opportunity for this to be reviewed and aligned. A Race informed that the OWG had discussed this in depth and it was noted that one of the main differences in funding and support was around accommodation and that nurses were able to make use of student accommodation available at the University but the teams were aware of this issue and were following up on action around this concern. On behalf of A Heseltine, S Rawling queried the cost of accommodation as reported and queried whether this was the same for the international nurses. T King advised that as reported, the nurses were able to utilise student accommodation at the university whereas the radiologist were provided with hotel accommodation. However, there has not been sufficient accommodation at the university for the nurses, therefore, alternative arrangements have also had to be put in place. S Rawlings queried, as part of the continued support of staff wellbeing, whether the department teams had been involved in the regular Schwartz Rounds held at the Trust to maximise the support available. G Whitehouse commented that this was an area that could be progressed. A further comment received from A Heseltine was that the pastoral care needed to match the nursing pastoral care and she had queried as to whether the two areas could support each other rather than working in isolation. S Thomas advised that the pastoral care for nursing was run by the corporate team, but would be happy to work together on a single approach for pastoral care. C Lisseman advised that pastoral care was also available through the apprenticeship team. In response to a question from S Rawlings on what further work may be required to support and improve staff morale, G Whitehouse stated that one of the biggest issues was around work pressures impacted by vacancies, therefore, by continuing the initiatives on workforce recruitment would be important to ensure work pressures were kept at a reasonable level. S Rawlings suggested that the details on the Career Wellbeing Conference scheduled for the 28th March were shared with colleagues to highlight the event and queried whether staff would be attending the health and wellbeing training for managers and supervisors; G Whitehouse stated that he believed that colleagues would be in attendance. In response to a query from S Rawlings on an employment tribunal, A Race provided an update on this to the committee which was in relation to a management of change process. He advised that there had been wide engagement with staff and the regional union representative for the Society of Radiographers in order to try to reach an agreed resolution.	

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4.2	**Health and Wellbeing Update** P Nar provided an update from the reports presented, key points to note: • The Trust was holding the first Health and wellbeing and Career Wellbeing conference on the 28th March where the stand alone Menopause policy and guidance would be launched. • A health and wellbeing employee voice group to be launched. • The wellbeing hub continues to support staff by offering a food bank and free breakfast refreshments daily. • Collaborative work continues with colleagues at Walsall and at Dudley. At Walsall, looking to introduce a stand along policy on neuro-diversity and a joint health and wellbeing initiative calendar. • The Trust would be taking part in the Improve Well Pilot which was being hosted through the ICB and jointly piloting the Improved Well app with the Dudley Group. In response to a question raised by S Rawlings regarding the Wellbeing conference, P Nar advised that the event had been widely publicised through all the communications media channels as well as pull-up banners posted around the site and events would be available at all three sites. In regards to the bookings, to date, numbers had looked very positive. A Duffell questioned how closely the menopause policy was aligned to the national policy, P Nar advised that the team had been privy to review the national policy prior to its release so the RWT policy was closely aligned. P Nar highlighted the key points from the dashboard data, which reported on: • Management referrals into the OH department • Fast track service implemented for physiotherapy for staff with the majority seen within 10 working days • To support staff, the Employee Assistance programme was still available and provided by BHSF. • The mental first aid training programme was to be reinstated. • Health and wellbeing champion training continued to be rolled out. • 360 staff had completed the Respond Training on wellbeing conversations and the training has received some good feedback. A question submitted by A Heseltine was around assurance that as many different areas and departments of the Trust were joining the training offered; P Nar commented that the training sessions were widely publicised and going forward she would look at including this data within her update report as attendees' areas of work were recorded.	**Action: 2023/016 P Nar**
4.3	**Digital Workforce Impacts Update** A Nisbet provided an update on the report presented, key points to note: • The outcome results from the Woden survey, which was the Wolverhampton and Walsall digital enablement programme looking at the capabilities across the workforce at both organisations was due to be presented. However, there had been some delay in pulling the information together and this was currently being validated. She advised that she would bring back the results report to a future meeting. • The Digital Fellowship programme was a flex on the clinical fellowship programme and was around creating opportunities for digital healthcare	**Action:2023/017 A Nisbet**

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	for people within the organisation. The Trust currently employed three digital fellows who were mentored by Microsoft. • Work was underway with Microsoft on the development of creating a syllabus for a digital apprentice and she would be linking in with the Trust's apprentice team and Lead to look at developing opportunities for people within the organisation, which also linked into the NHSE digital workforce plan, to build a digital workforce and build capacity and expertise in this area. S Rawling queried, on behalf of A Heseltine, how staff were responding to the work. A Nisbet commented that there had been an increase in staff contacting the department to find out how they could engage with digital better, how they could access the skills and whether any mandatory training or a syllabus for training would be available. She stated that the work with Microsoft would support and create some of those opportunities and the outcome results from the survey would provide guidance as to what the workforce wanted and needed going forward.	
4.4	**Staff Engagement and Surveys** G Parry provided an update on the outcomes from the national 2022 NHS Staff survey. She reported that the People Promise was now being recognised and embedding across the Trust and it was a useful tool in engaging staff in the survey. The key points to note: • 34% of staff engaged with the survey, which was slightly lower that the previous year, but to note, the Trust's headcount had increased. • The survey had been a full census, open to all staff, and there was increased opportunities for staff to be able to complete on line. • The survey had been open to all bank staff and this would become mandatory from 2023. • The work around the staff survey was a continuous activity throughout the year and a new "Creating a Great Employee Experience voice group" had been established. There were a number of initiatives being developed, a number of these jointly with Walsall, such as the Joint Behavioural Framework which would support in boosting staff morale etc. • The Divisions and Directorates were reviewing and reassessing action plans against the results which would be monitored by the Staff Survey Oversight Group and these would be cascaded down to staff groups. S Rawlings commented that given the work around Race Awareness it was concerning that staff continued to experience discrimination and that staff were feeling pressured at work. In response to a question put forward by A Heseltine on whether the working practices in the areas highlighted in green were replicated in areas highlighted in red and was there any gaps in leadership, G Parry reported that there was continued focus in all areas to make further improvements. A Duffell commented that in terms of leadership, it might be worthwhile identifying the vacancy position for any areas in red as some areas may be suffering due to vacancy gaps. G Parry advised that for one area within the Trust, the team had carried out an assessment to provide a culture heat map which had proved to be a very worthwhile exercise. S Evans commented that the NHS has had a difficult couple of years during and following the pandemic, and given the current financial climate, this would all add	

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	additional pressures on staff morale and wellbeing. To start to improve people's mindset going forward and to support the behavioural change programme which would take time to embed, physical conversations with staff on the ground were needed in order to start to build on the change culture and good practice. A Race stated that at the March Staff Survey Oversight Group, it had been agreed to bring back the divisional action plans to the May Oversight Group meeting alongside some triangulation of divisional data and this would be brought to PODC for information.	
5.	**KEY RISKS**	
5.1	**New Risks** In response to A Duffell's query to the Committee as to whether they considered the requirement for a BAF risk on retention, A Race queried as to whether the retention position was affecting the Trust's ability to deliver on its strategic objectives. He stated that there was a good supply of staff and there were low vacancy levels, with the main risk around skill mix and experience, so the current retention position did not stand out any more than other areas in not meeting the set target. He informed that the update on retention was presented to the Committee every couple of months through the resourcing report, so there would be continued focus on the position, and he proposed the requirement of a retention plan in order to be assured of the delivery in improvements. A Duffell proposed that as that the Trust was not a national outlier, the divisions were not highlighting retention as a continued risk and the Joint Strategy was underway and would include elements on retention, that this issue was brought back for further consideration in six months time unless there was a change in the data presented that caused some concern. C Wilson advised that NHS England had issued five high impact actions for nursing and midwifery on retention, which were not purely for nursing : • Introduction of pension advice • Medical guidance • Working towards preceptorship goal framework • Introduction of legacy mentors and • Completion of self-assessment tool, which has been completed and submitted to the ICB. She advised that the five requirements had been actioned and proposed that these were also brought back in six months for reflection, unless the data reported something different. The Committee agreed with the proposals put forward, to keep a watching brief and to bring back this item for consideration in six months time, unless the data raised concerns in the meantime.	**Action:2023/018** **A Duffell** **A Race**
5.2	**Board Assurance Framework (BAF)** A Duffell reported that there were no changes to the current BAF risk SR17 and no additional comments raised.	

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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 areas of focus had been covered during the meeting. A Duffell requested M Dent to identify when the initial 12 month objectives had been agreed as these were possibly due for reconsideration for the next 12 months ahead. S Rawling requested that the new Chair for the Committee would was informed of this requirement. A Race commented that as previously mentioned, the Trust Workforce strategic objectives were due to the May meeting and would be happy to consider these as part of that work. However, with the joint strategy underway, this work may also inform the strategi objectives, so was a transition year.	**Action:2023/019** **M Dent** **A Heseltine**
7.	**Any Other Business**	
7.1	**Final meeting for S Rawlings, Non-Executive Member** S Rawlings advised that this was her last meeting as one of the Non-Executives members of the Committee and thanked the committee for their support over the last few months.	
8.	**Items for Escalating in the Chair's Report to Trust Board** Items noted for escalation to the Trust Board as part of the Chair's report : • Revised Joint People Strategy • Junior Doctors pay proposal • Workforce, Finance and Activity Planning submissions due to the ICB • The agreed targets and thresholds for KPIs • Radiology Deep Dive update • Health and wellbeing Conference and launch of the menopause policy • Digital workforce update • Review of the strategic objectives • Retention review and the agreement to reconsider the risk position in six months	
9.	**Evaluation of Today's meeting** The Chairman thanked the group for their contributions, challenges and participation in the meeting.	
10.	**Date and time of Next Meeting** 9.30am-11.30am, 26th May 2023 via MS Teams	

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	**Wednesday 22 March 2023**
Venue	**Virtual (via MS Teams due to COVID 19)**
Time	**1.00pm to 3.00pm**

	Name	**Role**
Present:	Louise Toner **(LT)** Chair	Non-Executive Director
	Allison Heseltine **(AH)**	Associate Non-Executive Director
	Debra Hickman **(DH)**	Director of Nursing
	Dr B McKaig (**BM)**	Chief Medical Officer
	Michelle Metcalfe **(MMe)**	Group Deputy Director of Assurance
	Martina Morris **(MMo)**	Deputy Director of Nursing
	Gwen Nuttall **(GN)**	Chief Operating Officer

Apologies:	Kevin Bostock	Group Director of Assurance
	Ann-Marie Cannaby	Group Chief Nurse
	Julie Jones	Non-Executive Director
	Dr J Odum	Chief Medical Officer
	Dr G Pickavance	Non-Executive Director
	Catherine Wilson	Deputy Director of Nursing

Attendees:	Dr Richard Heaver **(RH)**	Clinical Director – Neonatology
	Dr Nina Johns **(NJ)**	Consultant Obstetrician
	Tracy Palmer **(TP)**	Director of Midwifery

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1	**Apologies for absence** Apologies were noted.	
1a	**Declarations of Interest** None declared.	
2	**Minutes of the Previous Quality Governance Assurance Committee dated 22 February 2023** MMo asked for the following changes to be noted for the minutes: • Page 4: Can we change the statement re PU Summit as follows: **There was a pressure ulcer summit held in February to discuss recent incidents and enable us to take forward key learning.** • Page 5: Can we amend the statement referring to the wound healing and prevention document as follows: **The Trust has developed a wound healing and prevention ambition plan.** • Page 6: **Bacteraemia is misspelled – please can this be corrected.** • Page 8: Please can the statement referring to international staff be changed as follows: **MMo stated that it was important to acknowledge the large contribution international staff are making across the organisation.** • Page 10. Please can the recent visit statement be changed as follows: **MMo commented that following a recent NHSE visit**…. *then leave the rest of the statement as it is.* • Page 11: can we amend this statement as follows: **MMo asked the meeting for their opinion on the strategy and asked in the committee were content to take it forward to TMC in March and subsequently Trust Board for sign off in April.** The minutes dated February 2023 were accepted as a true and accurate record.	
3	**Matters arising from the Minutes** Action log updated accordingly.	
4	**Regular Reports**	
4.1	**Cancer Improvement Plan (for information only) – G Nuttall** The attached was received and acknowledged by the group. GN informed the meeting that even though the metric looks like a sea of red, GN believes that the Trust is making improvements against the various metrics. The expectation of the numbers of patient waiting over 62 days has increased from 2022 / 2023 into 2023 / 2024. The Trust was supposed to achieve a target of no more than 140 people waiting over 62 days, however in 2023 / 2024 the number will be increased to 195.	

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	This has happened nationally, due to more people being referred into cancer via the 2-week wait or being picked up through alternative portals with a diagnosis of cancer. Unfortunately, this is a legacy of COVID. Also, the expectations of the acuity and staging of the cancer treatment. This new Trust target for the number of people waiting at the end of March 2024 is 195, currently the Trust is at 260 people, GN noted the challenges the Trust is facing to hit the target. The biggest area of concern and one of the largest volumes of tumour sites is renal / kidney. GN advised the meeting that the Trust had been struggling with managing and coming up with a plan to reduce the number of patients waiting. There have been several meetings and in February following discussions, the managerial approach to seek mutual aid had produced nothing, therefore, an alternative route was sought and this involved using the national GIRFT team for Urology. BM informed the meeting that discussions have been held with a Leeds hospital who seem to be willing and keen to be able to take some patients from this Trust and with two London hospitals, both indicating their willingness to help out. The Trust is currently writing to all of the patients affected, asking the more urgent patients (65) if they will be happy to travel to have the required surgery. GN mentioned that the Surgeon at this RWT is undertaking additional lists, taking into account his mental and physical wellbeing. GN reported that the Trust is looking to explore the use of the private sector, which will use a Consultant who works at Stoke. The meeting was informed that Dudley completed a urological procedure last week, using robots. A much longer strategic plan will come into place across the Black Country for the treatment of urological cancer, but the backlog has to be cleared before there is any chance of success. GN reminded the meeting that this issue is on the Trust Risk Register. LT commented that it is a positive way forward for the Trust. GN confirmed that by 31 March 2024 this Trust will have no more than 195 patients waiting over 62-days for their treatment. GN informed the meeting of the Histopathology turnaround times, they are currently no way near where they should be, for either RWT or as a system. Further ongoing discussions will be held with BCPS Management Team with regards to improvement of the turnaround times. GN reported that BCPS have a plan for recovery, however, this is currently too long. A Trust Cancer Clinician has been appointed.	
4.2	**Trust Risk Register – M Metcalfe** MMe presented the above report to the meeting. The meeting noted that there were five new risks: ➢ 5984 – Urology Renal Surgery ➢ 5479 – Cath Labs Capacity Risk	

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	➢ 4913 – Emergency Gynaecology Service in D18 and lack of Gynae Ward ➢ 5980 – Back log of new Gynae Patients – capacity does not meet demand ➢ 5619 – Inadequate ventilation in all Birthing Rooms on Delivery Suite The meeting was advised that the removed risk 5677 is the correct number but the incorrect written explanation. This risk has been merged into a Trust wide risk. MMe to amend the front sheet. There are seven red risks: ➢ 5849 – Reduced scan capacity in Fetal Medicine Department ➢ 5802 – Division 2 MFFD patient numbers ➢ 5246 – Lack of Consultant cover with Caner Services ➢ 5610 - Increase in Haemodialysis numbers ➢ 4900 – Histology cases breaching turnaround time target ➢ 5667 – Cancer backlog ➢ 5388 - Mental Capacity Assessment MMe noted that the above risks had been on the risk register for a while. The meeting noted the following risks that were overdue a review: ➢ 5536 – Provision of Mental Health Beds ➢ 5388 – Mental Capacity Assessment ➢ 5488 – Safe medicines management ➢ 5610 – Increase in Haemodialysis numbers LT asked why the above were overdue especially 5388 and 5488 as a large amount of work has been undertaken in these areas. LT enquired how long a risk is allowed to be overdue before it is reviewed and if this due to work pressures. DH advised that 5388 had been on the risk register for a while. DH continued that the quantification of numbers, what should be expected in the organisation. Some of the delays are due to benchmarking and visits elsewhere, to look at example where there is a high level of MCA reporting to determine the drivers and how this is being managed. Good information has been brought back and is helping to inform what actions the trust needs to take to review of the risk. DH apologised for the delay; however, DH feels that the visits were really important in terms of quantification and some external learning. The risk will be updated and the Head of Safeguarding is taking the lead. Regarding risk 5488, DH has met with the Clinical Director of Pharmacy and Medicines Optimisation who confirmed that there has been a lot of dialogue in terms of progressing as a lot of the actions will require resource and will be added to the risk register accordingly. BM confirmed that there is currently an issue with storage and Estates for to secure temperature-controlled fridges and other facilities sand therefore, it was difficult to update this risk at this current time. The risk also includes Medicines administrations audits that are being completed in non-EPMA areas. BM suggested breaking the risk down into actions to be undertaken / in plan / in place. AH replied that she supports the suggestion to split the risk as it can help with evidence to CQC that the Trust is progressing this risk. This was agreed.	

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	BM commented on the Mental Capacity Assessment risk 5388 and noted that this organisation has taken over the mental health risks and redefining them. BM advised the meeting that risk 5536 relates to something that this Trust has no control over, it is tier four beds across the system. BM suggested that this risk should be removed as it is a system risk and not a RWT risk. LT noted that the gall bladder disease risk 4596 has been on the risk register for quite some time and if it should be removed or as there are dates in 2024 if it should stay. This led to LT asking what happens to the risks that have been on for more than three years and enquired if they need to stay on etc, noting that one risk has been on the register since 2008. MMe commented that this is a good example of where the Trust needs to refresh. GN mentioned that risk 1984 sits under herself and that will be removed. After a discussion MMe invited LT and AH to the May bi-monthly Risk Register Review meeting. LT asked the meeting if we should be concerned with the number of risks relating to Gynae. GN replied that she is not worried about potential harms in Gynae, there is challenges around their waiting lists, following an increase in referrals for benign and malignant disease. The cancer referral numbers that have been received in recent months has been higher than predicted. GN confirmed that there is some backlog challenges and some increase waiting time pressures (the reason for the risk 5980). GN explained the reasons behind the delays including issues with Histopathology. Actions already in place include Saturday and Sunday working. Regarding risk 4913 GN informed the meeting that this risk was post COVID and changes were made following COVID as to where emergency Gynae patients were placed. GN assured the meeting that she does not feel this is a problem just a patient experience issue. DH agreed with GN. AH thanked GN, DH and BM for their explanations and raised a concern about staff morale. DH confirmed that there has been changes in leadership, workforce turnover. The meeting was advised that there has been a wrap-around support programme provided, both locally from Divisional and also from Corporate (a well-articulated action plan is in place which is being monitored via Divisions). AH asked if there will be an external review, BM advised that there is not an external review but there is an internal review based on a recent survey within General Surgery. BM mentioned that he is expecting an AGE review in May / June (date to be confirmed). There will be an internal review in April to look at the issues. BM informed the meeting that there is a lot of dissatisfaction country wide within General Surgery trainees, due to less supervision because of the nature of the Medical Wards having more senior support than General Surgery.	**MMe**
	Trust Risk Register Heat Maps – M Metcalfe This item was not discussed.	

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	Board Assurance Framework In the absence of Keith Wilshere, this report was deferred until April meeting.	
4.3	**Integrated Quality & Performance Report February 2023 – D Hickman & G Nuttall** DH presented the Quality section of the report to the meeting the following: There has been a small increase in complaints with a change in themes, there has been a reduction in numbers relating to general care, but it now relates to clinical treatment (appropriateness of treatment). Communication is now a theme with a shift from attitude to behaviour. Regarding Friends and Family Test (FFT), there is a small increase but across the Trust all of the touch points apart from a couple which are static have seen some increase. There is improvement in Emergency Department and In-Patients. DH reported that a lot of focus has gone into observations being on time and there has been a general improvement across the Trust, including the areas which have been experiencing more challenges. DH happily reported that the staff seem to be engaged and receptive to this piece of work. A summit was held regarding pressure ulcers and falls, again there has been improvement in the data submitted. DH advised the meeting that work continues in regard to C-Diff. Care Hours Per Patient – there is a slight increase in the registrant aspect, however, when the support staff alongside the registered are considered there has been a dip. There is a lot of activity through recruitment, the Clinical Fellows on the Ward E-Rosters. However, work needs to be undertaken on how to capture the data in E-Roster. GN presented the Performance section of the report to the meeting and advised that at Performance & Finance (P&F) regarding some of the metrics, predominately Emergency. GN noted the improvement that has been seen in January but particularly February regards to the ambulance handover. GN commented that this improvement has been since the additional capacity (ambulance receiving centre) has been available. The meeting was informed that the number of patients who are medically fit for discharge/do not meet the criteria to reside, the report states 65, however, GN reported 80 as the number as she includes Rehab patients. An action agreed at P&F earlier that an update would be undertaken of all the winter actions taken at place level. GN feels that report should come to both P&F and QGAC. LT asked what happens when the winter monies cease. GN replied that there will be two sources of money available. One will be purely the NHS (urgent & emergency care funds). The Trust has put in submissions for the bids and the Black Country have already been allocate £2.7million for the urgent & emergency care continuation. This is the lowest allocation	

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	received for the ICB's across the West Midlands and possibly nationally. The ICB will be appealing, enquiring why the amount is so low when additional support and funding was requested. RWT has received just over £600K and this is to retain the 12 beds that have been opened on the Gastro ward. GN advised that the second amount of money will be from the Service Development Funding (SDF) will be allocated through Better Care and will be a place-based scheme and this meeting will be held in a couple of weeks. GN explained what will happen once this meeting has taken place. LT enquired about the streaming and navigation pilot that is being run over two weeks. DH advised that is part of the national recommendation run by Emergency Departments up and down the country. This has essentially now been run by the RWT as a point of contact and run by a senior decision maker before the point of entry into the emergency department. This commences today as a pilot. AH mentioned that she had walked around the ARC and noted how positively staff were talking.	
5	**Subgroup Reports**	
5.1	**Quality & Safety Advisory Group Meeting – March 2023 – Chair's Report – Dr B McKaig** BM presented the Chair's report from February's QSAG meeting and noted the key items from the meeting: Successful increase in staffing numbers across nursing and the recognition of skill mix. A concern raised at the meeting was in regard to the audit completion rates which are low across three Divisions. BM has spoken to the Trust Audit Lead and reported that quarter four is a catchup opportunity and normally the figure would be around 70 to 80% of audit completion. Due to staffing issues in Governance and the Audit Lead having left, it is difficult for the Trust Audit Lead to be able to give an accurate number as to where the Trust is sitting currently. However, it is anticipated that the Trust will achieve 60% completion by the end of the year. The Trust lead is having trouble getting a formal report completed due to the gaps within the Audit and Governance teams (RWT). Assurance was given that there are still on-going audits within the Directorates, however, pulling them together in a formal report has been challenging. Therefore, the lead was unable to give a definitive position as to where we will get to. BM feels that some of the operational pressures that have been experienced over December and January and then recently with strike action will have an impact. On a positive note, the Cannock Chase Hospital surgical hub was approved with no conditions. LT asked about NICE Guidelines and alerts over 12 / 18 months and asked if this was connected with the Audit Department. BM replied that the way that the Trust manage some of the NICE guidance, is probably "long winded". BM commented that looking at how some of other organisations manage this Trust's processes are over-robust. There were no concerns about NICE Guidelines that were open that were a clinical risk, however it was highlighted that there are problems in terms of support for this group from the Governance Team. BM stressed that he is not putting it all towards the Governance Team as the Trust	

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	should manage when there are challenges around staffing issues. There have been no risks escalated around NICE Guidelines which had not been responded to. LT enquired about SEPSIS within Emergency Department (ED) noting that it is not as good as it needs to be. BM commented that the overall Trust SEPSIS data is challenging. There is going to be a change to how SEPSIS will be monitored. BM mentioned that there is still an expectation of antibiotics within one hour, which is where ED probably have more difficulty. LT commented that Walsall Healthcare Trust have had an increase in the number of patients with mental health issues attending ED and noted that it seems to be similar to this Trust given the very limited resources within Primary Care to be able to support individuals with mental health issues.	
6	**Assurance Reporting / Themed Reviews / Business**	
6.1	**Maternity Services Governance Report – T Palmer** TP presented the above report to the meeting and noted that annual bookings are slightly up over the past quarter, this is monitored daily. Despite this the Trust will be on plan for no more than 5,000 births. Births on Midwifery Led Unit (MLU) have remained stable however, there was a reduction in February. Regarding Smoking Cessation, the Trust is average to all the other Trusts as evident within Badgernet (database). However, the Trust has not hit the target of 6%. A full service would help to reduce this figure. Funding has been secured from the Local Authority via the Healthy Living funding. This has been secured for two years and has been helpful and the Trust has been able to appoint two more support workers to support the team. Induction rates, data pulled from Badgernet, indicates that the Trust is not an outlier. A piece of work is ongoing regionally to ascertain how delays can be reduced for women within the local hospitals. A joint piece of work is ongoing to see how women can be transferred safely, for example if Walsall have capacity. Regarding HSIB cases, from April 2019 to date there have been 24 completed investigations. Following these investigations, the majority of safety recommendations were around guidance (37%). This has been broken down to look at the themes and the biggest theme was related to a lack of service for Placenta Histopathology. A plan is now in place so this has improved following an agreement with the Pathology labs at RWT that they will do the recommended Histopathology on the placentas. TP noted the perinatal mortality report for October 2022 to January 2023, Clinical Negligence Scheme for Trusts (CNST) and advised the meeting that the Trust is at 100% with all of the standards and criteria. LT asked if TP had received confirmation that the above report was ok. TP confirmed that validation checks are taking place, however, this week a letter has been received stating that	

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	they are having problems with the database / cross referencing safety action 10 (early notification). AH asked TP what XUT was the abbreviation for. TP replied Ex Utero Transfer, these are women who have had babies in other units and being transferred with their babies after birth to our unit. AH enquired how learning is shared with other units if the Mum and baby has been transferred. TP reported that shared learning has greatly improved with the local maternity and neo-natal system. There is a workstream called the Best Start Workstream and some of the cases would have been discussed at this group and learning shared. The learning is then taken back to the units through a poster, monthly newsletter in terms of what has been learnt also it is taken through local forums and Governance. Cases are also discussed at the Operational Delivery Network (ODN) and at the Operational Board meetings for the LMNS. TP assured the meeting it is much improved than it was before, more outward sharing rather than locality. AH mentioned the safety recommendations from the Midwifery Services Governance Report, noting that 2.4 states that 15 of the completed reports having safety recommendations requiring an improvement related to local guidelines. AH enquired what was being done. TP replied that these are the other safety improvements that were revealed from the themes from the reports and they are broken down into themes. TP continued to explain the guidance and learning from this report. TP offered to breakdown the report for ease if the membership would like her to. AH asked if there are safety concerns what is being done about them. TP suggested that this she meets outside of this meeting with AH to discuss this report further. DH informed the meeting that the actions are discussed / reviewed / integrated at Executive Significant Event Review Group (ESERG). DH mentioned that there was a presentation created for staff within Maternity and she suggested that it could be shared with this meeting. TP to forward. DH advised the meeting that TP takes the report from ESERG into Trust Board in terms of SUI's. DH informed the meeting that she attends the HSIB feedback meeting to the Maternity Service and there are no alerting concerns from HSIB. DH suggested that some of the reports from HSIB can be shared with this meeting for assurance. LT noted in the SUI report with HSIB, about active cooling, regarding a discussion taking place about a certain case and it was determined that some of the key issues were not really an issue and would it have made a difference to the outcome. TP confirmed that all issues raised are picked up. TP assured the meeting that the babies are discussed at the weekly Governance forum, actions are picked up via the minutes and the expectation is these would be picked up immediately and confirmed the following week.	**TP**
6.2	**MBRRACE Report – 2020 – Dr Heaver / Dr Johns** NJ and RH presented the above report to the meeting noting that the report was produced in 2020 and released in November 2022. The report gives crude rates for still births / neo-natal deaths and then stabilised and adjusted rate. This is key into where a Trust is in the maternity / neo-natal services in terms of whether we are still a level three perinatal unit (RWT is currently one of these).	

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	Overall, the rates are slowly trending downwards (RWT), the position in line with the country rate which is also trending downwards. Looking at the population for this Trust compared to the national averages, Wolverhampton has twice the number of births between 24 to 27 weeks compared to the national average by population. Our population have a much higher rate of pre-term infants and that is associated with excess mortality. Also, the rates of deprivation, so the number of women giving birth in this Trust are more likely to live in areas of high deprivation than those giving birth across the UK. RJ suggested that the Trust needs to look at why women are delivering early and what can be done to improve the outcomes for these women. RJ reminded the meeting that during the period of the report it was COVID during 2020, where this area had some of the highest rates of infection outside of London and this affected our pregnant population, and it is now known that COVID has an increased risk of still-births. RH agreed with the above reporting and reminded the meeting that this hospital is relatively small for births, however, being a level three perinatal centre, the Trust has all of the high-risk women from the Black Country. The figures are worked out by the number of babies who die by how many births the Trust has, therefore the Trust is at a massive disadvantage. The Trust has around 5,000 births where some Trusts have 10,000 per year. The meeting discussed further noting that areas that score badly are those with high deprivation. RH suggested that women from high risk should be monitored more regularly at the Trust where hopefully the mortality figure would reduce. This was discussed further noting that a lot of these Mum's smoke, come from a high deprivation area etc. RJ mentioned that this would bring a lot of work to the Trust and potentially a lot of pressure to the Neo-natal unit. GN asked how does this area benchmarks against other areas of high deprivation. RH replied that the report does a good job of breaking areas down, however, no one area has the same issues as other areas. The key is, can this Trust bring the rates down and continue to bring down and possibly accept that this Trust will not get better than 5% categories. RJ agreed it would be a good idea to look at the data further for comparison. RJ asked about substantive funding for the smoking cessation service because this is an area which the Trust can influence. The Trust needs the confidence and a dedicated team to make the difference. DH agreed that this was a valued point and it is recognised that during COVID some of the priority work dropped. LT thanked RH and RJ for a very useful and informative discussion on the report.	
7	**Themed Review Items**	
	No issues to report this month	

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8	**Issues of Significance for Audit Committee** There were no issues of significance for Audit Committee. **Issues of Significance for the Trust Board** LT to produce a Chair's report and circulate for comment.	
9	**Any Other Business** LT informed the meeting that this meeting should normally get a Safeguarding report four times a year, however, the Head of Safeguarding across RWT and WHT had suggested that this is reduced to twice a year, a report in May (quarter 3 and quarter 4) and a report in October (quarter 1 and quarter 2). LT asked if there had been any discussion at RWT, noting that the Director of Nursing at WHT had approved this request from the Head. LT asked if the meeting thought it acceptable / happy to receive this report twice a year. DH replied that she thought it was due to the timing of the Trust Board reports. DH to speak to Head of Safeguarding and feedback to the meeting. ********** DH discussed with the meeting a potential Never Event that is out for an external review with a Consultant Dermatologist. There was an incident whereby there was some deliberations and conversations around whether it was a Never Event and the information the Trust had at the time; it was felt not to be. As a subsequent RCA was produced it gave more of an opinion that it did meet the criteria. It is a complex case hence the external review was sought. ********** DH informed the meeting that a Letter of Action was received last week from the Coroner which was relating to a fall. The incident had gone through the Serious Incident process, had been investigated and the issue when picked up by the Coroner was one of the completion of actions and timeline, secondly around the deliberation and the decision making of avoidability. A piece of work is being undertaken around pulling together the narrative, actions and updates for the Coroner, there is a fixed time for a response. This will update the process that is within MMo's team. ********** LT asked if the report had been received following the review of IPC processes by the Regional Infection Prevention and Control Nurse had been received. DH confirmed that the Trust had sent a reminder but are currently still waiting. ********** AH advised the meeting that she has now finished with NHSE.	**DH**

Item No		Action
10	**Evaluation of Meeting** Excellent meeting and excellent reports.	
11	**Date and time of Next Meeting:** **Wednesday 26 April 2023 at 1.00pm to 3.00pm, Via MS Teams**	

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	**Wednesday 26 April 2023**
Venue	**Virtual (via MS Teams due to COVID 19)**
Time	**1.00pm to 2.30pm**

	Name	**Role**
Present:	Louise Toner **(LT)** Chair	Non-Executive Director
	Allison Heseltine **(AH)**	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
	Gwen Nuttall **(GN)**	Chief Operating Officer
	Dr J Odum **(JO)**	Chief Medical Officer
	T Palmer **(TP)**	Director of Midwifery
	Dr G Pickavance **(GP)**	Non-Executive Director

Apologies:	Catherine Wilson	Deputy Director of Nursing

Attendees:	A Hussain	Risk Assurance Director – RSM UK Risk Assurance Services LLP

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1	**Apologies for absence** Apologies were noted.	
1a	**Declarations of Interest** None declared.	
2	**Minutes of the Previous Quality Governance Assurance Committee dated 22 March 2023** BMc asked if the following could be changed: Page 5, last paragraph, 3 sentence – change AGE to HEE. The minutes dated March 2023 were accepted as a true and accurate record.	
3	**Matters arising from the Minutes** Action log updated accordingly.	
4	**Regular Reports**	
4.1	**Cancer Improvement Plan (for information only) – G Nuttall** The above report was received by the meeting and GN gave key highlights update. GN alerted the Committee that it is more than likely that RWT and not the system is going to be escalated into Tier 2 and that is for more intervention. GN explained the tiers: • Tier 1 – worse tier • Tier 2 – local / regional intervention in terms of performance and metric • Tier 3 – local ICB oversight GN continued that rather than system escalation it goes on organisational performance. To date the formal notification has not been received but there have been two areas where the Trust has been identified where performance has not been as it should. One is the 62-day performance metric which the Trust has been challenged on, the second is the chemotherapy turnaround times. The Trust has submitted action plans to NHSE for both areas of concern. GN feels that chemotherapy turnaround times have provided enough assurance in terms of the actions that are being undertaken and this will not be a significant focus as improvement can already be seen. The Cancer 62-day metric, which was not being achieved pre-COVID and has been a struggle since. GN explained to the meeting the reason for the escalation and how it has been measured nationally, is not the number of patients that are waiting over 62-days, because the number of patients that RWT had in April 2022 has reduced to April 2023. Performance and the number of patients waiting is improving, it goes on the percentage of	

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	patients waiting on the waiting list who are over 62-days, hence what has triggered RWT. Currently the Trust has 12% of patients waiting over 62-days and that is in the top 20 nationally of the highest volume of patients waiting over 62-days, hence the trigger. GN mentioned that 50% of the patients waiting over 62-days are Urology patients and a number of these are waiting for nephrectomy or partial nephrectomy. GN confirmed that the Trust is currently waiting for the notification, some meetings have started to be booked in terms of further discussing the Trust recovery plan. The recovery plan is coming together. There are currently 70 patients who are waiting over 62-days and the recovery plan has several areas to it and GN is happy to share with Committee or discuss and agree at this meeting. GN did not take to Performance & Finance earlier. The action plan includes: 1. Increasing productivity at the RWT 2. National mutual aid which BMc explained at the March meeting – there are now only two organisations who can provide the mutual aid (Frimley Park and Leeds). All of the patients have been contacted to see who will travel. This will equate to over 10% of patients who wish to travel. There are clinical discussions taking place with patients at this moment (to do pre-operative checks and conversations with patients who have been thinking about if they wish to travel). Both of the organisations are quite a distance from Wolverhampton; however, the plan is coming to fruition and will be started in May 2023. 3. Russell Hall Hospital have acquired their robot and their Renal Consultant is undergoing his training for nephrectomy and partial nephrectomy on the robot. Patients, originally from Russell Hall that were transferred to RWT are now being transferred back to Dudley for treatment (approximately 20 patients). GN assured the meeting that there is a clear plan, that is all part of the wider plans for the Urology Area Network of the Black Country and the treatment of Renal Patients which will be focussed around Dudley, meaning a much longer and wider plan needs to be developed. Two other areas which are showing increases in patients waiting over 62 days: 1. Gynaecology – this is being closely monitored and will be reliant on mutual aid to solve within an appropriate time 2. Colorectal – this area is flagging nationally, following an increase in referrals after the campaign of Deborah James last year. GN commented that there are still challenges within Histopathology and the turnaround times with no significant improvement in the last few months and still out-sourcing. In terms of providing other assurance, the BCPS team presented to the System Cancer Board and received partial assurance of their plan. The reason it was partial is due to the timeframes	

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	that have been pushed back and challenged. Some is recruitment based and some are actions that other organisations need to undertake with a view to assisting BCPS in identifying what is urgent and not urgent. AH thanked GN for the update and mentioned about slippage in CTC due to staffing challenges and prioritisation of inpatient workloads. AH asked if patients are being kept in just to have the test rather than discharging them. GN confirmed that the Trust does have the opportunity to discharge patients with access to the diagnostics. However, GN does not think that RWT has overall proactive approach to this sometimes. Patients can be discharged and booked back in for a MRI or CT scan, there is more scope for the Trust to do that. There has been an increase in emergency conveyances and there has also been an increase regarding requests for inpatient diagnostics. There is a demand in capacity and robust clinical discussions are taking place between the referring teams and the radiologists. BMc mentioned that CTC MTC Colonography is a niche form of CT and there are only a certain number of both radiographers and radiologists who are trained to do the investigation. Therefore, if there is an imbalance of workload that can happen if staff are off on leave because the capacity of CTC is relatively tight. BMc advised the meeting that RWT links in with Russell's Hall for assistance. BMc assured the meeting that this was not a significant problem long term, it is more an intermittent bleep that is seen with staffing. GN assured the meeting that the Fine Needle Aspirations (FNA) are completed and patients are not kept in, therefore there is not an inpatient challenge.	
4.2	**Trust Risk Register – M Metcalfe** MMe presented the above report to the meeting and noted that two risks have closed **Risk 4913 and 5610** and there is one new risk **5957**. The meeting noted that there are less on-going risks than the previous month. LT asked if the new risk **5957**, was a national risk because of the particular system and asked if it was being dealt with nationally. MMe advised the meeting that it is recognised as a national issue and pressure needs to be kept on in terms of how the national team is supporting the fix / transition to a different system. LT asked about the two closed risks noting that the committee is advised why a risk is put onto the register but not why it has been closed. MMe agreed with this comment and suggested that an extra column is added on to advise why a risk has been removed. AH advised that risk **4913** was added to the Divisional Risk Register. MMe confirmed that it had been de-escalated. The meeting discussed further with GN advising that a lot of work is on-going in regard to privacy and dignity in respect of women with a gynaecological disorder. There has not been an increase in complaints or adverse outcomes as a result, hence why the risk was de-escalated. LT enquired about closed risk **5610** – increase in Haemodialysis numbers and asked if the private centre is providing an additional service. BMc confirmed that this was up and running in Bilston. GN briefly explained that following the Performance and Finance meeting earlier in the day, they have asked for an investigation into the contractual approval of the Bilston	

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	unit. GN feels that the investigation outcome might be formally escalated to Audit Committee following discussions held at all committees and Trust Board. GN assured the meeting that the clinical and all of the patient safety is perfect. LT asked about the SSNAP audit regarding the delay in emergency CT Angiogram scanning within ED. GN advised that the Trust had not seen the results of the national audit to date. LT noted that there were a couple of blank pages within the report, MMe advised that it was a formatting issue and she would pick up outside of the meeting.	
4.3	**Integrated Quality & Performance Report March 2023 – D Hickman & G Nuttall** DH presented the Quality section of the report to the meeting and advised that the Trust continues to move in a positive direction around observations on time. DH mentioned that from the data all of the "traditional" inpatient wards are all moving up. Areas to focus on include specific areas around the Paediatric Assessment Unit, Cardiology (Day Ward) and Day Centre. Some of the issues are less about observations and more about PAS and the updating in a timely manner. In March, C-Diff saw a spike, there is a full investigation on-going and an action plan is in place. The Trust has received a letter back in draft form from NHSE for full factual accuracy, to check the numbers included, following their invited visit related to IP&C there are a few comments which have been returned but nothing significant. The main items picked up from the visit and those feature in the letter so there are no additional comments that the Trust was not aware of. One area identified was the Estates backlog with issues regarding cleaning and the seals and the panelling behind the sinks where there are joins and how did these are cleaned within the Trust. There was support within the letter regarding the patient cleaning centre which is operating out of the old Discharge Lounge. This area mainly covers the medical block, therefore there is work ongoing to ensure all areas of the Trust can access the/a clearing centre. The actions that were fed back are already underway. DH noted that there has been shift in the care hours per patient day, indicating that there has been a lot of activity around recruitment. DH mentioned that there is a number of staff due to commence employment at RWT. GP asked if the C-Diff issue was due to transporting stuff around the hospital to be decontaminated that could potentially be infected. DH assured the meeting that this does not happen as the decontamination centre is more central to the medical block. Estates and Facilities are exploring options and opportunities on how to secure as a long-term venture. The Trust would support a centralised process. AH commented that the data is slowly going up despite all of the actions being put in and asked if the Trust is missing something.	

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	AH congratulated the Trust on the improvement within observations and with the Stroke pathways. LT noted that the induction of labour has featured in the report a number of times, and over the past couple of meetings that a QI project is planned, but to date it has not started and LT asked when it might commence. DH advised the meeting that she is unable to answer the question regarding commencing the project and informed the Committee of the carefulness of trying to reduce labour and the potential risk into birth. DH understands that it is a regional QI project that will also be delivered through the LMNS. LT commented that the numbers of women smokers at the time of delivery has risen and at the last meeting it was noted that more staff have been put into place. However, LT noted that in a recent QSAG report it talked about the tobacco dependency scheme and it was identified that the Wolverhampton area do not have the same set up as is available in other parts of the Black Country. DH understands that the provision across the Black Country was variable and through previous commissioning groups there was nothing specifically identified for Maternity at RWT and the Trust had a generic service. However, through the LMNS work and external funding this has been pooled and the Trust can now do targeting support for smoking cessation in Maternity. There will be improved provision going forward. LT sought clarity about Referral to Treatment and the 104 weeks as it states that there have been no patients waiting over the last few months. However, in the QSAG report it states that there are 32 patients waiting over 104 days. BMc advised that it was two different metrics, 104 days harm is patients who have waited more than 104 days for cancer treatment, 104 weeks is patients who have had to wait over two years. GN presented the Performance section of the report to the meeting by alert only. The Committee was advised of the number of patients who are waiting over 78 weeks on the performance element. At the end of March, the number was 85. The expectation nationally was the figure should be zero by the end of March. The impact of the Junior Doctors strike meant that the expectation would be nobody waiting over 78 weeks at the end of April. There was a further Junior Doctors strike during April, the expectation is now that no one will be waiting at the end of May. The meeting discussed further noting that a private sector company connected to Sandwell and West Birmingham which can provide some Urology and Gynaecology appointments. This Trust is transferring approximately 20 patients to be operated on by the private company. GN reported that there was some deterioration in the emergency metrics. March was a game of two halves. First two weeks were challenging, seeing an increase in COVID, increases in length of stay and increases in ED. Since the middle of March GN is pleased to report that April's metrics will be significantly improved. GN feels that the emergency metrics are moving in the right direction despite there being too many delays over one hour. GN assured the meeting that this Trust is not flagging nationally on the emergency metrics. LT commented that at the last meeting discussions were held regarding concerns with the monies that had been allocated and what the Trust had wanted to spend the monies on and what the funders had said the money had to be spent on. LT asked if anyone could update on the situation. GN advised the meeting that a decision had not yet been reached. The	

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	monies set aside for discharge in terms of the service development funds, of which Wolverhampton received £2.4million last year, it supported the virtual ward and additional support for Rapid Intervention Team. All indications are this will be reduced; therefore, decisions will need to be made to reduce capacity and the availability on some of the services. A risk assessment will need to be undertaken, along with discussions being undertaken within the Local Authority. GN thinks that the money with the Local Authority is secure, however they have made decisions to reduce some of the bed-based capacity that they had. Pressures being seen are at Dudley, Walsall and Staffordshire. GN clarified that this means patients have come to us and we have challenges in returning them to their own areas.	
4.4	**Internal Audit Opinion – A Hussain** LT asked AHu if the paper had been through Audit Committee. AH replied not yet, however the sections that make up the individual parts of the report have. AHu explained that they are required by the standards to provide the Trust with a annual opinion, which is taken from a series of reviews done throughout the year and reported back to the Audit Committee. The meeting was advised that the Trust was issued with nine audit reports, five of which resulted in positive assurance opinions – two substantial and three reasonable assurances, two negative assurance opinions and the remaining two reports were issued as advisory. AHu explained the report to the meeting. There are currently three reviews to be completed: • Data Security Protection (DSP) toolkit • Board Assurance Framework and Corporate Risk Register • Financial Sustainability Follow Up Review LT commented that there were members of this Committee that do not know any of the detail of the report and queried why the report was at this meeting having not been through the Audit Committee. MMo mentioned that previously to this meeting was the Quality Account rather than the Annual Report. The meeting discussed the report and expressed concern of the lack of level of detail. AH sought assurance that the paper will be going to the Audit Committee and it was confirmed that it would be.	
4.5	**Internal Audit Plan – A Hussain** This paper was deferred prior to the meeting because it has not been to the Audit Committee.	
5	**Subgroup Reports**	
5.1	**Quality & Safety Advisory Group Meeting – April 2023 – Chair's Report – Dr B McKaig** BMc presented the Chair's report from April's QSAG meeting and noted the key items from the meeting:	

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	104-day harm – 32 patients identified in February with no physical or psychological harm identified. On 1st May the Urology Services from Wolverhampton and Walsall will merge. RWT will inherit a not insignificant number of 104-day harm reports from Walsall as a result. **Hospital Transfusion Group** – no real concerns, only a couple of issues in regard to compliance of mandatory training. Main concern was in regard to the loss of two senior staff members. Recruitment is in place **Nutrition Support Steering Group –** lot of initiatives were put forward which are on-going. Key items from this report were the concerns or issues which need to be monitored. How weights are documented on MUST – there will be a module coming through Vital Pac next month and it is hoped that this will enable data to be tracked easier. The second issue is in regard to the timing of some of the audits. The last Never Event in the Trust was a mis-placed gastric tube and the last audit of that was some time ago and the outcomes of the audit were not particularly strong. A re-audit is due next month. BMc has asked for the audit to take place and the findings to be returned to himself to ensure improvements have taken place and assurance that the changes are having an impact. There is also staffing and support challenges within Gastro and Dietetics. **Radiology EV400** – annual report following an annual inspection which took place in May 2022. This report indicated compliance with all 17 criteria. **VTE Group -** report indicated that the group is in the process of developing a business case to try and incorporate the VTE Nurses and the Anti-Coagulant Team to provide a more robust support for the only CNS Practitioner. VTE compliance is currently at 92% - 93% with some areas having targeted interventions. There are two areas which need some specific targeting – one being lower-level embolisation within ED. Second being around Badger Net and how they were able to record post-natal VTE's prior to delivery. This was a national issue, apparently it was supposed to be fixed in March but at a meeting last week there was no update regarding if the problem had been fixed. TP advised the meeting that following an update it will be fixed in May. **Tobacco Dependency Service –** BMc advised that this meeting is currently targeting the high-risk areas – Cardiology and Stroke. Data is available for the last two months as the data needs to be taken 28-days post-discharge to assess if someone has continued to be able to give up smoking. During the two months of data, 40% have stayed off smoking. There are issues with the lack of support from the Pharmacies within the community of the Black Country and West Birmingham. **Divisional reports** – there were no significant issues raised, main themes being around skill mix, upskilling and new starters. BMc mentioned the work with the Divisions to have their reports to mirror the IQPR and the Division 2 report mirrors this ask. The aim now is to roll the mirror reports out to Division 1 and Division 3. Positive comments from the Divisions were the ability to look at the trends, allowing the Divisions to focus on the key themes that are trending instead of concentrating	

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	on one area. BMc commented that the work was undertaken by the Governance Team and thanked them for their help despite the workforce issues. LT asked why there was a delay in the Radiology EV400 report coming to this committee. BMc replied that there is a statutory requirement for any organisation providing radiotherapy to have an annual review to escalate to Board to ensure the department is fit for purpose. The report only comes once a year. It was agreed to ask for this report one month after the visit. LT asked what OPEL stood for in the Maternity report. BMc replied Operational Pressure Escalation Level and explained it is when the Trust goes onto level 2, level 3 etc that is OPEL. LT mentioned about staffing and international staffing being identified again from the same Division. LT commented that this has been identified a few times and LT reminded the meeting that there has been discussion about it and things were put in place to help. LT asked if the issue was getting better, DH replied that the numbers are coming through and the impact on the vacancy rate is a positive. The structure (not the content of the OSKI program) has been re-drafted. The Divisions have embraced and have done some targeted work in terms of utilising the national standards around OSKI and overseas recruitment to support the work that has already been done. When staff are moved to clinical areas, they are given additional support. DH assured the meeting that it was reported in a more positive manner and new staff are embraced in the work. LT asked about Audit completions for example Division 2, 54% completions with the expected completion to be 81% by the end of the year. BMc advised that the Trust Audit Lead has suggested that the expected Audit completion rate at the end of March 2023, was anticipated to be between 60 to 70 percent. Due to workforce challenges within the Governance team, there are struggles to get the information. Division 1 is currently 80% completed, Division 3 is similar and Division 2 is 54%. The ask will be which of the audits not completed are critical in terms of quality, safety and which ones do we need to carry over. BMc discussed a potential Never Event within Dermatology. This was externally reviewed by a Dermatologist in Nottingham who provided a report, which is now with the Commissioners, indicating that the patient's underlying condition was significantly abnormal condition and the actions taken by the Dermatologist were reasonable and it was not a Never Event. There is some learning from this incident, which is around process following LOCSIPS, communication within the room, communication with the patient etc. These actions will be picked up and managed.	**CE**
6	**Assurance Reporting / Themed Reviews / Business**	
6.1	**QGAC Annual Report – L Toner** LT acknowledged that this was a late submission. DH asked if the report is linked into the Quality Accounts. DH to ascertain if this report does go into the Quality Accounts.	**DH**

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	The meeting discussed the report and it was agreed to: • Move Mortality out of the specialised designation and move to a routine / assurance • LT to re-do the report • CE to send LT and MMe previous reports so they can see what has been previously submitted	**CE**
7	**Themed Review Items**	
	No issues to report this month	
8	**Issues of Significance for Audit Committee** There were no issues of significance for Audit Committee. **Issues of Significance for the Trust Board** LT to produce a Chair's report and circulate for comment.	
9	**Any Other Business** MMo checked that now the Trust has a joint Quality Safety Enabling Strategy where it would be considered at QGAC. It was agreed that it should be considered at April's meeting.	**CE**
10	**Evaluation of Meeting** Short meeting due to the light agenda.	
11	**Date and time of Next Meeting:** **Wednesday 24 May 2023 at 1.00pm to 3.00pm, Via MS Teams**	

The Royal Wolverhampton NHS Trust

Minutes of the Trust Management Committee

Date	24/03/2023
Time	13:30 - 15:30
Location	MS Teams Virtual Meeting
Chair	Prof. Loughton
Attendees:	Kevin Stringer, Catherine Wilson, Suneta Banga, Mark Greene, Prof. Cannaby, Lindsay Ibbs-George, Alan Duffell, Andrew Morgan, Gwen Nuttall, Nicky Ballard, Dr. McKaig, Prof. Loughton, Sian Thomas, Radhika McCathie, Lee Dowson, Beverly Morgan, Dr.Higgins, Louise Nickell, Sally Evans, Debra Hickman, Anita Macqueen, Adam Race, Nicky Ballard, Dr Odum, Olivia Powell, John Murphy, Alison Dowling, Kate Shaw, Angela Davis, Cody Long, Shyam Menon, Joanna Macve, Kate Salmon, Baldev Singh, Tracey Palmer, Magdalena Zajac

1 **Apologies for the absence: Stew Watson, Kevin Bostock, Tim Shayes, James Green, Nick Bruce, Simon Evans.**

2 **Declarations of interest**

Prof. Loughton confirmed 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 27th February 2023.**

Resolved: that the minutes were approved unchanged.

4 **Matters arising from the minutes.**

Prof. Loughton confirmed there were no matters arising from the minutes.

5 **Action Points list**

1. **Prepare a press release on the positive vacancy rate.**

Action item: Ms Evans to prepare a press release on the positive vacancy rate. Mr. Duffell to discuss with Ms Evans. It was confirmed that a press release had been published.

Resolved: it was agreed this action be 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 was added to the April TMC Agenda.

Resolved: it was agreed this action be closed.

6 **Key Current Issues/Topic Areas - none this month**

7 Elective Care Recovery

Ms. Nuttall highlighted the national focus was no patients waiting over 78 weeks by the end of March 2023, she said the date had been extended to the end of April due to the Junior Doctor's strike which took place in March. She said The Trust had predicted there would be over 83 patients at that time across three specialties: General Surgery, Urology, and Gynaecology. She highlighted 1670 patients were affected as a result of the Junior Doctors strike, in terms of cancellations which included day cases, inpatients diagnostic cases, and 1400 outpatient appointments. Ms. Nuttall said there had been an increase for all Trusts of the national target for patients waiting over 62 days during 23/24. She said this was due to the increase in 2 week wait referrals together with complex increases in conversion rates. She said the revised target for Royal Wolverhampton Trust (RWT) was 195 by the end of March 2024. She said currently, it was predicted the Trust had 239 patients waiting over 62 days . She mentioned challenges with Neurology and the treatment of patients awaiting partial nephrectomy. She also mentioned there was a mutual aid plan for treatment of those people which would be spread nationally across the Country. She said this was being led by Dr McKaig with the support of clinical teams.

Resolved: the Report was received and noted

8 By Exception Papers- none this month

9 Monthly Reports

9.1 Integrated Quality and Performance Report

Ms. Hickman said there had been concerns on Clinical Fellow applications due to movement from band 3 to 5 elements and ongoing work was taking place. She highlighted there had been an improvement on observations on time. She also mentioned there had been one catheter related MRSA case and work was ongoing in relation to passports associated with catheters.

Ms. Nuttall highlighted the national target had been reintroduced from the beginning of April of 4 hours for patients waiting in Emergency Department (ED). She said this meant 76% of patients must be seen treated and diagnosed from the ED and all other types of emergency portals within 4 hours. She said the target was currently being achieved by the Trust. She said there had been an improvement with ambulance handovers waiting over an hour. She also mentioned there had been an increase in ambulance conveyances from Shrewsbury and Telford.

Resolved: the Report was received and noted

9.2 Division 1 Quality, Governance and Nursing Report

Ms. Macqueen highlighted the Orthopaedic Elective Surgical Hub at Cannock Chase Hospital had been awarded accreditation without any conditions supplied.

Resolved: the Report was received and noted

9.3 Division 2 Quality, Governance and Nursing Report

Ms. Morgan highlighted there were 38 registered nurse vacancies with nurses in the pipeline to commence those posts. She said local recruitment events continued and work was being done to provide extra support overseas nurses.

Prof. Loughton asked for a for an update on overseas nurses after the meeting.

Action: Ms Morgan to provide an update to Prof Loughton on the position with overseas nurses.
Resolved: the Report was received and noted

9.4 Division 3 Quality, Governance and Nursing Report

Ms. Ballard highlighted the risks on pharmacy detailed within the report. She also mentioned the positive work with the Cannock Diagnostic Centre in Cannock. Prof. Loughton mentioned the challenges in overseas recruitment of pharmacists.

Resolved: the Report was received and noted

9.5 Executive Workforce Summary Report

Mr. Duffell mentioned the Junior Doctors strike action which was to take place for 4 days after Easter. He said the pay deal for nurses had not as yet been accepted. Mr. Duffell said the vacancy rate was 2.68% which was positive news. He said there had been an improvement in mandatory training. He said there was also focus on the retention rate.

Resolved: the Report was received and noted

10.10 NHS National Staff Survey results

Mr.Duffell said nationally there had been a decrease with staff survey results. He said the two indicators above national average were “would I recommend the organisation as a place of work and would I recommend a relative or friend to be treated at the Trust”. He said these had been above average for the Trust. He said it was the first year the Trust had included Bank staff, which would be mandated in future staff surveys.

Prof. Loughton said the bank staff and staff survey showed positive feedback. He also mentioned future actions were required around Pathology.

Resolved: the Report was received and noted

9.6 Chief Nurse (CNO) Nursing Report

Ms. Hickman highlighted there had been improvements in Maternity and Paediatrics with deterioration in inpatient areas and adults. She said action plans were in place with key themes being support. She said there had been a few reports of bullying, harassment, and environmental access issues, IT access. She said recruitment was positive at the Trust. She said work had taken place with the Pastoral Education team and the OPS team. She also mentioned work was being undertaken with the induction program with focus on accommodation.

Resolved: the Report was received and noted

9.7 Finance Position Report

Mr. Greene highlighted a £2.2 million deficit at the end of March 23 to achieve break even. He said the non-current balance sheet had been released and the Trust should have approximately £12 million worth of additional non-recurrent support through the Integrated Care Board (ICB) through income and risk share. Mr. Greene said the run rate showed an underlying pay overspend of approximately £1 million per month. He also mentioned the Trust had achieved its target for the ability to pay invoices on time.

Resolved: the Report was received and noted

9.8 Capital Programme Update

Mr. Stringer said the Capital Resource limit was £38.1 million and work was being done to achieve the target. He also mentioned the Trust had been awarded grants for the Public Sector Decarbonisation Funding (PSDS). He said by the end of March the organization had spent £52milions on the organization, which was positive news.

Resolved: the Report was received and noted

9.9 Financial Recovery Group Update

Ms. Nuttall said the target for the current financial year was £16.9 million and the Trust had achieved £14.7 million. She said currently the Cost Improvement Programme (CIP) target was 4% with a £28 million target which was challenging. She highlighted focus was required nationally and across the Black Country on efficiency and productivity. She said

there was no plan to achieve the CIP programme and work was required. She said the Trust was to relaunch outpatient plans.

Resolved: the Report was received and noted

10 Statutory or Mandated Reports (1/4, 6 monthly and Annual)

10.1 Acute Care Collaboration- deferred to next month

10.2 Health and Inequalities

Dr. Odum highlighted five national priorities of the health and inequalities report. He said priority one restoration of NHS services and inclusivity, work was being undertaking in maternity services at the Trust and within the community. He also mentioned a focus piece of work was being undertaken on ophthalmology. He said the second priority was digital enablement. He said positive work was being done for data sets capturing ethnicity data and other important data. He said the Trust had captured over 95% of the data across most of the domains apart from acute data of outpatients which was at 94%. He said the fourth priority patient populations at greatest risk work was being undertaken particular around smoking cessation. He said the last priority was around leadership and accountability, education and training was to take place.

Resolved: the Report was received and noted

10.3 Workforce Safeguards - Nursing and Allied Health Professionals (AHP)

Ms Hickman said the report was for noting.
Resolved: the Report was received and noted

10.4 TRR Heat Map

Ms. Cody highlighted 27 risks open, 1risk had been downgraded, 5 new risks have been added to the risk register and there were 4 risks overdue for review.

Resolved: the Report was received and noted

10.5 Midwifery Service Report

Ms. Palmer highlighted the positive feedback regarding the Care Quality Commission (CQC) Patient Perspective Survey. She said 39% of women in Wolverhampton had responded to the survey. She said focus work had commenced with service users with a focus on co-production. She said following the CQC improvement plan positive progress had been made on the Triage service and the Obstetric specific system. She also mentioned there had been a good response to workforce recruitment events which was positive news.

Resolved: the Report was received and noted

10.6 OneWolverhampton Place

Ms. Thomas said there had been significant successes over the past year, mainly relating to the quality of relationships and other qualitative elements. She said all the partner organizations had been asked to sign a partnership agreement.

Resolved: the Report was received and noted

10.7 Patient Experience Report

Ms. Dowling said there had been a decrease in complaints. She said there had been 69 formal complaints, 62 Patient Advice and Liaison Service (PALs) concerns and 70 cases local resolution. She highlighted the complaint handling had been 95% with the Ombudsman standards. She said there were no Ombudsman cases accepted for investigation or closed during this reporting period. She said clinical treatment received the highest volume of complaints. Ms. Dowling said there had been a significant improvement in both the response rate and recommendation rate for the Friend and Family test. She said 97,000 bookings had been made via the centralized visiting booking system. She said the Trust had been successful in obtaining funding from NHS charities together towards a project to implement for social isolation around positive mental well-being for Communities.

Resolved: the Report was received and noted

10.8 Contracting & Business Development update.

Resolved: the Report was deferred to April TMC

10.9 Education and training

Ms. Nickell said 17 additional doctors had commenced postgraduate medical training and the first cohort Aston Medical School would graduate this year. She said Aston Medical School and the General Medical Council (GMC) had visited the Trust for the Objective Structured Clinical Examination (Oski) quality assurance. She said positive feedback had been received. She also mentioned a business case was being developed to explore how to support a wider learning environment due to the increased number of students, trainees, and additional staff.

Resolved: the Report was received and noted

10.11 Infection prevention report

Dr Macve highlighted there was a Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia in February. She said the Board Assurance Framework was attached for reference.

Resolved: the Report was received and noted

10.12 Quality Framework (QF) – For Nurses | Midwives | Health Visitors | Allied Health Professionals | Pharmacists

Prof Cannaby highlighted the plan attached within the report and said beneath the plan were 5 plans, community, adult, paediatric, maternity and allied health professionals. She said the plan had been made across both RWT and Walsall Healthcare NHS Trusts and would be launched in April.

Resolved: the Report was received and noted

10.13 Joint Quality and Safety Enabling Strategy

Ms. Hickman said this was the review of the strategy which had previously been linked with patient experience. She said considerable engagement for the strategy had taken place.

Resolved: the Report was received and noted

10.14 Research & Development Report

Dr. McKaig said both Trusts would be taking part in research away stay strategy together with a research celebration in September.

Resolved: the Report was received and noted

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

11.4.1 Approval of new business case template

Ms. Salmon said the template had been approved at TMC at WHT and would also be used by the Capital Review Group.

Resolved: the new business case template was approved

12 **Outline/proposals for change – none this month**

13 **Policies/Strategies**

13.1 **Policies, Procedures, Guidelines and Strategies Update**

13.1.1 **New, Menopause in the Workplace Policy**
Resolved: New, Menopause in the Workplace Policy was Approved.

13.1.2 **HR03, Disciplinary Policy**
Resolved: HR03, Disciplinary Policy was Approved

13.1.3 **OP94, Supportive Mealtimes Policy**
Resolved: OP94, Supportive Mealtimes Policy was Approved

13.1.4 **OP79, Water Safety Policy**
Resolved: OP79, Water Safety Policy was Approved

13.1.5 **CP04, Discharge Policy**
Resolved: CP04, Discharge Policy was Approved

14 **Any new Risks or changed risks as a result of the meeting.**

15 **AOB**

Mr. Singh said extensive amount of digital work had been done around end-of-life care. He also mentioned the Wolverhampton Primary Care Academic group had been created with grant money which was positive news. He finally mentioned it was proposed the Fellowship Program, would assist GPs with the recruitment of Primary Care physicians.

Prof. Loughton said it was positive news around Primary Care.

16 **Date and time of the next meeting 28 April 2023**

The Royal Wolverhampton NHS Trust

Minutes of the Trust Management Committee

Date 28/04/2023
Time 13:30 - 15:30
Location MS Teams Virtual Meeting
Chair Prof. Loughton
Attendees: Catherine Wilson, Suneta Banga, Mark Greene, Prof. Cannaby, Lindsay Ibbs-George, Alan Duffell, Andrew Morgan, Gwen Nuttall, Nicky Ballard, Dr. McKaig, Prof. Loughton, Radhika McCathie, Lee Dowson, Beverly Morgan, Dr.Higgins, Sally Evans, Debra Hickman, Adam Race, Nicky Ballard, Dr Odum, Kate Shaw, Angela Davis, Shyam Menon, Baldev Singh, Tracey Palmer, Magdalena Zajac, Stew Watson, Doreen Black, Pauline Boyle, Lewis Grant, Michelle Metcalfe, Dr Ananth Viswanath, Timothy Shayes

1 **Apologies for the absence: John Murphy, Kate Cheshire, Simon Evans, Kevin Stringer, Rosalind Leslie, Nick Bruce, Sian Thomas, Damian Murphy, Louise Nickell**

2 **Declarations of interest**

Prof. Loughton confirmed 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 24th March 2023.**

Resolved: that the minutes were approved unchanged.

4 **Matters arising from the minutes.**

Prof. Loughton confirmed there were no matters arising from the minutes.

5 **Action Points list**

1. **Overseas nurses.**

Action item: Ms Morgan to provide an update to Prof Loughton on the position with overseas nurses.
Ms Morgan said several meetings had taken place with the group, she draft outlined the process had been completed and discussed at the Senior Sister/Charge Nurse Education forum which received positive feedback.
Resolved: Ms. Morgan to arrange a meeting with Professor Loughton to update following the above and the action be closed

6 **Key Current Issues/Topic Areas - none this month**

7 Elective Care Recovery

Ms. Nuttall highlighted national focus was no patients waiting over 78 weeks by the end of March 2023. She said the date had been extended to the end of May due to the Junior Doctor's strike. She said currently there were 117 patients waiting over 78 weeks across three specialties: General Surgery, Urology, and Gynaecology. She said it was anticipated the number would increase to 142 during May and the Trust would require mutual aid. She said currently the Trust had been flagged red nationally on the percentage of patients who had been waiting over 62 days on the cancer waiting list. She said the specialties effected were urology, patients waiting for nephrectomies, Gynaecology, Colorectal and Skin. She mentioned a risk had been identified in the position with urology and added to the Risk Register. She said a plan was in place including increasing the capacity of Consultants. She said the robot had commenced at Russells Hall Hospital and patients had been transferred for treatment. She said mutual aid had been offered from Leeds Teaching Hospitals NHS Trust and Frimley Park Hospital and only 15-20% of patients had agreed to travel to those hospital sites.

Resolved: the Report was received and noted

8 By Exception Papers- none this month

9 Monthly Reports

9.1 Integrated Quality and Performance Report

Ms. Hickman said there had been improvements in observation on time. She highlighted there was a 20% national increase in C-Difficule and the Trust was transient with its numbers on C-Difficule. She said a response letter had been received following the peer review visit from NHSEI. She said areas of focus were backlog maintenance, opportunities on supporting DECAMP and issues around storage. She said the safety indicators remained in a stable position with a gradual increase.

Ms. Nuttall said the report highlighted data for March and asked all to note at the end of March 85 patients were waiting over 78 weeks. She said there had been a deterioration in the emergency care metrics for March and there had been improvement in April.

Resolved: the Report was received and noted

9.2 Division 1 Quality, Governance and Nursing Report

Ms. Black highlighted the continued improvements in nurse vacancy levels and the risk was to be reviewed and downgraded. Prof. Loughton asked what the number of vacancies were within the Division. Ms. Black said there were 61 vacancies and 61 in the pipeline.

Resolved: the Report was received and noted

9.3 Division 2 Quality, Governance and Nursing Report

Ms. Morgan highlighted there were 34 registered nurse vacancies. She said the Stay Cross Divisional Program had been produced to support internationally recruited nurses which was awaiting approval from the Senior Nurses team.

Prof Loughton asked if surveys were submitted to overseas nurses to identify any issues or concerns, they may have. Ms Morgan said 1-to-1 interviews took place with the nurses Prof. Loughton asked whether surveys could be sent out to obtain feedback from the nurses.

Resolved: the Report was received and noted
Action: Ms. Hickman to create a survey for international overseas nurses to complete, to include the input from Prof. Singh in relation to Clinical Fellows.

9.4 Division 3 Quality, Governance and Nursing Report

Ms. Ballard highlighted there was one severe harm being overexposure in radiology. She mentioned the improvement of the staffing position.

Prof Loughton asked where there was comparative data across the Black Country. Mr. Duffell said the Trust compared well to other Trusts. Prof. Loughton asked that a dashboard should be included with comparisons.

Resolved: the Report was received and noted

9.5 Executive Workforce Summary Report

Mr. Duffell said in relation to Consultants the British Medical Association (BMA) were currently in negotiation with the Government. He said he was not aware of any conversations for Junior Doctors with the BMA. He said the Royal College of Nursing (RCN) rejected the pay offer which had been presented for the agenda for change. He said a meeting was to take place on the 2 May where the results would be reviewed. There was a discussion on industrial action.

Ms. Nuttall said the RCN strike had not directly impacted services across the Black Country an alert had been issued that surrounding organizations particularly Worcester and Birmingham may not be able to take all major trauma and paediatric intensive care patients which could result in considerable risk of harm.

Mr Race said the vacancy rate was below 3% which was positive news he said there had also been an improvement on appraisals.

Resolved: the Report was received and noted

9.6 Chief Nursing Officer and Director of Nursing Report

Ms. Hickman said the clinical ward accreditation had taken place. She said the vacancy was in a good position but there were some people still in the pipeline. She said the metric for falls was in a positive position, but communication had been received from the Coroner around the falls process and the falls process was being reviewed. She also mentioned there had been challenges in timeliness, response and delegation of complaints and work was in progress.

Resolved: the Report was received and noted

9.7 Finance Position Report Month 12

Mr. Greene highlighted the Trust achieved a break-even position with a surplus of £90 thousand Mr. Greene said that all capital requirements had been achieved.

Resolved: the Report was received and noted

9.8 Capital Programme Update

Mr. Watson said the organization spent 99.7% which was approximately £67 million spend for last year.

Resolved: the Report was received and noted

9.9 Financial Recovery Group Update

Ms. Nuttall said the Cost Improvement Programme (CIP) financial recovery expectations had been amended from £28 million being 4% to £43 million 6.2%. She said this was challenging and focus was required on productivity, efficiency and achieving the best clinical outcomes possible. She said the operating plan included a focus on outpatient transformation to reduce follow-up appointments by 25% and reduce waiting times.

Prof Loughton said it needed to be considered what could be done to engage the Trust in being as efficient as possible. Ms. Hickman said there needed to be focus on quality and improvement to achieve efficiency.

Resolved: the Report was received and noted

10 Statutory or Mandated Reports (1/4, 6 monthly and Annual)

10.1 ICS Development

Mr. Shayes introduced the report with an overview of the infrastructure in place to take forward the Integrated Care Board (ICB) priorities for 23/24.

Resolved: the Report was received and noted

10.2 Financial Planning 2023/24 revised proposal

Mr. Greene went through the presentation slides and provided updates on the financial planning. Mr. Singh asked if the cash flow issue and the deficit had been shared with organizations. Mr. Greene said the deficits had not been shared but would be shared across Integrated Care Board (ICB). He said there was ongoing discussion on how to manage cash flow. Prof. Loughton highlighted cash flow would not effect meeting the wage bill.

Resolved: the Report was received and noted

10.3 Capital Programme Update 2023/24-5year plan.

Mr. Watson said there remained a challenge in accessing capital due to Integrated Care Board (ICB) pressures. He highlighted currently nearly £52m had been confirmed or secured, subject to the approval of funding terms and evaluation of the business case. He said the Trust was exploring funding opportunities. He said major projects continued for Wrekin House. He mentioned significant investment had been for additional theatres in Cannock Chase Hospital. He said work continued with decarbonization and the solar farm. He highlighted that Trust was assisting partners within the Integrated Care Service with advice, funding and services. He mentioned car parking would continue to be a challenge whilst development works were taking place. He said the Trust was working towards the NHS green targets as well as dealing with challenging resources within the construction industry.

Mr. Duffell asked whether further comms should be issued to remind staff about hybrid work. Ms. Evans said regular messages were being circulated. Prof. Loughton asked for the message to be reiterated to staff.

Resolved: the Report was received and noted
Action: comms to be sent out reminding staff of hybrid working

10.4 Contracting & Business Development update (deferred from March)

Mr. Shayes said the Trust was unsuccessful for the bid for alcohol testing for the Driving and Vehicle Licensing Agency (DVLA) service.

Resolved: the Report was received and noted

11 Business Cases

11.1 Division 1

11.1.1 Replacement of Blood Issue Fridge at Cannock Chase

Resolved: Replacement of Blood Issue Fridge at Cannock Chase report was Approved.

11.2 Division 2 - none this month

11.3 Division 3

11.3.1 NICE TA605 Xeomin (botulinum neurotoxin type A) for treating chronic sialorrhoea.

Resolved: NICE TA605 Xeomin (botulinum neurotoxin type A) for treating chronic sialorrhoea report was Approved.

11.4 Corporate- none this month

12 Outline/proposals for change – none this month

13 Policies/Strategies

13.1 Policies, Procedures, Guidelines and Strategies Update

13.1.1 HR16, Freedom to Speak Up Policy (previously Raising Concerns at Work Policy and Procedure)

Resolved: HR16, Freedom to Speak Up Policy (previously Raising Concerns at Work Policy and Procedure) was Approved.

13.1.2 New, GDL10, Guidance and Statement of Intent for Transgender Inclusion

Resolved: New, GDL10, Guidance and Statement of Intent for Transgender Inclusion Policy was Approved

13.1.3 OP39, Patient Access Policy

Resolved: OP39, Patient Access Policy was Approved

13.1.4 HS33, Driving for Work Policy

Resolved: HS33, Driving for Work Policy was Approved

13.1.5 OP102, Non-Elective Surgery Policy

Resolved: OP102, Non-Elective Surgery Policy was Approved

13.1.6 New, PRT04, Respiratory Illness Protocol

Resolved: New, PRT04, Respiratory Illness Protocol was Approved

13.1.7 **HR24, Secondment Policy**
Resolved: HR24, Secondment Policy was Approved.

14 **Any new Risks or changed risks as a result of the meeting.**

15 **AOB**

Ms Palmer said the single delivery plan had been received for maternity-neonatal services which was being reviewed and an update would be provided to the next meeting.

16 **Date and time of the next meeting 26 May 2023 at 1:30 pm.**

The Royal Wolverhampton NHS
NHS Trust

Minutes of the Audit Committee

DATE Thursday, 9 February 2023
VENUE MS Teams Virtual Meeting
TIME 10.00 am

PRESENT

Ms Julie Jones	Non-Executive Director (Chair)
Professor Louise Toner	Non-Executive Director

IN ATTENDANCE

Mr James Green	Interim Finance Director
Mr Mark Greene	Deputy Chief Financial Officer
Mr Nick Bruce	Associate Chief Technology Officer
Mr Richard Jones (part)	Deputy Head of Security and Car Parking/LSMS
Mr Asam Hussain	RSM – Internal Audit
Mr Mike Gennard	RSM – Internal Audit
Ms Samantha Bostock	RSM – Counter Fraud
Ms Sarah Brown	KPMG – External Audit
Mr Keith Wilshere (part)	Company Secretary
Mr Nathan Joy-Johnson (part)	Group Director of Procurement
Mrs Katie Winchurch	Personal Assistant – Deputy Chief Financial Officer

Item No		Action
1/2023	**Apologies for Absence** Mr John Dunn, Mr Simon Evans, Mr Junior Hemans, Mr Kevin Stringer, Mr Kevin Bostock, Ms Andrea Deegan and Ms Erin Sims	
2/2023	**Minutes of the Previous Meeting** The minutes of the Audit Committee meeting held on the 13 December 2022, were reviewed, and approved by the committee.	
3/2023	**Matters Arising** There were no matters arising.	
4/2023	**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.	
5/2023	**Declarations of Interest** No interests were declared.	

Item No		Action
6/2023	**Quality Governance Assurance Committee (QGAC)** L Toner updated members of the committee on areas of interest following the last QGAC meeting. She advised there had been no changes and the key themes on the QGAC agenda predominately remained the restoration recovery plan, staffing, medicine management and ambulance waits.	
7/2023	**Performance and Finance Committee (P&FC)** J Green updated members of the committee on areas of interest following the last P&FC meeting. J Green advised that the P&FC meeting had focused on the financial year 2022/23 and reported that the Trust was still on target to hit the forecast position but advised there were financial pressures emerging in recent months and there were potential risks to be managed throughout the remainder of the financial year. It was noted that a discussion had taken place on the planning cycle in activity terms. The national ambition was to hit 108% of 2019/20 levels and currently the Trust was at 103% so still a way to go in terms of recovery of services in activity terms. J Green advised that the Divisions were trying to estimate how this might be achieved on the financial element and reiterated the current financial climate was very difficult heading into 2023/24. J Green reported on the potential impact that might happen as a result of financial plans across the system. He advised that the Trust had made submissions of the financial plan into the system and the financial position across all organisations were a deficit one. It was noted that the impact of this will mean the system effectively will be in a form of escalation due to there being an unlikelihood of delivering a breakeven position with the resources available for 2023/24. J Green reported that the Black Country had received quite a low level of uplift, second lowest in the country compared to other systems. It was noted that the Regional Team were producing reports to the National Team each week. J Green advised that the size of the gap will start to emerge over the coming weeks as the National Team are made aware of each system scale of deficit, which will result in those systems with the largest deficits will be in some form of escalation. Members noted that there were 11 systems in the West Midlands and that the Trust was very close to the top so would invariably be escalated to the national level to have some form of intervention imminently. J Green advised that the sort of controls that might be implemented were as set out when the deficit protocol was issued in the Autumn of last year. He advised it started to become quite punitive in terms of ability to commit expenditure and invest into services and that local level investment above £100,000 would require sign off by the ICB and if the whole system were in deficit would require sign off by the Regional Office. J Green advised members to be aware of the scrutiny that the Trust would be subject to and the potential controls that would be in place with regard to the Trust's ability to commit expenditure. Therefore, resulting in an impact on the Trust's independence to deliver services as normal.	

Item No		Action
	S Brown asked if the Trust was still expecting to achieve a breakeven position for the financial year 2022/23 and if the concern related to the next financial year. J Green responded that the Trust was still forecasting a breakeven position for the financial year 2022/23 but confirmed it would be challenging for the Trust and other organisations in the system. However, the main challenge would be in the next financial year 2023/24.	
8/2023	**Trust Management Committee (TMC)** J Green updated members of the committee on areas of interest following the last meeting of TMC on the 27 January 2023. He advised that in terms of agenda items the usual reports were presented with no significant issues raised and there was nothing new in terms of risk that the committee needed to be made aware of.	
9/2023	**Board Assurance Framework (BAF) plus Collaborative Work with Walsall and BAF Risks** K Wilshere presented the BAF report to members of the committee. He advised members that this was the most up to date version that was currently available and that the Chief Operating Officer, was currently working on SR16. K Wilshere advised the committee that the strongest potential risk related to 'Recruitment and Retention' and PODC. It was also noted that there needed to be an amendment to the overall Summary Guide to identify Cyber Risk when it's completed against all four of the strategic aims. J Jones referred to 9c of the report relating to the policy review of recruitment and retention and advised that this was a difficult area to articulate as a risk, but noted that discussions were taking place regularly which was reassuring. K Wilshere advised the committee that the previous risk around Trust staffing had been closed as there was less evidence for the risk to be maintained as the Trust vacancy rate dropped. J Green referred to Risk 15 – Finance and advised the committee that the Trust was likely to have very significant deficits in planning terms for 2023/24 and therefore, it was highly unlikely that the current risk would decrease. Members noted that Risk 15 was currently at a score of 20 and it may move up into a more controlled measure in the near future. **RESOLVED:** The committee noted the detail of the BAF**.**	**K Wilshere**
10/2023	**Security Report** R Jones presented the quarterly progress report on security issues within the Trust to members of the committee. He referred to the Community Services and VI Practices and advised the committee that a lot of work was underway for access control and CCTV. It was noted that there had been a slight delay, but work had commenced with the GP practices to bolster security and improve the staff welfare at the sites.	

Item No		Action
	R Jones advised that the staff car parking at the Trust and at Walsall Trust was causing issues as there had been a lot of construction work recently on both sites which was restricting car parking spaces due to closures of car parking whilst these projects were being undertaken. Members noted the decrease in income for the quarter which was due to the ongoing issues with the car parking maintenance and equipment. R Jones advised that a tendering exercise had been undertaken to get a new supplier to upgrade and install a new public car parking system. He confirmed that once the upgrade and new equipment was installed contactless payments would be available at the barriers and patients and visitors would be able to pay at any of the car parking payment machines and not be restricted to the payment machine at the car park they were parked on. L Toner enquired about the response to the bid for a Community Response Team. R Jones confirmed that a paper had been submitted and advised that he was waiting for a response to the bid. The Chair asked if enough was being done by the Trust to encourage environmentally friendly ways of travelling to the Trust to minimise the number of cars coming on to site. R Jones responded that regular communications were going out to staff. J Green confirmed that the Trust did have support mechanisms in place and advised that there had been discussion at Executive level to encourage a hybrid working approach by staff. **RESOLVED:** The committee thanked R Jones for the progress report on security issues within the Trust.	
11/2023	**Cyber Risk Management** J Watts presented the Cyber Risk Management report to members of the committee. N Bruce advised that the phishing exercise that the committee approved had been completed. J Watts advised that One Advance had shared the final forensic reports with NHS Digital, and she noted that the assurance rating for One Advance Systems had been rated as high and, therefore, safe to use. She confirmed that a copy of the One Advance Forensic reports would be shared with the Committee and undertook to circulate a copy when available. J Watts referred to the Threat, Protection and Defence Tool which was part of the phishing exercise and confirmed this had now been completed resulting in some interesting findings. It was noted that there was a requirement to increase education across the user estate on malicious emails as 28% of users opened the malicious email and clicked on the link and 17% entered usernames and password. Going forward J Watts confirmed that the team were looking at a communication education plan and this would provide access to NHS Digital phishing education videos. J Watt confirmed that she would address this with N Bruce and the Communications Team to ensure the information was circulated to all users. In addition, a further phishing exercise would be undertaken in a couple of months' time. The Chair asked of the 2,837 users that clicked on the link was there a mixture of departments, job roles, part time or full time and was there a trend of users that were more likely to click on the link.	**J Watts**

Item No		Action
	J Watts confirmed she had looked at the departmental information and there were no trends, however, to provide the committee with the statistics broken down by department she would add this detail to the next Cyber Risk Management report presented to the September meeting of the committee. A Hussain enquired how quickly would the education plan be going out to all users given the dynamic and changing nature of cyber risk exposure the message needed to be communicated quickly in order to protect the Trust. J Watts confirmed the plan was to send a generalised education communication to all users to advise them that this exercise had been carried out and to email all the users who did click on the link to ensure they have read the education communication and to ensure they know the IT Team are always there if advice was needed. J Watts advised that the final area of note was that the team were implementing a major change of internet filtering which would be carried out over the next four to six weeks. The Chair referred to page 5 and asked how many users with privileged access remained uncompleted. J Watts responded that the only team left to have the access is the Software Services Team which was approximately 25 users. The Chair thanks N Bruce and J Watts for their detailed report and asked for the results of the phishing exercise to be made available at the next meeting of the committee. **RESOLVED:** The committee noted the detail of the Cyber Risk Management Report.	**J Watts** **N Bruce/J Watts**
12/2023 12.1	**<u>Internal Audit and Counter Fraud – RSM</u>** <u>Internal Audit Progress Report (including update on Recommendation Tracking)</u> A Hussain presented the Progress Report to members of the committee. It was noted that since the last meeting of the committee the following Internal Audit reports had been finalised and issued: - • Financial Sustainability (7.22/23) • Key Financial Controls – Accounts Receivable (8.22/23) • Private Sector Contracts (5.22/23) Members noted that there had been one change to the Internal Audit Plan which related to the Place Project Management review and a request had been made to defer it to next year. A Hussain confirmed that he had spoken with K Stringer and the proposal was to use the available resources to do a follow up audit on the 'Financial Sustainability' actions. A Hussain confirmed that the R&D report had been issued in draft and there were no major weaknesses to report to the committee.	

Item No		Action
	A Hussain referred to the action tracking Appendix B (page 90) and advised that since the last committee 41 actions were due and the closure rate had only been 5 with 10 having been updated, which meant 26 actions had not received a response. The Chair referred to the 'Key Financial Controls' - 'General Ledger' and 'Accounts Receivables' audits and reported that the 'substantial' assurance was very reassuring and asked that the committee's congratulations be passed on to the Finance Team. The Chair referred to the outstanding Internal Audit actions some of which were noted as being 'high recommendations' and suggested the escalation to Trust Management Committee to reinforce the importance of the actions being addressed and the importance and priority this work should take. The Chair advised that she was aware of the work undertaken by A L Stirling in chasing responsible managers to update their actions. **RESOLVED:** The committee noted the detail of the Internal Audit Progress Report.	
12.2	<u>Internal audit report: 8.22/23 – Key Financial Controls – Accounts Receivable</u> The committee noted the detail of the Key Financial Controls – Accounts Receivables audit report.	
12.3	<u>Internal audit report: 7.22/23 – Financial Sustainability (7.22/23)</u> The committee noted the detail of the Financial Sustainability audit report.	
12.4	<u>Local Counter Fraud Specialist (LCFS) Progress Report</u> S Bostock presented the LCFS progress report to members of the committee. S Bostock advised that the report summarised the work undertaken since the last meeting of the committee in December 2022 on the proactive and reactive work. She confirmed that Fraud Awareness Sessions had been provided to the Boards of both Wolverhampton and Walsall covering fraud issues, bribery, and cyber-crime. She reported that the Fraud Culture survey had been shared across the Trust, which would assess staff awareness in understanding fraud and bribery. However, it was noted that the return rate was relatively low but with the assistance of the Communications Team the distribution of the survey continued along with assistance from individual managers to circulate to their teams. S Bostock reported there had been one new referral since the last committee. She advised that the benchmark figure was around 12 and the Trust had received 15 year to date, which gave assurance to the committee that staff were confident to speak up on any concerns they had with Counter Fraud or HR. S Bostock referred to the reactive work and summary of cases page 6 of the report and confirmed two cases had been closed since the last committee and six cases remained ongoing. The committee referred to 'emerging risks and alerts issued' and noted that there was a marked increase in mandate fraud. S Bostock advised that fraud alerts continued to be shared regularly with the Trust to ensure that it was equipped with the knowledge and skills to not expose the Trust to any of these potential risks. **RESOLVED:** The committee noted the detail of the Counter Fraud Progress Report.	

Item No		Action
12.5	Draft Counter Fraud Workplan 2023/24 S Bostock presented the draft Counter Fraud Workplan 2023/24 to members of the committee. She advised the committee that two joint exercises with Internal Audit were being proposed subject to the Internal Audit Plan being approved, namely Consultant Job Planning and Sickness Absence. The reviews would look at the Trust's policies and procedures and undertake testing in the named areas. S Bostock advised the committee that they were looking at providing two bespoke awareness sessions to Finance and HR alongside the remote training sessions on recruitment and ID verification checking. It was also noted that the Trust would take part in the International Fraud Awareness week in November. **RESOLVED:** The committee noted the detail of the draft Counter Fraud Workplan 2023/24.	
13/2023 13.1	**External Audit – KPMG** External Audit Plan for the year ended 31 March 2023 S Brown presented the External Audit Plan for the year ended 31 March 2023 to members of the committee for the audit of the financial statements and the VFM arrangement for the year ending 31st March 2023. S Brown advised that the External Audit Plan was subject to changes nationally across the system, but confirmed that this was the position currently. She reported that she was expecting to bring another version of the plan to the committee or indeed any changes to the plan would be brought back to the committee. S Brown referred to page 5 and advised the committee of the materiality levels that had increased which was largely a reflection of the increase in the revenue benchmark and advised that any audit adjustments above £300,000 would be reported to the committee whether they were adjusted or unadjusted. The Chair asked about the requirement of valuing the Solar Farm and asked if this would be a different approach to that of valuing the hospital, land, and buildings. S Brown responded that the Solar Farm was still currently under construction and therefore as it wasn't complete it could not yet be valued. She confirmed that the work that would be undertaken on the Solar Farm was to look at the costs that had been incurred and are included in the accounts. S Brown referred to the risk from expenditure recognition. She advised that the risk was considered to be in existence as there were significant pressures in the system and for the Trust particularly in 2023/24. It was noted that the risk was considered to be around existence of expenditure with the potential incentive to bring some of the expenditure forward into this year to relieve some of the pressures that can be seen going forward. S Brown advised that this would be a key area that would be kept under review up until undertaking the Audit.	

Item No		Action
	S Brown confirmed there had been some changes to the auditing standards with one area identified being fraud and ensuring that sufficient work was completed on risk assessments and how to identify high risk journals and how they could be potentially manipulating the financial position. S Brown noted that the timetable for the final accounts deadline had changed to the end of June she advised that they were keen to work to a tighter deadline internally with the Finance Team, but it did give some room if anything were to arise. She noted this has worked well in previous years to undertake the Audit in May and report to the Audit Committee at the end of May. S Brown referred to the 'value for money (VFM) risk assessment' section of the report. The remit to provide a conclusion over value for money and to focus on three domains which are financial sustainability, governance and the 3E's. She advised that with regard to 'financial sustainability' there was a significant risk, but this didn't mean this would result in a significant weakness. The Chair referred to the significant risk on 'financial sustainability' for VFM and asked if additional evidence would be required from management and the Board this year and if there was anything more the committee needed to do. S Brown responded that there was a slight difference between the Going Concern assessment and the VFM assessment. The Going Concern assessment for the NHS was relatively straightforward due to the way the guidance was written. As long as there was a financial plan in place and the Trust continued to operate and had a remit to deliver services it would continue as a 'going concern'. It was noted that the major issue was around the VFM side and the financial viability of the Trust and the system over the next 12-18 months. **RESOLVED:** The committee noted the detail of the External Audit Plan for the year ended 31 March 2023.	
14/2023	**Governance Arrangements for ICS and ICB** J Green gave a brief update in the absence of S Evans relating to the Place arrangements. He advised that the position currently was that they were out to consultation from the ICB.	
15/2023	**Single Tender Actions and Suspension Breaches** N Joy-Johnson presented the Single Tender Actions and Suspension Breaches report to members of the committee. He advised the committee that the report presented included the single tender waiver data that was missing from the previous quarterly report. It was noted that the figure detailed in the report of 0.18% of overall breaches was incorrect and the figure should read 0.43% and an updated report would be circulated. N Joy-Johnson reported that the overall breaches for the period 1 October 2022 to 31 December 2022 were 64 breaches which represented 0.43% of overall purchase orders, the figures compared to UHNM were 150 breaches and 1.02%.	**N Joy-Johnson**

Item No		Action
	N Joy-Johnson referred to pages 3 and 6 of the report and the detail of the single tender waivers and breaches above £100,000. It was noted that the total breaches of single tender waivers related to only 7 out of 14,000 of orders that were raised in this period and didn't indicate that compliance hadn't been followed. The Chair referred to page 3 and asked if all the reasons given for all the orders over £100,000 were correct. N Joy-Johnson confirmed that the reason for the codes was that they were linked to the SFI's and suggested that going forward if there were instances were there wasn't the option to go out to tender or to competition then these could be removed from the report. The Chair thanked N Joy-Johnson for a very helpful, detailed report which gave assurance to the committee. **RESOLVED:** The committee noted the Single Tender Actions and Suspension Breaches report.	
16/2023	**Losses and Special Payments Report** M Greene presented the Losses and Special Payments report for the period 1 November 2022 to 31 December 2022 with approval requested for losses outside Officers' delegated limits for the period 2 December 2022 to 31 January 2023. M Greene asked for retrospective approval for £56,870 which related to an ongoing case detailed at Appendix A to be written off. **RESOLVED:** Members of the Committee approved the detail in the Losses and Special Payments report and approved the retrospective write off of debt of £56,870.	
17/2023	**GI02 - Financial Management Policy** K Wilshere presented G102 Financial Management Policy Report for members information. Members noted that this policy had recently been approved at Trust Board. K Wilshere advised that as identified at the Board meeting, Appendix A of the policy needed to be changed so that it was consistent with the limits in the policy. **RESOLVED:** The committee noted the report.	
18/2023	**Self- Assessment of the Committee's Effectiveness Questionnaire** K Wilshere agreed to circulate the 'Self-Assessment of the Committee's Effectiveness Questionnaire' to members of the committee. He advised members that this would be presented as a link and a QR code and needed to be completed in 8 weeks.	**K Wilshere**
19/2023	**Audit Committee Annual Cycle of Business 2023** The committee reviewed the committee's Annual Cycle of Business. It was agreed that the committee would continue to complete and sign off the audit in May 2023 which had been the practice in previous years despite the extension of the deadline to the end of June 2023.	

Item No		Action
20/2023	**Matters for Escalation** The Chair referred K Wilshere to the discussion that took place in his absence over the concern raised by Internal Audit on the lack of updates on Internal Audit recommendations despite some being 'medium and high' risks and suggested that this be taken to Trust Management Committee for escalation. K Wilshere confirmed he would discuss this with A L Stirling and Internal Audit in targeting individuals who are not addressing their audit recommendations.	**K Wilshere**
21/2023	**Any Other Business** No additional business was raised by members of the committee.	
22/2023	**Review of the Meeting** The Chair reminded members that this was an 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 with relevant discussion, involvement, and challenges from members. The quality of the agenda items had been very good, and the reports had been easy to read.	
23/2023	**Date and Time of Next Meeting** 26 May 2023 at 10.30 am	
24/2023	**Future Meeting Dates** 12 September 2023 – 10.00 am private meeting with Internal/External Audit/LCFS with committee members. 10.30 am full committee meeting. 12 December 2023 – 10.30 am	

Trust Board Committee Chairs Assurance Report

The Royal Wolverhampton NHS Trust

Name of Committee:	Audit Committee
Date(s) of Committee Meetings since last Board	26 May 2023
Chair of Committee:	Julie Jones
Date of Report:	30 May 2023

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	• The Committee had previously escalated to Trust Management Committee their concern that recommendations raised by internal audit were not being updated on iBabs to demonstrate that actions had been addressed in accordance with the agreed timescales. Whilst there has been some improvement, the committee again noted that updates were required.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Following escalation from P&FC, members noted that committee's investigation into retrospective procurement approvals and discussed the linkage with the internal audit report of Private Sector Contracts, which gave '**reasonable** assurance' but raised parallel concerns in some areas. The committee will follow this up at its September meeting once further work has been undertaken for P&FC.

ASSURE **Positive assurances & highlights of note for the Board**	• The committee reviewed the BAF and discussed current risks, in particular the importance of the Cost Improvement Plan. • The quarterly security report gave assurance that risks were being managed. • In addition to Private Sector Contracts, internal audit reports of Research & Development (LCRN) and the Data Security & Protection Toolkit were received, with no high-risk recommendations raised. The committee also received oral assurances that the BAF/TRR audit had been completed and a report giving '**substantial** assurance' would be issued. • The internal audit plan for 2023/24 was reviewed. • The committee received the Local Counter Fraud Service annual report together with a progress report. • External audit outlined the results of their audit for the year ended 31 March 2023 and the committee was assured that there were no material unadjusted errors or significant control weaknesses. • A significant item of business for the committee this meeting was reviewing the Trust's annual report and financial statements for the year ended 31 March 2023, as supported by detailed explanatory papers by officers. Based on the reports provided and the feedback from external audit, the financial statements were recommended to the Trust Board for approval. • In addition, the draft Quality Report for 2022/23 was also reviewed. • The committee received a report detailing Single Tender Actions and Suspension Breaches.
Recommendation(s) to the Board	• Losses and special payment proposed write offs were agreed for final approval by the Trust Board. • The Trust's financial statements for the year ended 31 March 2023 were recommended to the Trust Board for approval.
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. • Members and visitors had previously been tasked with completing a self-assessment of the committee's effectiveness. The committee reviewed the outcome of this self-assessment but noted that less than ideal numbers of responses had been received. It was agreed that the survey would be recirculated. That said, it was clear from those responses received that the committee should review the level of information it receives under each agenda item; members agreed to meet outside of committee to discuss this.

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 noted that the meeting had a full agenda of almost 700 pages with some very important documents to consider, but that thanks to the quality and timeliness of the papers the meeting was able to be conducted efficiently. • Members noted the need for a new committee member to be appointed to replace Mr Hemans.
Items for Reference Pack	• None

Audit Committee – Review of Activities 2022/23

Meetings held in Year

The Audit Committee met four times in the year (May, September, December 2022, and February 2023).

Membership/Attendance

Membership during the year has changed with R Dunshea and M Martin ceasing to be a member of the committee in May 2022. J Jones, J Dunn and J Hemans joined the committee in May 2022 with J Jones becoming the Chair in September 2022.

The Audit Committee has been quorate at each of its meetings, with attendance over the four meetings being as follows: -

	May 2022	**September 2022**	**December 2022**	**February 2023**
R Dunshea (Chair to May 2022)	✓ (last meeting)			
M Martin	X (last meeting)			
L Toner	✓	✓	✓	✓
J Jones (Chair from September 2022)	✓	✓	✓	✓
J Dunn	✓	✓	✓	X
J Hemans	✓	✓	✓	X

Business Conducted

In the course of its four meetings, the Committee has considered and where required, taken a view on the following: -

- The Trusts Annual Accounts 2021/22 and Annual Report and the related reports from both Internal and External Auditors

- Charity Fund Annual Accounts and Annual Report 2021/22 and the related report of the External Auditors

- The Annual Reports of Internal Audit (including the Head of Internal Audit Opinion) and of the Local Counter-Fraud Specialist for 2021/22

- Risk Management and Board Assurance Framework

- Regular reports form the Head of Security and Car Parking and the Annual Report

- The External Auditors Annual Audit Letter for 2021/22

- The External Audit Plans 2021/22 for both the Trust and the Trusts Charitable Funds

- Internal Audit and LCFS plans for 2021/22 and regular reports detailing progress against the agreed plans.

- Regular reports identifying the progress the Trust has made in implementing recommendations agreed in Action Plans consequent on Internal Audit reports, with particular attention paid to "high" and "medium" priority recommendations.

- Reviewed and agreed the Trust Fraud Policy based on best practice.

- The Trusts Annual Governance Statement for 2021/22, was discussed at the Audit Committee meeting in May 2022.

In addition to the above, the Audit Committee has: -

- reviewed its Terms of Reference and draft Head of Internal Audit Opinion

- held regular private meetings with Internal and External Auditors and LCFS

- submitted the minutes of its meetings to the Board, with the Chairs report highlighting any issues of significance.

- Commenced a performance review of its activities and agreed KPIs for the three main assurance providers – Internal Audit, External Audit and LCFS

The Committee has reviewed its work plan together with its Terms of Reference and concluded that it has complied with its Terms of Reference.

The Royal Wolverhampton NHS Trust

Trust Board	
Meeting Date:	6 June 2023
Title of Report:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2022/23
Action Requested:	Receive and note
For the attention of the Board	
Assure	To provide assurance of the Trust emergency preparedness activities and statutory compliance with the Civil Contingencies Act 2004.
Author Contact Details:	Tel 01902 694310 Email diane.preston@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement. b) Safe and responsive urgent and emergency care
Support our Colleagues	a) Improve overall staff engagement
Resource Implications:	None
Report Data Caveats	Do not apply
CQC Domains	Safe: Effective: Caring: Responsive: Well-led.
Equality and Diversity Impact	None
Risks: BAF/ TRR	1542 – Green
Risk: Appetite	None
Public or Private:	Public
Other formal bodies involved:	Emergency Planning Group – RWT Local Health Resilience Forum (LHRF) West Midlands
References	EPRR Framework 2022, Civil Contingencies Act 2004

Brief/Executive Report Details	
Brief/Executive Summary Title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2022/23
Item/paragraph 1.0	This report provides an account of the Trust emergency preparedness activities undertaken from 1 April 2022 – 31 March 2023. It details planning progress to ensure the Trusts resilience in the event of a disruption incident. This includes the development of emergency planning and preparedness, training and exercising, assurance requirements as well as instances where the Trust has had to respond to extraordinary circumstances. It details the events the Trust has responded to in 22-23, training undertaken and the assessment of the organisation against the EPRR core standards. The Trust was overall assessed as partially compliant.
2.0.	The annual report has been approved by the Trust Management Committee on 26th May 2023 and is shared with the Public Board for information.

The Royal Wolverhampton NHS Trust

Emergency Preparedness, Resilience and Response (EPRR)

Annual Report 2022/2023

Department: Emergency Preparedness
Date: May 2023

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

Care Colleagues Collaboration Communities

CONTENTS

ABBREVIATIONS

AEO	Accountable Emergency Officer
BC	Business Continuity
CCA	Civil Contingencies Act 2004
CBRNe	Chemical, Biological, Radiological, Nuclear, and explosive
CRR	Community Risk Register
CWG	Commonwealth Games
ED	Emergency Department
EP	Emergency Planning
EPRR	Emergency Preparedness, Resilience and Response
GDPR	General Data Protection Regulation
HEPOG	Health Emergency Preparedness Officers Group
ICB	Integrated Care Board
ICC	Incident Coordination Centre
MI	Major Incident
NRR	National Risk Register
SDEC	Same Day Emergency Care
SPOC	Single Point of Contact
UKHSA	UK Health Security Agency
WMAS	West Midlands Ambulance Service

1.0 BACKGROUND

The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level.

The NHS England Emergency Preparedness Framework was reissued in July 2022 with several new requirements, which the emergency planning team are currently working on to update plans and activities.

From July 2022, the NHS structure changed when NHS England established the Integrated Care Boards (ICB) and abolished Clinical Commissioning Groups. Working with NHS England, the ICB provide command, control and co-ordination as required for emergency preparedness incidents. The ICB is now classified as a Category 1 responder under the CCA 2004. The Trust has been working in partnership with the ICB to ensure compliance and the delivery of the legal duties.

As a category one responder, the Trust is subject to the following civil protection duties.

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance coordination.
- Cooperate with other local responders to enhance coordination and efficiency.

2.0 INTRODUCTION

This paper describes the EPRR activities of The Royal Wolverhampton NHS Trust during 1 April 2022 to 31 March 2023, to meet the required requirements of the Civil Contingencies Act 2004 and the updated NHS England Emergency Preparedness framework 2022.

This includes the development of emergency plans, incident response training, assurance requirements and lessons identified following local incidents. During this reporting period the Trust has placed great focus on preparedness for the 2022 Birmingham Commonwealth Games, planning for industrial strike action and the continuing response to COVID-19.

3.0 RISK ASSESSMENT

The National Risk Register (NRR) and Community Risk Register (CRR) for EPRR are intended to capture a range of civil emergencies which may affect the Trust's ability to deliver its duty under the Civil Contingencies Act (2004).

The Trust maintains an internal EPRR risk register which is managed by the Emergency Preparedness team. This is reviewed regularly and mirrors the National and Community Risk Registers. It details arrangements to mitigate risks to the Trust and scoring is based on consequence and likelihood.

This follows the Trust's risk management policy allowing for consistent identification and assessment.

4.0 GOVERNANCE ARRANGEMENTS

The overall responsibility for complying with the Civil Contingencies Act (2004) and EPRR Framework sits with the Chief Executive who is responsible for ensuring, through appropriate delegation of responsibility within the organisation and relevant core standards are met.

The Accountable Emergency Officer (AEO), the Chief Operating Officer is the Executive Director with delegated responsibility for ensuring resilience across the organisation and the delivery of safe and responsive responses to all kinds of emergency disruptions, supported by the Head of EPRR.

Operational management is provided by the Head of EPRR who represents the Trust at local and regional forums including the Health Emergency Preparedness Officers Group (HEPOG). The Head of EPRR also takes responsibility for ensuring compliance with the Civil Contingencies Act (2004), current NHS Emergency Preparedness, Response and Resilience guidance (2022) and other government led guidance.

The Trust has an Emergency Planning Group (chaired by COO/AEO) which meets six-monthly. This is supported by two sub-groups: Major Incident Planning (chaired by Divisional Medical Director) and Business Continuity (chaired by Deputy Chief Operating Officer) which meets on a quarterly basis.

5.0. PARTNERSHIP WORKING

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal groups of which the Trust is a member of Birmingham, Solihull, and Black Country Local Health Resilience Partnership (LHRP) and locally the Wolverhampton Protect and Prepare Board.

The purpose of these groups is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England/Improvement.

6.0 PLANNING AND PREPAREDNESS ACTIVITIES

Over the last year, a number of plans and policies have been reviewed and updated to incorporate changes in national guidance and changes in NHS structure. These have been approved at the relevant groups and are include below.

Plan / policy	Update
EPRR policy	The Trust EPRR policy has been updated to reflect changes in the new NHS structure and updated EPRR Framework published in July 2022. This was approved at TMC in September 2022.
Major incident and mass casualty plan	The Trust Major Incident plan was revised in March 2023 to ensure ongoing capability in responding to a disruptive incident. The plan includes updates as a result of changes to the NHS structure and NHS England incident response plan. It also includes the role of Same Day Emergency Care (SDEC), which now operate across several service areas, and will be used as part of a major incident response. The plan was submitted to the major incident group and emergency planning group for approval and ratification. The plan will shortly be available on the Trust intranet. All major incidents are currently being reviewed in line with changes, with the addition of new ones.
Heatwave plan 2022	The Trust Heatwave plan was reviewed and launched in May 2022, in line with national heatwave guidance. The main changes to the plan include rebranding of PHE to UKHSA. During the heatwave period, the UKHSA issued a level four heat health warning. As a result, the Trust evoked its heatwave plan. As part of continued preparedness, the Trust was also requested to provide assurance statements to the ICB.
Cold Weather plan 2022	The Trust Cold Weather plan was reviewed in November 2022, in line with national guidance. Minor changes were made to take into account rebranding of PHE to UKHSA and NHS structure changes.
Chemical, Biological, Radiation and Nuclear (CBRN) plan	The Trusts CBRNe plan has been reviewed and updated in June 2022. This is in line with its three yearly review process.
Mutual Aid Agreement Oct 2022	Mutual Aid agreement has been agreed with Walsall Healthcare NHS Trust.

Shelter & Evacuation Plan April 2022	Plan has been produced to provide a framework for the shelter and evacuation of patients, staff, and visitors to a suitable place of safety in the event of response to a major disruption at the Royal Wolverhampton NHS Trust. Approved by EPG Mar 2022.

7.0. SPOC MAILBOX

The Trust has in place a Single Point of Contact (SPOC) mailbox for business-as-usual requests. This is monitored by the EPRR Team, throughout the course of the working day and continues to be operational. The EPRR Team are responsible for forwarding guidance and information requests received from the ICB, to relevant staff. This was a requirement as part of the NHS structure changes.

8.0 TRAINING

This year, there has been increased focus on delivering major incident training aimed at staff new to on call. This has returned to face-to-face training. Full details are listed below.

Training	Update	Date
Tactical Command training MS Teams	Tactical command training has been delivered to 18 on call managers. The aim of the sessions is to provide managers with an update on EPRR arrangements in being able to respond to a major incident and to build their competence. Two sessions were cancelled in December 2022 and March 2023 due to Trust pressures because of staff strike action. More training dates are planned for this year.	Nov 22 Jan 23 Feb 23
Electronic grab packs	The electronic grab packed launched in May 2021 provides a repository for major incident action cards and guidance. This is reviewed regularly so that Trust on call directors and managers have access to the latest information. Training on using the system is delivered as part of tactical command training.	On going
Strategic and tactical e-learning	E-learning is available for on call directors and Trust on call managers. It covers the Trust's EPRR command and control arrangements in responding to emergency incidents.	On-going

	E-learning also includes a series of multiple-choice assessment questions.	
Principles of Health Command	A training course has been developed by NHS England to support the development of knowledge and competencies as an effective strategic leader operating in several different environments, including multi-agency Strategic Coordinating Groups, Regional, System and operational strategic groups and Incident management Teams. The training was undertaken via MS Teams and covered aspects linked to EPRR legal aspects and the importance of learning from incidents. Eleven directors/s attended the course from November 22 to February 23.	Nov 22 Dec 22 Jan 23 Feb 23
CBRN training	CBRN/Major incident training for ED staff recommenced in April 2022 and will run through to October 2023. A number of in-service study days have been arranged which includes refresher training on incident management as well as ram-gene training. An ED course has been set up to run through the year. This is aimed at ED staff to provide awareness training on major incident and CBRN response. Major incident training for ED reception staff was also commenced in April 2022. This provides awareness of actions to take following presentation of a contaminated patient.	

9.0 EXERCISES

As part of the requirements under the Civil Contingencies Act (2004), the Trust is required to regularly test its emergency arrangements. This includes the below.

- communication tests at least every 6 months
- tabletop exercises at least every year; and
- a live or simulated live exercises at least every 3 years.

The Trust has taken part in the below exercises during 2022/23.

Exercises	Update	Date
Communication exercise	An internal communication exercise was undertaken in July 2022, utilising the electronic system Alert Cascade. This was aimed at on call managers and directors. Response rates from members was over 70%. Further tests are planned to take place throughout the year. The Trust has been working towards improving use of Alert Cascade and has developed a standard operating procedure to support with keeping emergency contacts up to date. This has been produced alongside the information Governance team to ensure compliance with GDPR. The Trust also participated in a number of external communications tests linked to the ICB and NHS England. This tested both the Trust incident mailbox and voice call. These were carried out in July 2022 in readiness for the Birmingham Commonwealth Games.	July 2022
Exercise Artic Willow Winter preparedness and operational pressures	The Trust took part in exercise Artic Willow, an external exercise led by the UK Health Security Agency (UKHSA), involving ICB. And NHS England Resilience. This was held via MS Teams and explored EPRR arrangements to concurrent issues including industrial action, power outages and rising operational pressures. The exercise focused on decision making, mutual aid support from resilience partners and business continuity management. A services of learning points were identified from this exercise, which the Trust is reviewing and will establish a work programme to reflect some of this learning.	Dec 2022
Electrical Service Outage	An exercise to respond to the total loss of incoming electrical supply at the Trust Incoming substation, without warning. This exercise was split into 2 phases: Phase 1 with the Trust's electrical engineers and Phase 2 to test operational business continuity arrangements to follow.	Jan 2023

With the continual response to COVID-19 and operational pressures the Trust has stood down various exercises. An exercise programme is currently being developed to ensure these exercises are resumed to meet the statutory obligations under the Civil Contingencies Act 2004. The following exercises are planned to take place this year.

- Data security, cyber incident May 2023 (tabletop exercise using MS Teams)
- Intensive Critical Care response to major incident, July 2023 (live exercise)
- Trust business continuity response to electrical outage phase 2 (tabletop exercise using MS Teams) date TBC.
- CBRN - response to radiation contamination incident (live exercise) date TBC

10.0 INCIDENTS

10.1 ADASTRA CYBER ATTACK

On the 4 August 2022, a major outage occurred which affected systems provided by Advanced. This caused disruptions to Adastra software impacting services provided by NHS 111.

The Trust Cyber Security Team provided support to ensure we were resilient throughout this incident. Contingency measure was put in place and NHS Resilience (NHS England EPRR) managed the incident through regional teams and national support and coordination.

10.2 EVACUATION OF WARD

On the 16 December 2022, two ward areas at New Cross Hospital site were evacuated due to a flood on the roof.

An incident debrief is due to take place on the 31 May 2023.

10.3 EXTERNAL PHONE OUTAGE

On the 21 March 2023, the Trust experienced a telephony issue which affected inbound and outbound calls at New Cross Hospital. This included alert phones in ED, Maternity and Cardiology. The incident was declared at 05:00 and reported to the ICB and NHS England.

The issue was related to the consumer portion of the Vodafone network in the Small Heath SBC. This impacted other large organisations as well as the Trust running on the Vodafone service. The incident was resolved by Vodafone, and the Trust stood down the incident at 11:51.

Community & GP telephony was understood as not being impacted and the hospital satellite sites for Cannock and West Park were also unaffected. Disruption was limited to the New Cross site and business continuity plans for reverting to mobile

communication technology and unified IP comms was used. External stakeholders such as WMAS was informed, and a business continuity process invoked for emergency portal response regarding Emergency ambulance calls.
Following the incident, a full incident brief was undertaken to identify lessons learned and recommendations.

11.0. REIONAL AND NATIONAL ACTIVITIES

11.1 BIRMINGHAM 2022 COMMONWEALTH GAMES

Birmingham hosted the Commonwealth Games which started on the 28 July 2022. This involved 11 days of sporting activities across fifteen venues in the West Midlands. Wolverhampton was in the footfall of the Cycle Time Trial which took place on the 4 August. The route started and finished at West Park and went across Dudley and South Staffordshire area.

Since November 2021, the Trust has been involved with extensive regional and local planning to support preparedness for the games and service continuity across the Trust hospital sites.

On the 4 August, the Trust activated the silver incident control room, to provide support with any operational issues during the day. There were a couple of minor issues on the day for the community teams which were resolved quickly. Overall, there were no significant patient concerns. This was a good test of the incident control room set up which went well. Assurance returns were submitted to the ICB and NHS England throughout the period.

11.2 INDUSTRIAL ACTION

Following national dispute about NHS pay, members from various NHS Trusts have taken part in industrial action. The Trust formed a task and finish group in October 2022 to support ongoing delivery of services during the first period of nurse and ambulance strikes. As the Trust did not receive a mandate for the initial nursing strikes, impact on Trust services has been minimal.

In light of the announcement of junior doctor strike dates, extensive planning has been underway. Divisional teams have been working to ensure that robust plans are in place to maintain safe patient care, whilst also ensuring support is in place for colleagues who have chosen to take strike action. This has led to a considerable number of appointments being rescheduled during the below strike periods.

- 7am on Monday 13 March until 7am on Thursday 16 March.
- 7am on Tuesday 11 April until 7am on Saturday 15 April.

During these strike dates, the Tactical (silver) control room has been activated to support with any operational issues. The Trust Chief Medical Director and COO/AEO have led this. The Trust has also been required to submit regular situation reports to the ICB and NHS England.

The Trust Task and Finish Group will continue to meet to support effective planning following failed attempts at negotiations with the Government.

12.0 ASSURANCE AND OBLIGATIONS

12.1 EPRR CORE STANDARDS

The core standards for EPRR have been revised and were issued in July 2022. These standards are an underpinning requirement for NHS funded organisations. Assessment against the standards provide an assurance rating on EPPR activities and demonstrates we have plans in place to effectively deal with a wide range of emergency incidents.

This year, the Trust overall was rated as 'partially compliant' against 64 standards. A breakdown is provided in the below table. Throughout the assessment process the Trust has taken part in many confirm and challenge sessions led by the ICB and overseen by the regional EPRR team. Final submission was made to the Local Health Resilience Partnership Group in November 2022.

.	Fully compliant	Partially compliant	Non-compliant
Trust compliance	54	10	0

An action plan has been put in place to support progress with the standards identified as partially compliant.

A monitoring and assurance meeting took place in March 2023 with the ICB to provide assurance of progress on the 10 identified partially compliant standards.

12.2 CBRN audit

The West Midlands Ambulance Service (WMAS) undertook an annual review of the Trusts decontamination facilities and equipment in November 2022. A self-assessment tool was completed prior to a site visit from WMAS review team. This was followed by a challenge and confirm process on the submitted responses.

A final report was shared which identifies key findings. Overall, the assessment was well received with no recommendations and WMAS representative noted areas of best practice. The Trust was noted as having well developed CBRN plans, and decontamination procedures in line with national requirements.

13.0 PRIORITIES FOR 2023/24

- Core Standards to achieve and maintain full compliance.
- On-going Training, Trust on call managers.

- A series of exercises as outlined in work programme.
- Review of National Occupational Standards and Core Competencies of key staffing groups for Emergency Preparedness.
- On-going planning and preparedness for industrial action

The Royal Wolverhampton NHS Trust

TRUST BOARD		
Meeting Date:	6th June 2023	
Title of Report	Infection Prevention and Control Annual Report 2022/23	
Action Requested:	**Receive for assurance, accept report**	
For the attention of the Board		
Assure	- The Infection Prevention and Control Annual Report 2022/23 provides assurance of performance against internal and external objectives and achievements in the year period. - Below external 2022/23 targets for *E. coli, Pseudomonas aeruginosa* and *Klebsiella* species bacteraemia. - CPE screening continues to pick up patients and reduce the risk of spread – total of 53 new patients identified 2022/23. - Maintained compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health and Social Care, 2015). - National and regional COVID-19 guidance reviewed and implemented through a respiratory virus (including COVID-19 and influenza) joint corporate risk assessment (RWT and WHT) which was cited as an exemplar process by NHS England and the Integrated Care Board (ICB) and was shared regionally.	
Advise	- COVID-19 activity continued in 2022/23 requiring ongoing monitoring of patients, outbreak management and placed pressure on side-rooms utilisation. - Above internal 2022/23 targets for Meticillin sensitive *Staphylococcus aureus* (MSSA), Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia and Device-Related Hospital Acquired Bacteraemias (DRHABs).	
Alert	Above external *C difficile* target with 72 (against annual target for 2022/23 of 58)	
Author and Responsible Director Contact Details:	Matthew Reid Tel 88293 email: matthewreid@nhs.net Debra Hickman, Director of Nursing Debra.hickman@nhs.net	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement c) Safe and responsive urgent and emergency care
	Support our Colleagues	c) Improve overall staff engagement
	Improve the Healthcare of our Communities	c) Deliver improvements at PLACE in the health of our communities
	Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability d) Progress joint working across Wolverhampton and Walsall e) Facilitate research that improves the quality of care

The Royal Wolverhampton NHS Trust

Resource Implications:	
Report Data Caveats	
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	None
Risks: BAF/ TRR	Trust reputational risk if infections increase
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	ICB, Public Health contract IP services from RWT
References	The Health and Social Care Act 2008 Code of Practice on the prevention and control of infection and related guidance (2015)
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:		Infection Prevention and Control 2022/23 Annual Report
1.0	The Annual Report highlights all the achievements and performance data for 2022/23. It highlights • the extensive work the IP team have undertaken to ensure that the organisation has responded accordingly to changes in national and regional COVID-19 guidance, and in so ensuring staff and patient safety is maintained. • the collaborative work with Public Health and the Local Authority to support care homes and other high-risk settings. • the collaborative and partnership working with Infection Prevention colleagues at Walsall Healthcare Trust. • RWT performance against internal and external trajectories. • support given to Wolverhampton GPs. • Audit and Surveillance. • Policy reviews. • Infection Prevention Serious incidents reported. • Intravenous Resource, Tuberculosis, Surgical Site Infection Surveillance and Continence teams' performance. **Resource/legal/financial/reputation implications** None **Link to BAF/Key risks** IP BAF and IP risks are discussed monthly at Infection Prevention and Control group (IPCG). **Proposals** The 2022/23 Annual Report is accepted.	

EXECUTIVE SUMMARY

The Infection Prevention (IP) Team have seen another busy year, with challenges in the form of continued COVID-19 cases, and an increase in the number of cases of influenza, Group A Streptococcus, Respiratory syncytial virus (RSV) and *Clostridioides difficile*. Despite this, The Royal Wolverhampton NHS Trust (RWT) has maintained compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015). This report takes the opportunity to celebrate the successes and highlights the increasing challenges going forward.

Increased risk factors for healthcare acquired infections (HCAIs) are recognised in the ageing population, complexity and level of illness or disease, alongside changes in use of health services, and the expanding threat of highly resistant organisms. These are all considered when drawing up our local strategy for preventing HCAI. The work of the IP Team includes education, research and development, standard and policy setting, establishing assurance processes and, most importantly, ensuring patient safety in the prevention of spread and acquisition of new infections across RWT and the wider community. During 2022/23 the IP Team have continued to ensure that both staff and patients are updated with national guidance and the appropriate PPE recommendations, particularly regarding COVID-19 and influenza. The IP team have strived to undertake proactive work, for example taking opportunities for staff education, involvement in regional and national initiatives and audits.

There were two RWT-attributable MRSA bloodstream infections during 2022/23; following investigation the root cause was thought to be related to an infected pressure sore (May 2022), and for the second case likely due to a catheter associated urinary tract infection.

Clostridioides difficile (*C. diff*) was over trajectory this year with 72 RWT-attributable cases during the year, against an objective of 58.

Unfortunately, RWT recorded 58 device related hospital-acquired bacteraemias (DRHABs) during 2022/23 against an internal trajectory of 48. This was a slight improvement from last year where 60 were reported.

There was an increase in patients identified with Carbapenemase Producing Enterbacteriales (CPE). 53 were identified compared with 27 (2021/22) 18 (2020/21) similar to pre-pandemic case numbers (56 in 2019/20). Patients are still risk assessed as previously in line with National guidance.

Environmental controls have been a top priority in our approach to tackling HCAI;

- The deep clean schedule has been challenged due to unavailability of a decant ward for majority of the year, due to extra bed capacity being required.
- Enhanced cleaning continued due to the high volume of COVID-19 patients.

Due to an observed increase in numbers of *Clostridioides difficile* cases RWT requested a peer visit from the regional Infection, Prevention and Control (IPC) lead at NHS England (NHSE). Overall, the visit was very positive, and areas for improvement are being actioned. Following a previous visit that was completed in the Trust in November 2021 the Trust were assessed as ‘Green’ on the NHSE Midlands Internal Infection Prevention and Control (IPC) matrix. Since that visit NHSE have changed the terminology used to align with the terminology used in the National Operating Framework (NOF). Following the peer visit, on considering the findings against the NHSE Midlands Internal IPC Matrix NHSE confirmed that the Trust have been assessed as **routine monitoring and support.**

The Intravenous Resource Team continues to deliver a high standard of line care with increasing numbers of patients discharged on Outpatient Parenteral Antibiotic Therapy (OPAT) and some months, record numbers of lines were inserted. This is a year-on-year trend.

Surgical Site Infection (SSI) Surveillance continues across all specialities, data is shared with Consultant surgeons and surgical teams via a monthly dashboard.

Influenza preparedness and prevention for patients and staff was a key activity. In line with national numbers of cases RWT has seen several influenza cases during this season. The uptake of influenza vaccine among front-line staff was 41% which was a decrease from uptake in 2021/22 (58%).

There has continued to be proactive engagement and partnership working with our Public Health colleagues. Outbreak management support to care homes and very sheltered housing establishments across the Wolverhampton health economy was maintained, ensuring a seamless service across healthcare facilities throughout the city. During periods of reduced outbreak activity, infection prevention audits and education took place in care homes. In the acute Trust there were 2 outbreaks of flu and only 2 Norovirus outbreaks; however, there were 85 outbreaks of COVID-19 (39 in 2021/22).

This year saw an outbreak on Monkey Pox nationally, there were 3,585 laboratory-detected cases of monkeypox in the UK (Sept 2022). This included 3,439 confirmed and 146 highly probable cases. The majority of cases were identified in London residents, with the cases being predominantly male. The IPT worked with regional UK Health Security Agency (UKHSA) teams, Occupational Health and Wellbeing and Sexual health teams to support case identification and management.

The IP team continued to forge relationships and partnership working with Walsall Healthcare Trust IP colleagues and wider. Throughout 2022/23 both Trusts jointly developed, and amended accordingly, a respiratory virus (including COVID-19 and influenza) corporate risk assessment. This was cited as an exemplar process by NHS England and the Integrated Care Board (ICB) and was shared regionally.

There have been four risks managed by IP team during 2022/23 relating to:

- Risk of delay in reporting and investigation of healthcare acquired COVID-19 infections
- CPE screening not undertaken according to updated National guidance
- The Trust is at risk of increased incidence of Healthcare Acquired Infections (HCAI) as there are a limited number of side rooms and a limited number of side rooms with ensuite facilities
- Risk of outbreaks with potential to cause patient harm, disrupt activity and give rise to media attention

INTRODUCTION

The existing Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (also referred to as The Hygiene Code) was updated in December 2022:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

The code of practice document has been updated to reflect changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the role of infection prevention and control (IPC) (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance. The new document takes account of changes to the IPC landscape

and nomenclature that have occurred since the COVID-19 pandemic. The law states that the Code must be considered by the CQC when it makes decisions about registration. The regulations also say that providers must have regard to the Code when deciding how they will comply with registration requirements. So, by following the Code, registered providers can show that they meet the requirement set out in the regulations. The Code aims to exemplify what providers need to do to comply with the regulations.

CQC review the code requirements in relation to Fundamental Standard Regulation 12 – Safe care and treatment and Fundamental Standard Regulation 15 - Premises and equipment. The Trust is declaring full compliance with the Code.

INFECTION PREVENTION REPORTING STRUCTURE

Infection Prevention and Control Group (IPCG)

The IPCG continued to meet monthly during 2022/23, with meetings chaired by the Medical Director. Monthly reports are received by IPCG from the operational teams and supporting departments which demonstrate and assure compliance; this includes dashboards from the clinical Divisions and reports from Hotel Services, Pharmacy, Estates, the Decontamination Lead and Occupational Health and Wellbeing. COVID-19 data and the Infection Prevention Board Assurance Framework document was also discussed. These meetings took place on Microsoft Teams.

The Head of Nursing for Corporate Support Services sits on the Trust's Senior Nurses Leadership Forum and the Senior Matron Infection Prevention sits on the Environment Group and Matrons, Ward Managers, Senior Nurses, Midwives, Health Visitors and Allied Health Professions Group.

These forums offer an additional opportunity to feedback information to the wards and departments and receive information to inform the priorities and actions of the Infection Prevention Team.

Infection Prevention continues to report to the Integrated Care Board (ICB) (formerly Clinical Commissioning Group (CCG) as part of the commissioned services, to include jointly funded projects with Public Health.

The Infection Prevention Team attend relevant meetings regarding Estates development, procurement and commissioning when required.

A Consultant Microbiologist sits on the Medicines Management Group. The Microbiologists continue to work with the Antimicrobial Pharmacist in monitoring, auditing, and education on the use of antimicrobials, and an Antimicrobial Stewardship Group meets regularly. The Ward Pharmacists monitor antimicrobial use around the hospital. An antimicrobial ward round has been in place since July 2021 which includes Consultant Microbiologist, Antimicrobial Pharmacist, and an Infection Prevention Practitioner.

The Infection Prevention Team meets weekly to review and discuss COVID-19 data, progress against the annual programme of work, surveillance data, team aspects and governance data which include policy, patient literature, audit and effectiveness, NICE guidance compliance, investigations including root cause analyses (RCA) completed and lessons learnt, compliments and complaints, internal and external visits and reviews, Freedom of Information requests, action plan monitoring and Health and Safety compliance.

Reports to the Trust Board

At every Trust Board the Director of Nursing presents the Chief Nursing Officer (CNO) Report for the organisation, which includes the most recent infection prevention performance data. Bi-monthly IP reports are presented to Trust Board, therefore, ensuring full sight and access to all information concerning the Trust's performance against the external and internal infection prevention targets and other infection related issues. Infection Prevention Board Assurance Framework document was presented at Trust Management Committee, Trust Board and Quality Governance Assurance Committee (GCAC). The Consultant Microbiologist delivers an IP report to the Quality & Safety Assurance Group (QSAG) twice yearly.

The Infection Prevention Team (IPT) comprises the following individuals:

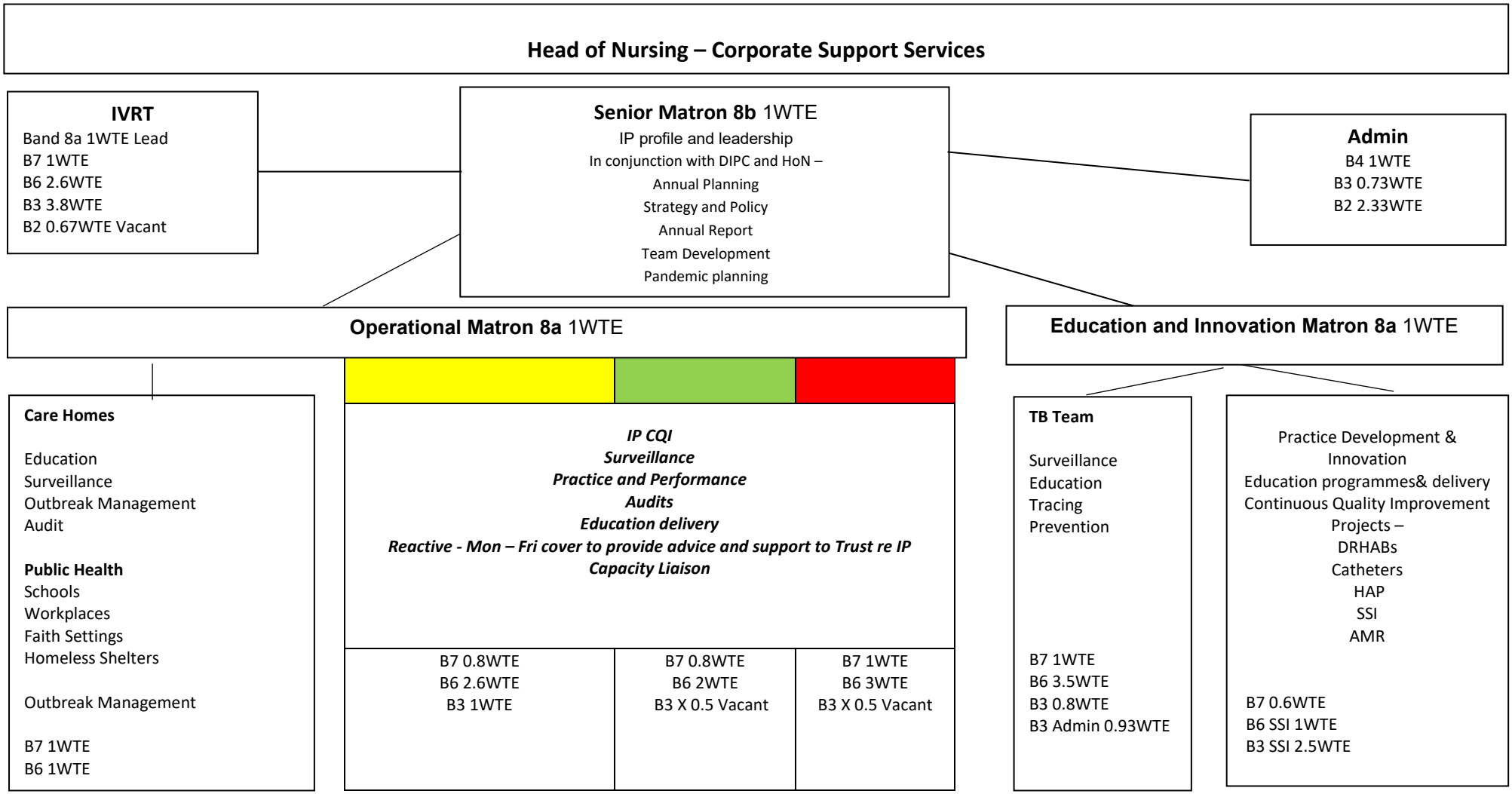
Sessional Commitment to Infection Prevention:

Name	Title	Sessional Commitment to Infection Prevention
Dr J Macve	Consultant Microbiologist, Infection Control Doctor	5.0 PA
Dr D K Dobie	Consultant Microbiologist, RWT Head of Microbiology Department, Infection Control Doctor Wolverhampton Service specification - Primary care, Pandemic Influenza lead	2.0 PA
Dr H E Jones	Consultant Microbiologist	0.5 PA
Dr K French	Consultant Microbiologist, Antimicrobial Stewardship lead started in post March 2021	0.5 PA
Dr A Johnson	Locum Consultant Microbiologist August – December 2022	0.5 PA

Pharmacy Staff

Mrs P Kang	Antimicrobial Stewardship Pharmacist	0.67WTE
Mrs H Sandhu	Antimicrobial Stewardship Pharmacist	1.0WTE

Infection Prevention Service 2022



Infection Prevention Risks

Risk	Open/closed	Current grade	Key points of update
5599 - If due to an increase Covid cases the Trust is unable to achieve policy for the reporting and investigation of healthcare acquired COVID infections, there will be the following impacts: risk to Trust reputation where Datix and investigation reports are not available for any future complaints and litigation. Delay in 'Duty of candour' (DoC) response to individuals affected Delay in identifying areas for learning and improvement.	**Closed March 2023**		Weekly Covid incident review. (Feb 21) DoC processes initiated where triggered for HCAI Covid infections. All HCAI Covid death and Outbreak RCAs (along with SJR input) are signed off at an Executive group (ESERG) Risk closed as currently no delay in 'Duty of candour' (DoC) response to individuals affected or a delay in identifying areas for learning and improvement.
5648 – If CPE screening is not undertaken according to updated guidance RWT will not identify positive patients and will increase the risk of nosocomial transmission and outbreaks	Open	6 Yellow	Patients are risk assessed on admission but this only includes if travel abroad or has been an inpatient in another health care setting not including RWT. A business case is required by Microbiology to enable RWT to be fully compliant with the updated guidance.
5682 - The Trust is at risk of increased incidence of Healthcare Acquired Infections (HCAI) as there are a limited number of side rooms and a limited number of side rooms with ensuite facilities	Open	9 Amber	Patients are risk assessed on admission IP10 Isolation Policy and IP10 Appendix 1 Risk Categorisation table (RAG rated) available to support Explore converting bays into additional side rooms with ensuite facilities Work completed for 4 ensuite single rooms (2 on C26, and 2 on C14).
5777 – (Accepted on TRR May 22) – Risk of outbreaks with potential to cause patient harm, disrupt activity and give rise to media attention	Open	9 Amber	Wearing of face masks – patients and staff compliance Gaps in Screening compliance COVID dashboard in place IP 7 day working Compliance with Mandatory training for IP Level 1 and Level 2 is below expectations Community transmission remains high Increasing numbers of in-patient flu and COVID-19 positive cases.

Infection Prevention and Control Budget 2022/23

The funding for the Infection Prevention Team in Wolverhampton provided by RWT in 2022/23 consisted of a combination of RWT, Public Health and CCG funding.

A service provision continued to the Black Country and West Birmingham CCG providing advice, quality assurance and education to independent contractors in Wolverhampton including contracted GPs and dentists and care homes, the funding for which is now detailed in a service specification.

A service level agreement with Public Health provides the provision of flu and norovirus outbreak management to all Wolverhampton care homes and very sheltered housing. Following the expiry of COVID-19 grant funding to Public Health teams in October 2022 the

contract reverted to the pre pandemic contract to support Wolverhampton Care homes with outbreak management, from April 2023 a new service level agreement has been agreed.

The total combined funding from the Trust, CCG and Public Health was £1,308,546.

	Pay	**Non-pay**
Infection Prevention (including provision to Wolverhampton CCG, Public Health, and surgical site infection surveillance)	£1,186,902	£121,644

The Infection Prevention Team have had another challenging year due to COVID-19 Pandemic. National guidance changed frequently, and this was disseminated and implemented throughout the Trust upon receipt. Policies, flowcharts, standard operating procedures, and protocols were written and updated accordingly. The team were an integral part of the Silver Command and bed meetings ensuring that the Trust were fully informed of the progress of the pandemic and the number of cases and outbreaks within RWT.

All individuals in the Team are members of the Infection Prevention Society (IPS) and attend conferences, courses, and study days to network with other IP team members in other organisations. NHS England/Improvement (NHSEI) facilitated collaborative groups to share resources and educational packages for *C. diff*, gram negative, SSI and Gloves off campaign which the IP team were active members of. There is also ongoing collaborative work taking place with Walsall Healthcare Trust, with shared learning and opportunities for further development.

The Team successfully provided support and leadership for sheltered housing and care home facilities, successfully working alongside the Community Rapid Intervention Team (RIT) to greatly enhance provision for COVID-19, Norovirus and Flu outbreak management and prevention of admission to acute services. Regular meetings were held with Wolverhampton CCG, local authority, and Public Health to ensure that the care homes, predominantly, were managed appropriately.

Research, development, and innovation

The team were unable to complete any research work however there was some innovative work commenced around the use of urinary catheters with the design of a catheter passport. This was piloted on one ward in April/May 2022, the passport will be rolled out across the Trust in 2023 alongside a catheter pack to promote safe practice in the insertion of catheters and to support sustainability. As COVID-19 numbers reduced, the team were supporting areas in the restoration of business as usual and promoting a back to basics approach delivering *C. diff* focus education weeks across the Trust. In November 2022 the IP team hosted an interactive quiz for the Trust with 3 teams headed by Executives battling to answer questions and raise awareness of the basics of IP.

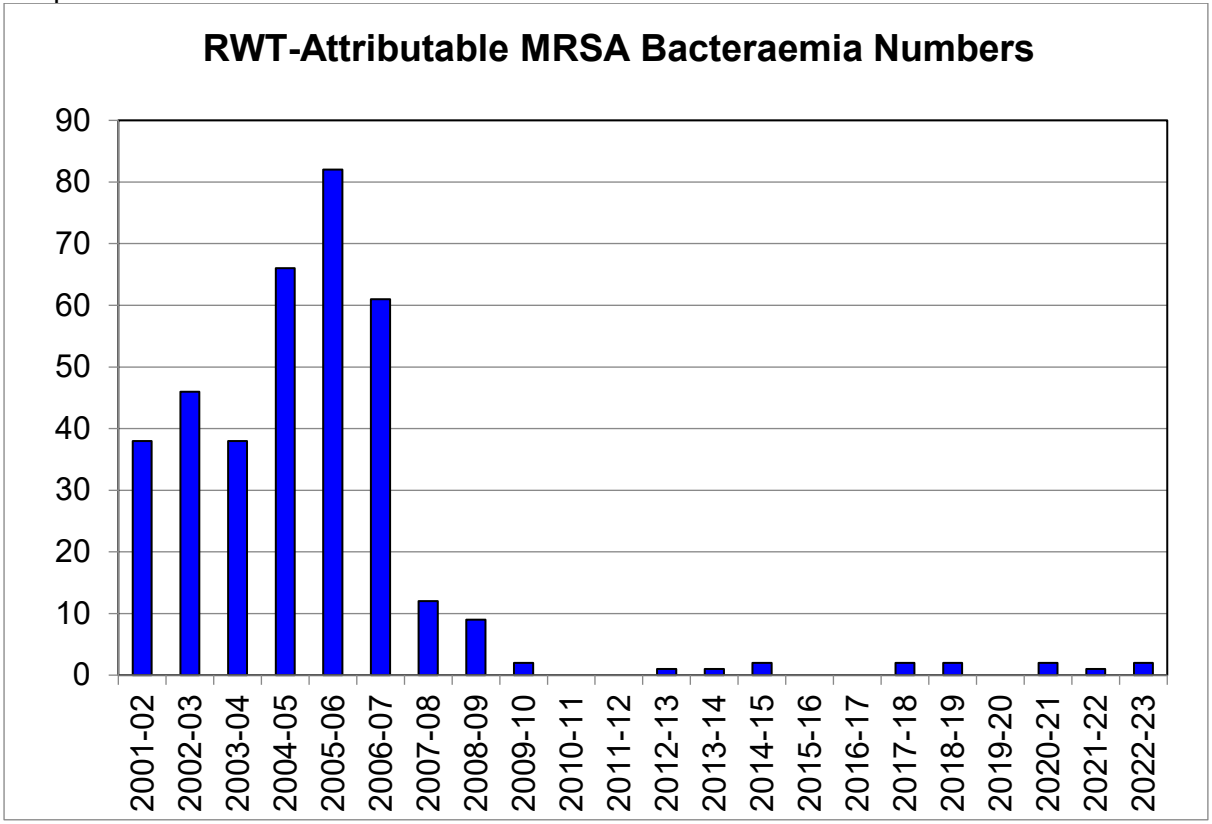
PERFORMANCE

a. Meticillin Resistant *Staph. aureus* (MRSA) Bacteraemias

The targets for the acute Trust and Wolverhampton CCG for MRSA bacteraemia are zero each year. RWT had two MRSA bacteraemias attributed to it during 2022-23. The first episode was in May 2022, and was thought to have arisen from infected pressure sores. The second bacteraemia was in February 2023 and was deemed to have come from an infection associated with a urinary catheter. Graph 1 shows the number of RWT attributable MRSA bacteraemias for each year since 2005-06.

Four patients who had not had any recent contact with RWT were found to have an MRSA bacteraemia on admission to New Cross Hospital; all the cases were attributed to Black Country and West Birmingham ICB. Of these, two episodes were for the same patient who presented each time with a groin abscess, one was thought to be from a chest infection and the fourth was thought to be due to a urinary catheter-related infection. All cases in Wolverhampton had root cause analyses (RCAs) undertaken and Serious Incident review meetings took place, to which the RWT IPT contributed.

Graph 1



b. Meticillin Sensitive *Staph. aureus* (MSSA) Bacteraemias

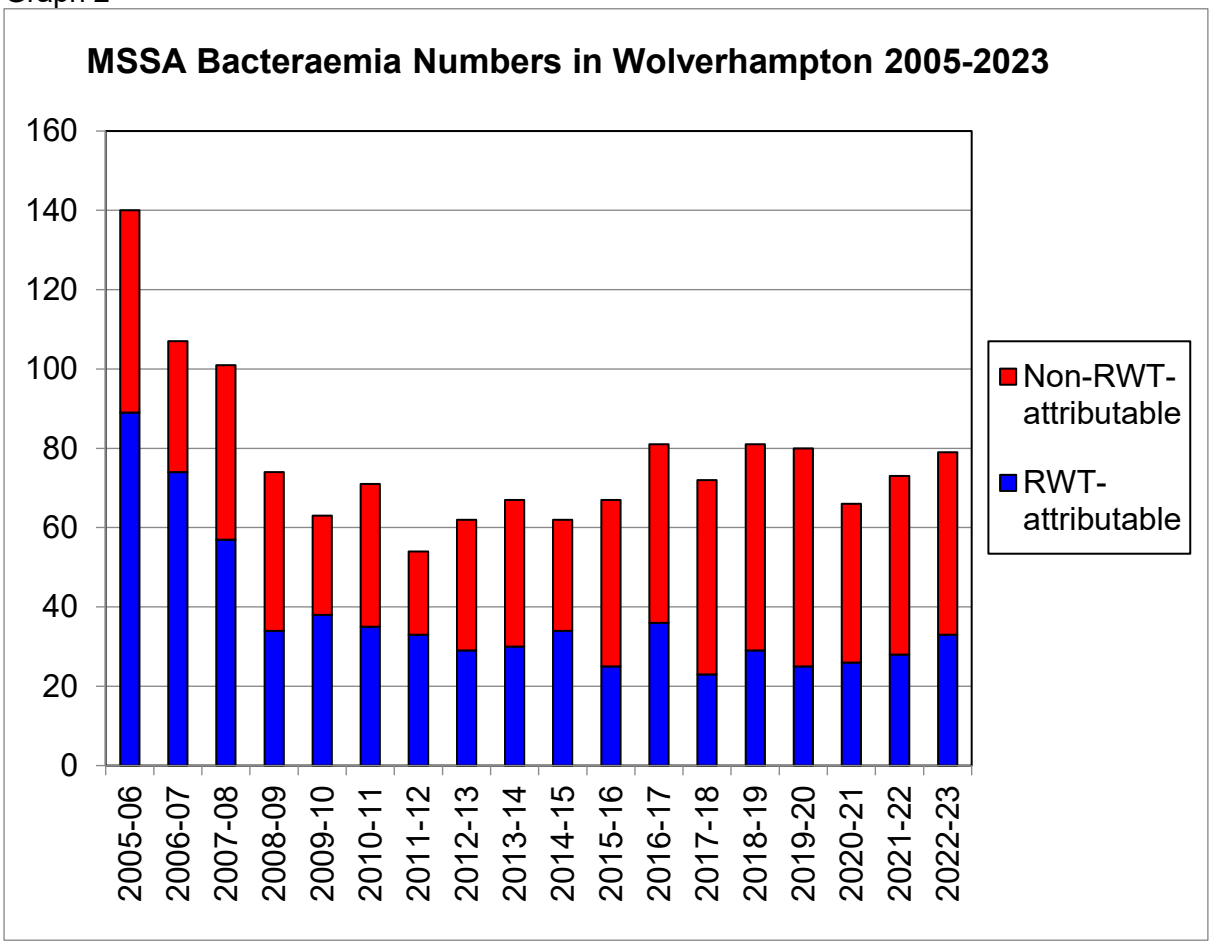
National mandatory surveillance of MSSA bacteraemia began in January 2011, but locally we have undertaken surveillance of these infections for much longer than this, with this information used as a Key Performance Indicator (KPI) across the organisation. Graph 2 shows the annual total number of MSSA bacteraemia diagnosed in Wolverhampton since 2005-06, split according to whether these infections were attributable to RWT or not using our in-house definition of attribution (which includes patients who have been recently discharged from our hospital, or are regular or day-case attenders as being RWT-attributable).

It can be seen that the total number of cases is higher than the previous year's total, and the number of RWT-attributable cases is the highest it has been since 2016-17. We exceeded our

internal target of 24 cases in the year by nine. Against the external definition of attribution there were 26 RWT-attributable MSSA bacteraemias, compared with 19 cases last year.

An RCA is undertaken on all RWT-attributable MSSA bacteraemias. These revealed: fifteen were related to IV lines, 6 were related to skin infection including infected pressure ulcers, three were from the urinary tract (including one related to a nephrostomy and one to a urinary catheter), two were due to discitis, one was due to an infected port, one was thought to have an abdominal source, one was due to sinusitis, one was following a urological procedure and the source was uncertain for three.

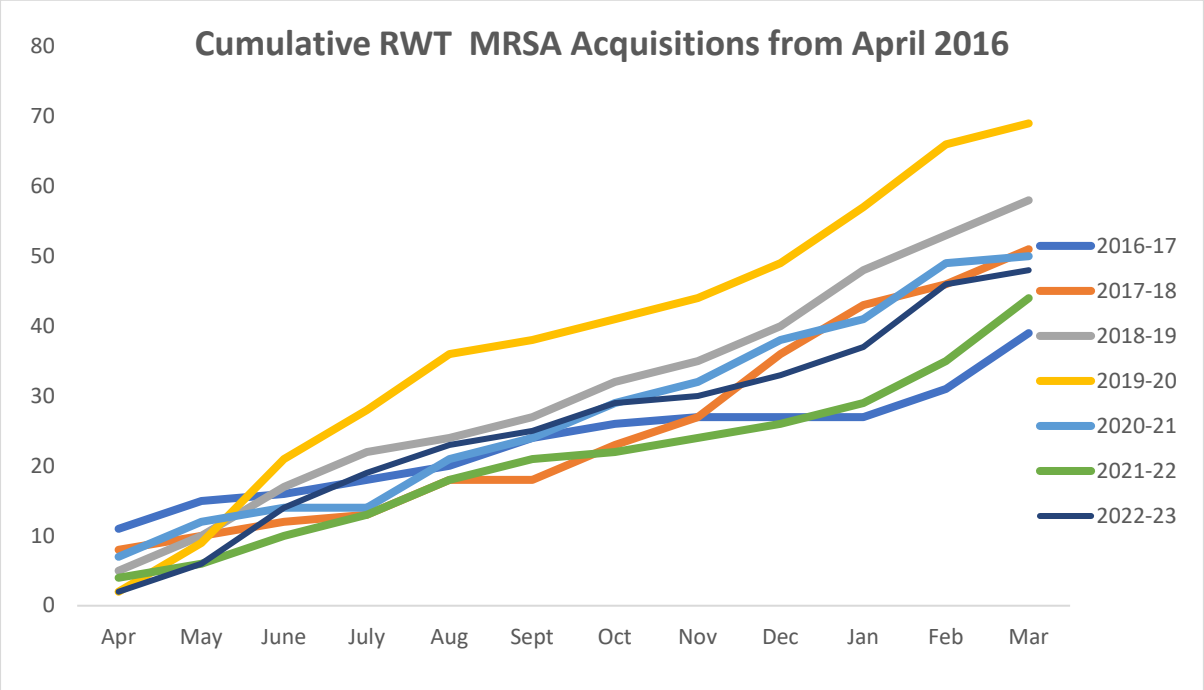
Graph 2



c. MRSA Acquisitions

Universal admission screening for MRSA has enabled us to monitor the acquisition of MRSA in RWT and use this as another KPI for the organisation. Graph 3 shows the number of MRSA acquisitions across RWT (including Cannock Chase Hospital from November 2014) over the past seven years. It can be seen that there were 4 more acquisitions this year than in 2021-22. However, this number still remains below 50 which is better than the four previous years. This demonstrates the importance of ensuring that admission screening regularly achieves our 90% target, as happened in 2021-22. Clusters of acquisitions were found on wards C24, C18, A8. Ward C14 had two separate clusters 7 months apart. Period of increased incidence (PII) meetings were arranged, with actions including improvements in screening and staff education on hand hygiene and the decontamination of equipment.

Graph 3



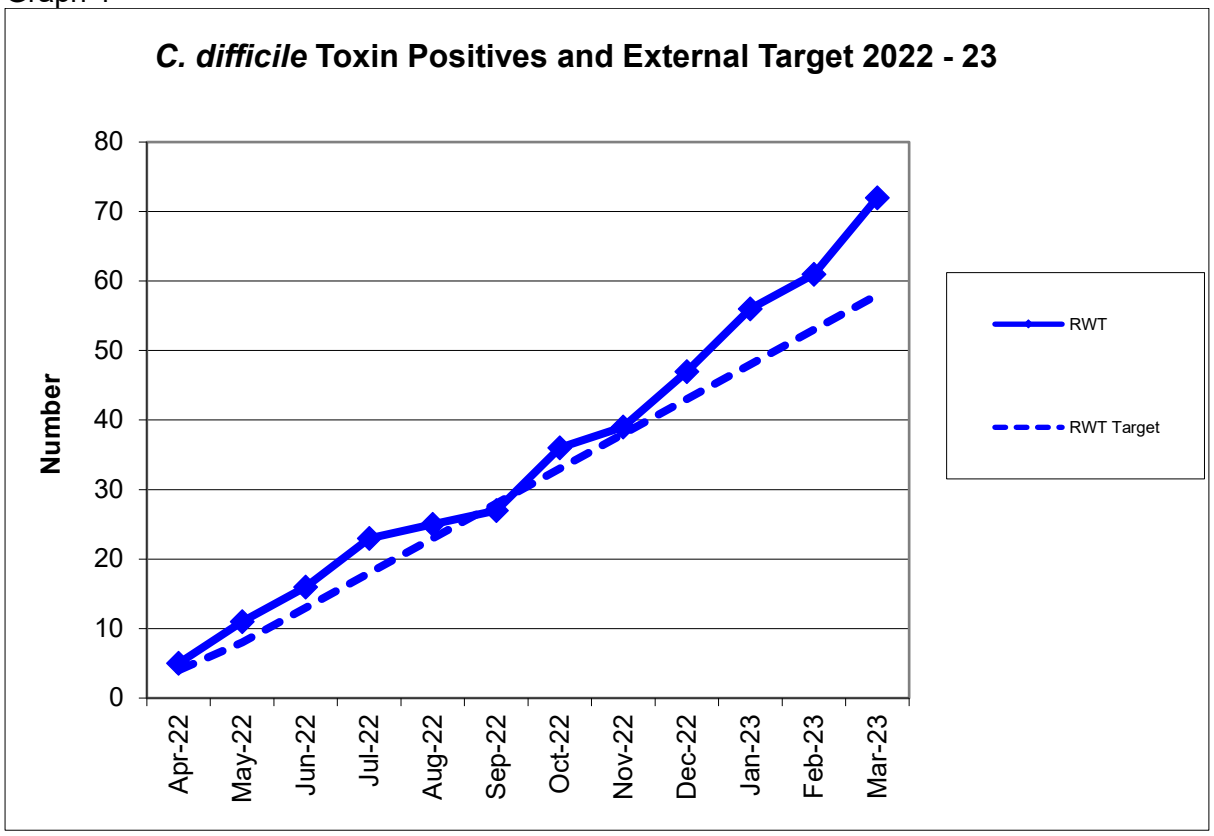
d. Glycopeptide Resistant Enterococci (GRE) Bacteraemias

During the year there were nine GRE bacteraemias in RWT in-patients. This compares with one case last year, and between two and nine cases per year during each of the preceding twelve years. The cases this year included four from Clinical Haematology Unit, three from A14 and one each from A8 and Deanesly ward.

e. *Clostridioides difficile*

Objectives for the number of *C. difficile* infections for Acute Trusts and CCGs were set for the year 2022-23 by NHS England based on nationally set target rates. The external objective for the number of *C. difficile* infections for RWT was 58 cases. At the end of the year, RWT had had 72 cases, so had exceeded the trajectory. The definition of an acute Trust-attributable case was changed in the year 2019-20, to include patients who had been discharged within 28 days of the positive sample, and also samples taken more than two rather than three days following admission. Wolverhampton CCG is now included in Birmingham and Black Country ICB therefore the number of community Wolverhampton cases is no longer easily monitored. Graph 4 shows the cumulative monthly performance against target for RWT.

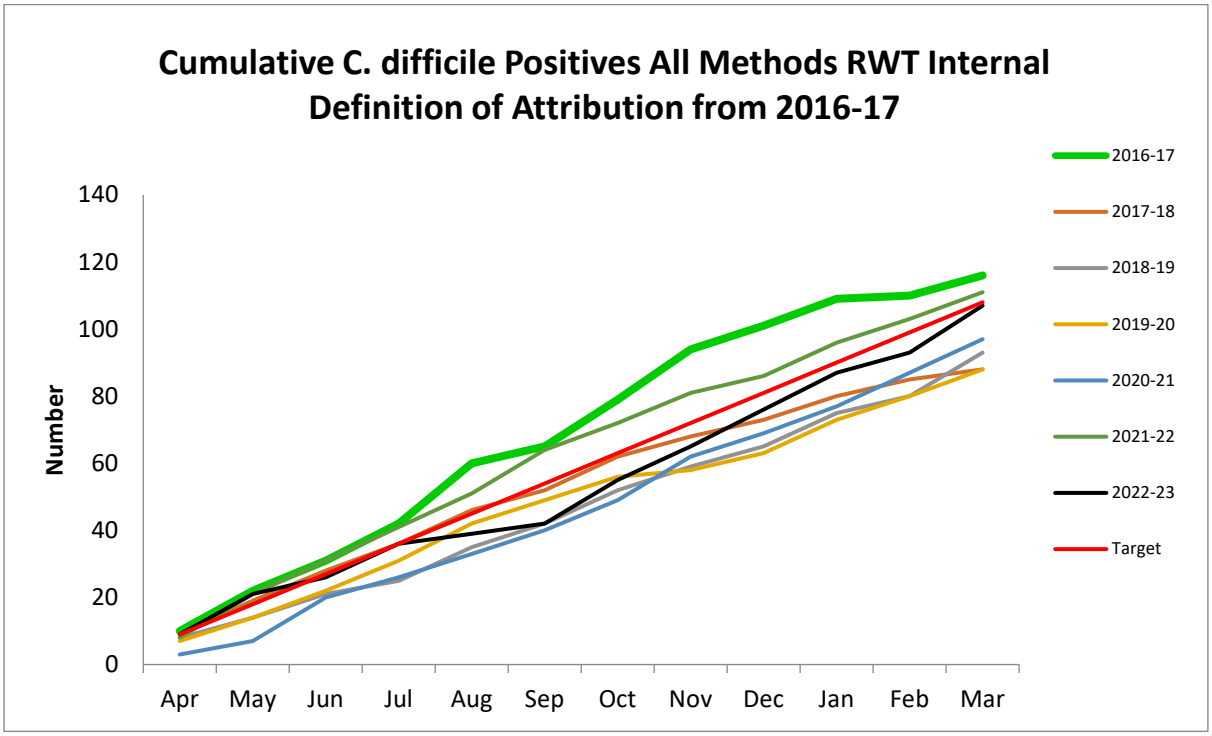
Graph 4



Negotiation is allowed with the commissioners of acute services to determine if any of the RWT-attributable cases could be determined to have been unavoidable. Of the cases in 2022-23, 22 were deemed avoidable, with 39 unavoidable. The cases for March are outstanding at the time of writing.

The objectives are based on Department of Health and Social Care (DHSC) definitions of attribution of infections, which only takes into account discharge from hospital within the last 28 days and only records those cases that give a *C. difficile* toxin positive result. Internally, we set another target that, in addition to counting the cases included in the DHSC definition, also includes cases against RWT if infection is diagnosed within six weeks of discharge, unless the patient had been housed in another healthcare institution since discharge. This internal definition of infection includes all cases diagnosed with either a positive *C. difficile* PCR or toxin result. The PCR test is a measure of colonisation with strains of *C. difficile* capable of causing disease and allows us to better monitor the spread of *C. difficile*. It enables us to take appropriate barrier precautions with such patients to prevent spread or contamination of the environment, and to pre-emptively treat such patients if they develop symptoms. This year there were 107 cases diagnosed against the internal definition of attribution in comparison which just below our internal target of 108 cases (Graph 5).

Graph 5



If there are possible linked cases on a ward or clinical area, the isolates are sent for ribotyping to determine if the same strain of *C. difficile* has spread. In the past, several different strains were usually reported from each apparent cluster, which gives assurance that no transmission has occurred on the ward. However, ribotyping has demonstrated likely or definite spread between patients on a number of wards in 2022-23. Testing for three patients on WP2 indicated spread on this ward, while testing for a further two patients on this ward indicated spread of a different strain, which was confirmed by sub-type analysis. Ribotyping also indicated spread between two patients on the Stroke ward, which was confirmed by sub-type analysis; a further incident on the Stroke ward also occurred where ribotyping indicates spread between two patients. On C26 ward, ribotyping indicates possible spread between two patients, however sub-type analysis was not available in time for this report. Deep cleans, including hydrogen peroxide environmental decontamination, are carried out on all wards where apparent spread has occurred, while audits of the environment, practices on the ward and antimicrobial use are also undertaken. The ability to undertake routine full ward deep cleans has been limited by the inconsistent availability of a decant ward. Regular hydrogen peroxide decontamination of side-rooms in which *C difficile* infected patients are located has been limited by pressures on the limited isolation facilities available in the Trust.

f. Hospital Acquired Bacteraemia (HABs) and Device-Related Hospital Acquired Bacteraemias (DRHABs)

Device-Related Hospital Acquired Bacteraemias (DRHABs) are used as another KPI for the Trust. All positive blood cultures are designated as being either significant or a contaminant by a Consultant Microbiologist, and the source of all significant positive blood cultures is determined. If the source is an implanted medical device and the patient has been in hospital for more than 48 hours when the blood culture was taken, or is within two weeks of discharge, or is a regular day-case attender, then it is designated as a DRHAB. Graph 6 shows how the Trust's performance has improved over the years that this data has been collected, although in 2020-21 the numbers increased. The DRHAB target for this year was 48 and there were 58 DRHABs, which is an improvement on the previous two years. No target is set for HABs.

Graph 6

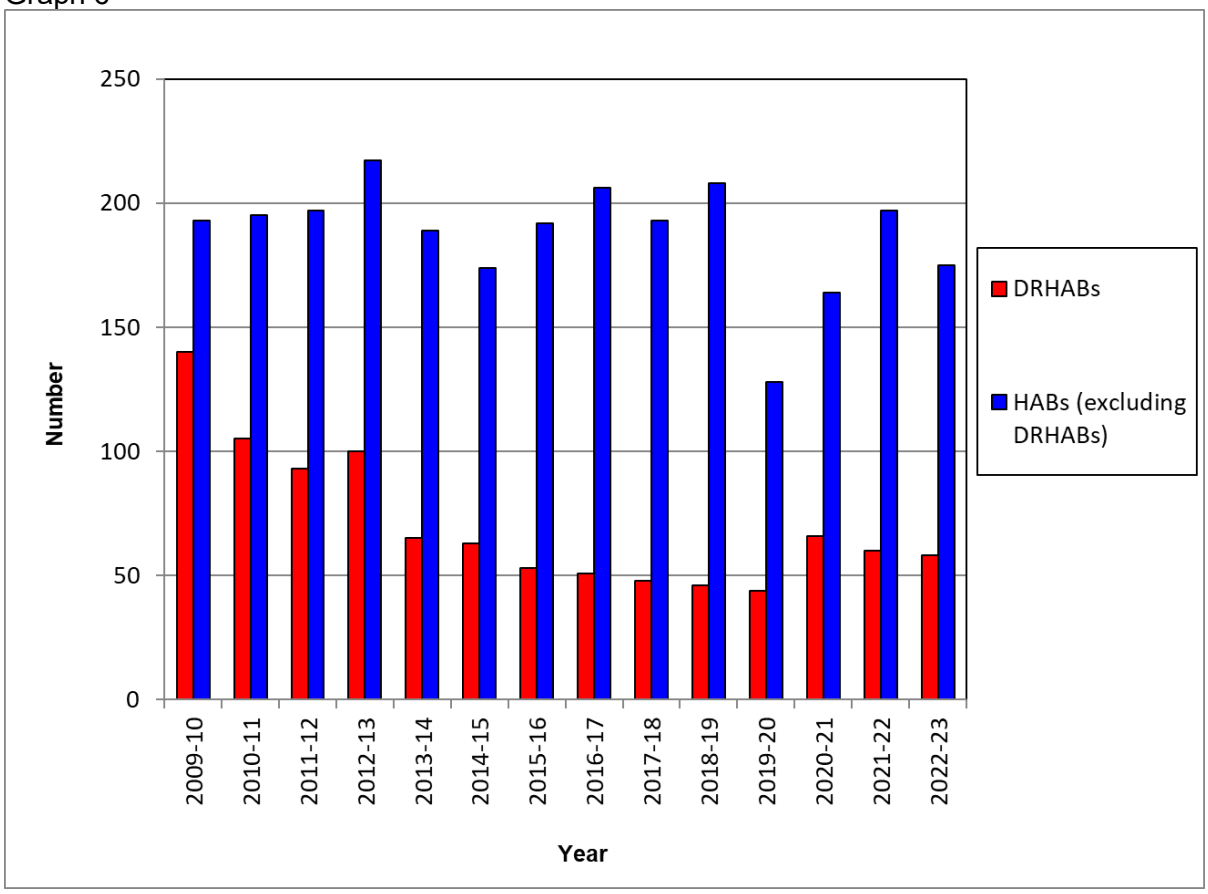


Table 1 shows the blood culture data, with sources of DRHABs over the course of the year and data from the previous two years and from the first year this data was collected, for comparison. It demonstrates that, following an increase in the numbers in 2020-21, we have seen a decrease over the last two years, although this remains higher than the annual numbers that were achieved prior to the COVID-19 pandemic. Table 2 shows that critical care DRHAB numbers remained low following the high numbers in 2020-21 (possible reasons for the high numbers included increased patient numbers, use of non-critical care staff, and use of the prone position for care of COVID-19 patients). Line infections are lower than last year but still up on previous years, with higher numbers in areas such as oncology and renal dialysis (Table 2)

Table 1

	2009-10	2020-21	2021-22	2022-23
Blood Cultures taken	**10,943**	**17,013**	**15,990**	**19,076**
Blood Culture positives	**1,113**	**1,151**	**1, 127**	**1,150**
Blood Culture significant	**824**	**755**	**835**	**782**
Blood Culture contaminants	**299**	**394**	**292**	**368**
Hospital Acquired Bacteraemia (HABs)	**333**	**230**	**257**	**233**
Device-Related HABs:	**140**	**66**	**60**	**58**
Lines	91	30	39	36
Urinary Catheters	15	24	18	20
VAP	14	5	0	0
?VAP/?Line	7	3	0	0
Nephrostomy	4	2	1	2
Pacemaker	4	0	1	0
PEG	1	0	0	0
Other	4	1	1	0

Table 2

Ward / Area	**2009-10**	**2020-21**	**2021-22**	**2022-23**
Clinical Haematology Unit	35	3	5	7
Durnall / Chemotherapy	7	3	0	8
Deanesly Ward	6	2	2	0
Neonatal Unit	26	7	11	3
RDU (including satellite units)	19	5	10	10
Critical Care Unit	8	16	1	1
Cardiac (excluding CCU)	3	1	1	2
Surgical Wards	21	8	8	10
Medical Wards	12	14	16	12
West Park and Cannock Chase Hospitals	0	3	3	2
Other wards	3	4	3	3

g. Gram negative Bacteraemias

In August 2021, objectives were issued for the first time to Trusts by NHS England for the numbers of bacteraemias caused by the Gram negative organisms *Escherichia coli, Klebsiella* species *and Pseudomonas aeruginosa*. These objectives were issued again in 2022-23 and include all bacteraemias that occur on day 2 or more of admission, or within 28 days of discharge from any inpatient admission, including day case admissions. These Gram negative organisms are found in the gastrointestinal tract, and most commonly are associated with infections of the urinary tract or biliary tree. Table 2 shows that in 2022-23 RWT was below the threshold of 103 *E. coli* bacteraemias, with 95 for the year. *Klebsiella* and *P. aeruginosa* bacteraemias were also below the 2022-23 objectives. For comparison the numbers from the previous years are also shown in the table. The COVID-19 pandemic most likely affected numbers in 2020, however numbers of Gram negative bacteraemias in 2018 were higher than in 2019. The reasons for these fluctuations are unknown (please note historical numbers are taken from internal data sets and so may not entirely match those numbers held by NHS England).

Other than targeting the small number of these infections that are related to devices (device-related RWT-attributable E. coli bacteremia fell from over 11% in 2010-11 to just under 4% of the total in 2020-21), the ubiquity of these organisms in the gastrointestinal tract and the nature of the infections that they cause mean that other targets for intervention are not clear cut.

Table 3

	***Escherichia* coli**	***Klebsiella* spp**	***Pseudomonas aeruginosa***
Target 2022-23	**103**	**35**	**18**
Number 2022-23	95	32	17
Number 2021-22	103	36	16
Number 2020	81	22	18
Number 2019	97	20	14
Number 2018	122	43	18

h. Carbapenemase-Producing Enterbacteriales (CPEs)

The carbapenem group of antibiotics are regarded as the antibiotic of last resort in many situations in which they are used. CPEs are organisms that produce enzymes (the common enzymes being NDM, KPC, and OXA-48) that destroy these antibiotics. RWT has had a comprehensive screening strategy for a number of years to try to control the spread of these organisms. However, new guidance regarding screening was issued in 2020 by Public Health England, which recommended rectal screening of all patients admitted to high risk areas including critical care and oncology units, and also all patients who have been admitted to hospital in the last year. Currently RWT still uses a risk based screening strategy to include all patients who have travelled abroad or had healthcare in a hospital other than RWT in the last year. We continue to be unable to implement the new guidance so far, because the need to agree a screening method across the four Black Country Pathology Service Trusts has prevented progress with this.

Table 3 shows that up until the end of 2017-18 the number of patients in Wolverhampton found to be carrying these organisms was rising annually, but in 2018-19 this rise appears to have stalled. This may be related to introduction of the CPE policy including improved detection of carriers, reducing incidences of spread. In the spring of 2019-20, however, molecular testing was introduced as the first-line screening method. This is far more sensitive and is capable of detecting multiple resistance mechanisms. Of note, prior to the introduction of this method it was very difficult to detect OXA-48 producing organisms; the huge increase in this group is undoubtedly due to the improved sensitivity of the test rather than a real increase in numbers.

In 2020-21 there was a marked decrease in the number of new patients identified carrying CPE. This most likely reflects the reduction in overseas travel due to the COVID-19 pandemic, with perhaps a contribution also from reduced screening due to reduced elective activity. As the country has seen a recovery in both international travel and elective hospital activity, numbers started to rise again, and this year returned to pre-pandemic levels.

The majority of CPEs continue to be detected from screening samples rather than from clinical isolates, which shows the screening strategy is working. However, there were 10 patients identified as positive from clinical samples, which is the highest number to date. Five of these patients were from the community with little information available as to their risk factors. Of those patients who had samples taken in the Trust, two were known to have foreign travel as a risk factor. The remaining three were inpatients, where no risk factors had been identified (positive samples were one blood culture, one sputum and one urine specimen). Screening of contact patients did not find any further cases.

There was one possible outbreak of CPE during the year, where two patients on ICCU were positive on rectal screening one week apart, with the same CPE enzyme (KPC). These isolates were both *Klebsiella pneumoniae*, and so could be sent for typing, which demonstrated that they were unique and not related. While this result is encouraging, this does not entirely rule out transmission, because the 'KPC' gene can be transferred between different organism strains, and it is currently not possible with the technology available to determine if there has been cross-infection with the same enzyme.

Table 3

	NDM	OXA-48	KPC	Others	Total
2012-13	2	0	0	0	**2**
2013-14	5	1	2	0	**8**
2014-15	2	0	6	0	**8**
2015-16	4	1	7	0	**12**
2016-17	7	2	10	0	**19**
2017-18	19	6	9	2	**34***
2018-19	15	3	2	0	**20**
2019-20	26	34	5	2	**56***
2020-21	6	12	4	0	**18***
2021-22	10	14	4	0	**27***
2022-23	22	32	7	0	**53***

*The number of patients is fewer than the combined number of resistance mechanisms because some patients carried more than one resistance mechanism.

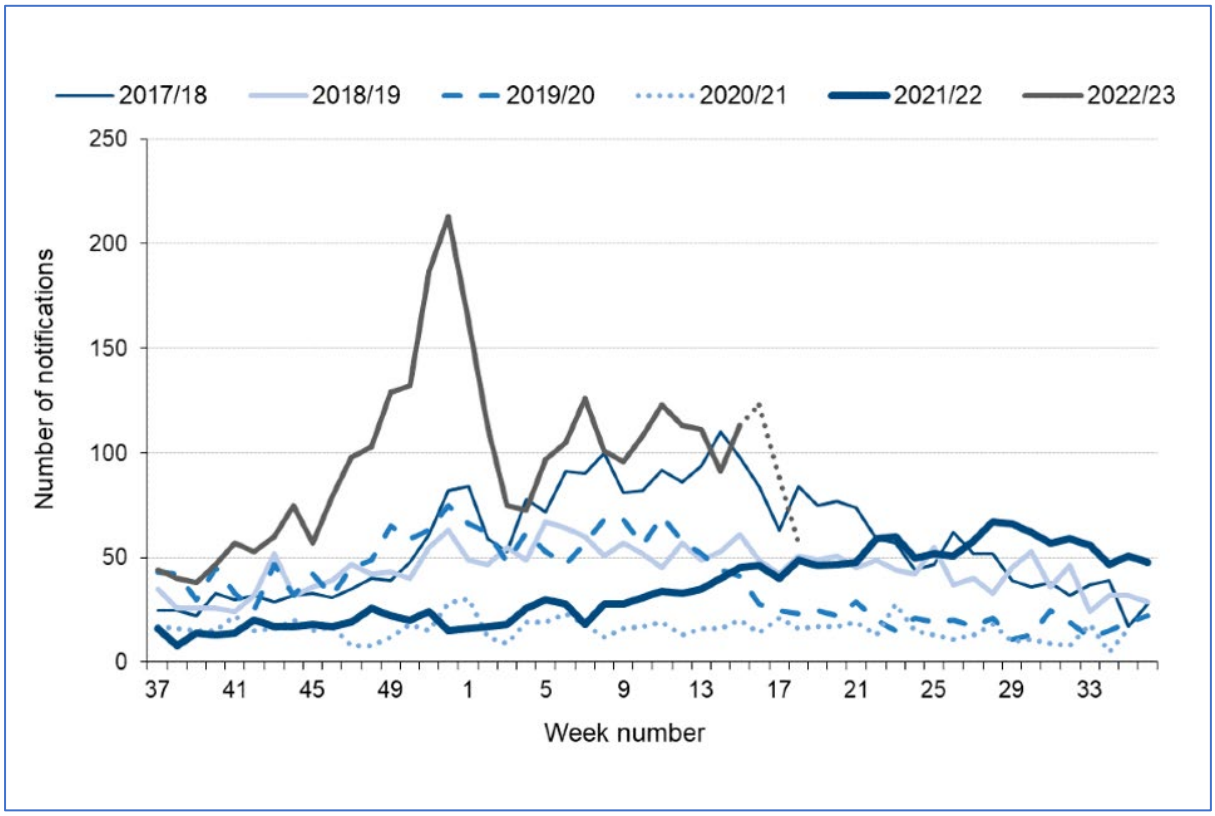
Table 4

	Detected from screens	Detected from clinical samples	Total
2012-13	0	2	2
2013-14	2	6	8
2014-15	1	6	7
2015-16	4	7	11
2016-17	13	5	18
2017-18	31	3	34
2018-19	20	0	20
2019-20	48	8	56
2020-21	13	5	18
2021-22	25	2	27
2022-23	43	10	43

i. Scarlet fever (group A streptococci (GAS)), invasive group A streptococci (iGAS)

An increase in cases of GAS and iGAS occurred nationally in 2022/23. This resulted in an increase beyond expected levels of GP consultations and in ED attendances. Guidance updates were communicated to appropriate areas and colleagues within the Trust. More serious infection (iGAS) may occur when the bacteria gets into parts of the body where bacteria usually are not found, such as the blood. Graph 7 shows the increase in iGAS activity in England in 2022/23.

Graph 7



OUTBREAKS AND INCIDENTS

The Trust has an Outbreak/Serious Incidents (SI) Policy and serious incidents are reported and managed in line with this policy. Outbreaks/Incidents are managed by Post Incident Review meetings (PIR) held within seven working days wherever practicable and chaired by an Executive Director supported by key healthcare professionals. A 48-hour report is completed by the Infection Prevention Team to outline the suspected outbreak or incident, and this is submitted to the area concerned. If the subsequent PIR investigation and sampling confirms that it is an SI a thirty-day report is compiled, agreed with Directorates, and submitted to the Commissioners. If typing results indicate that it is not an outbreak and other ward indicators are assessed to be at the required infection prevention standards, then a request to downgrade the SI can be made to the Commissioners. Frequent meetings are held to manage and monitor the outbreak/incident to discuss individual cases and arrange appropriate sampling or screening, support patient experience and care, inform, arrange appropriate decontamination of the affected areas, and reduce the risk of spread to other areas whilst maintaining the operational function of the hospital and patient flow. Different

outbreaks/incidents demand different responses but are managed with precision and collaborative working between the multi-disciplinary teams across the Health Economy.

COVID-19

There were 85 outbreaks across the Organisation. Grand Outbreak meetings were arranged where each outbreak was discussed and investigated. External partners including NHS England/Improvement (NHSE/I), the Integrated Care Board (ICB) Wolverhampton Place and UK Health Security Agency (UKHSA) were all invited to attend. In January 2023 the ICB COVID-19 Outbreak Serious Incident (SI) reporting process for the Black Country System v1.1 was introduced in the Trust. This guidance informed the decision to report COVID-19 outbreaks through local outbreak management processes and National reporting unless there was an impact on a service, ward closure or moderate/severe harm was identified where the Trust SI process was followed.
Healthcare associated infections were identified following NHSE/I guidance in June 2020. Cases that were identified 8 – 14 days post admission are classed as probable and over 14 days definite were all investigated through the Datix process. There was a total of 674 HCAI in 2022/23

- Quarter 1 April – June – 137
- Quarter 2 July – September – 152
- Quarter 3 October – December – 181
- Quarter 4 January – February – 204

Common themes from COVID-19 outbreak meetings

- Infection Prevention is everyone's business. All staff should feel empowered to question other staff if they are not wearing appropriate PPE, washing their hands or social distancing.
- Ventilation – open windows for 10 minutes every hour.
- Patients not wearing face masks.
- PPE usage. Fatigue amongst staff to always wear appropriate PPE.
- Reintroduction of controlled visiting
- Asymptomatic routine Lateral Flow testing ceased for healthcare staff.
- Community COVID-19 screening changes.
- Changes in National guidance to business as usual.

Norovirus or Suspected Norovirus
Norovirus is a self-limiting diarrhoea and vomiting bug that usually lasts 48 – 72 hours and is usually more prevalent in the winter months earning it the nickname "Winter Vomiting Bug". There were 2 outbreaks of confirmed Norovirus, 1 resulting in a ward closure.

Influenza
This is a respiratory virus. There were 2 COVID-19 and Influenza A, dual infection outbreaks detected.

***Clostridioides difficile* related incidents and outbreaks**
All patients identified with *C. difficile* are reviewed following the sample result by the IPT/ Microbiologist and again on a weekly ward round. Increased incidence of *C. difficile* is managed and monitored in line with IP06 Policy. An increase in incidence within a 28-day period triggers a Post Incident Review (PIR) or a Serious Incident (SI) depending on the circumstances. Any actions from the review meetings are implemented at ward level.

There were 9 SIs reported in 2022/23 involving *C. difficile*. 1 case had *Clostridioides difficile (C diff)* recorded on Part 1a of the death certificate, in 2 incidents the cases were found to have different ribotypes. Robust actions were identified following each PIR to include increased environmental cleaning using hydrogen peroxide vapour (HPV), hand hygiene assessments for all staff in the areas and reinforcement of infection prevention principles including timely sampling and isolation at onset of symptoms.

A review visit at the request of the Trust was carried out by NHSEI on 31st January 2023. One of the key areas of good practice identified was the Patient Equipment Cleaning Centre (PECC). The team were observed cleaning patient beds and equipment to a high standard to support the ward teams, however it was noted that the PECC would benefit from a permanent location that could be configured to support long term service improvement with decontamination of patient equipment across the whole site. Following the visit, the Trust remained in the **routine monitoring and support** category (NHSE Midlands IPC escalation matrix/ NHS Operating Framework). All key themes identified for improvement were added to the Trust *C. diff* action plan.

Carbapenemase-Producing Enterbacteriales (CPE)

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are also some of the most common causes of urinary tract, intra-abdominal and bloodstream infections. They include species such as *Escherichia coli*, *Klebsiella* spp. and E*nterobacter* spp.

The carbapenems are a family of antibiotics including meropenem and ertapenem that are usually reserved for serious infections caused by drug-resistant Gram-negative bacteria (including *Enterobacteriaceae*). Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. There are several different types of Carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common. In the UK over recent years, there has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. Several clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

There has been an increase in CPE cases detected in 2022/23 possibly due to increased screening as elective activity increased and the return of international travel following the lifting of COVID-19 restrictions. Most identified cases were detected on screens following risk assessment on admission and were isolated prior to the result. There was one possible outbreak of CPE during the year, where two patients on ICCU were positive on rectal screening one week apart, with the same CPE enzyme.

HOTEL SERVICES AND DEEP CLEAN PROGRAMME

The Trust's Housekeeping Services are managed in-house.
The Housekeeping Services are split into three sections for the different sites covered: New Cross Hospital, West Park Hospital and Community Premises and Cannock Chase Hospital. The table below details who is responsible for which area:

Area	Manager	Deputy
New Cross Hospital	Amy Hill	Tina Tipton
Cannock Chase Hospital	Nick Reidy	Damian Jones
West Park & Community Premises	Brendan Houston	Julie Burgess

The management structure for each of the three areas is supported by a well-trained team of Day and Evening Supervisors.

The Community premises include the following sites:
Castlecroft Medical Centre, Coalway Road, Lea Road Medical Practice, Mander Centre, Oxley Practice, Pendeford Health Centre, Penn Manor, Primrose Lane Health Centre, Maltings, Warstones, Maurice Jackson Renal Unit, Thornley Street Surgery and West Park GP Surgery.
The Housekeeping Services Managers and Head of Hotel Services meet monthly with the Head of Nursing for Corporate Support Services (to include Infection Prevention) at the Environment Group. This meeting is chaired by the Head of Hotel Services, who presents a report from the Environment Group to the IPCG.

Training
During the year priority has been given to ensure that all Hotel Services staff, Housekeeping, Catering and Portering completed their annual mandatory hand hygiene and IP Level 1 training.

Monitoring
The cleanliness technical audits are conducted by the Hotel Services Monitoring Officer and the Domestic Supervisors in accordance with the "National Standards of Healthcare Cleanliness, 2021". This document assigns areas within hospitals a 'functional risk' (FR), and this informs the frequency of the audit:

- FR1 areas are audited weekly
- FR2 areas are audited monthly
- FR3 areas are audited bi-monthly
- FR4 areas are audited quarterly
- FR5 areas are audited six-monthly
- FR6 areas are audited annually

In the main, the audits are carried out electronically, using a bespoke monitoring system.

Budget Allocation
The pay budget for the whole of Housekeeping Services for the year 2022/23 was £9,014,122; the non-pay budget was £1,027,877.

Clinical Responsibility / Access
The Domestic Staff play a pivotal role in ensuring the hospital is a safe environment for patients, visitors and staff. The Domestic Services Department is very receptive to clinical need and responds to emergency and urgent situations rapidly and fully whenever possible 24 hours a day.

Deep Clean
This team has been in place since October 2008 and are required to deep clean all areas at least annually.

To support the Deep Clean Programme, the Housekeeping Department also operates its own in-house Hydrogen Peroxide Vapour (HPV) system. This is used, in both the annual scheduled programme and also used throughout the year, to support the eradication of Norovirus and *C. difficile*. Even without a dedicated decant ward this has been a successful programme this year.

Ultra Violet Light Decontamination
The Domestic Service trialled the use of UV-C light decontamination throughout 2019-2020 on AMU. This has resulted in the Trust approving a business case that has allowed the Housekeeping Service at New Cross Hospital to proactively decontaminate areas on AMU, the Emergency Department, and Renal treatment area with a timely turn around since 2020-2021 and has carried on throughout the following years.

Patient Equipment Cleaning Centre (PEC Centre)
2022-2023 saw the implementation of the Patient Equipment Cleaning Centre being reintroduced. This service manually cleans patient beds, mattresses, over bed tables, and patient chairs after 'green' and 'amber' discharges with a chlorine and detergent solution. The equipment is then steam cleaned followed by HPV decontamination before being placed, covered, in clean storage.

These clean equipment sets are dispatched to discharges where the domestic cleans the rest of the room and the dirty equipment taken away to the dirty storage area of the PEC Centre awaiting decontamination.
The service is currently only able to be used to assist push model discharge areas as well as assisting wards that require a deep clean but are unable to decant.

ANTIMICROBIAL STEWARDSHIP (AMS)

- **Antimicrobial use**
- **Antimicrobial resistance data**
- **AMS team activities**

ANTIMICROBIAL USE

We report on the following markers of antibiotic use:

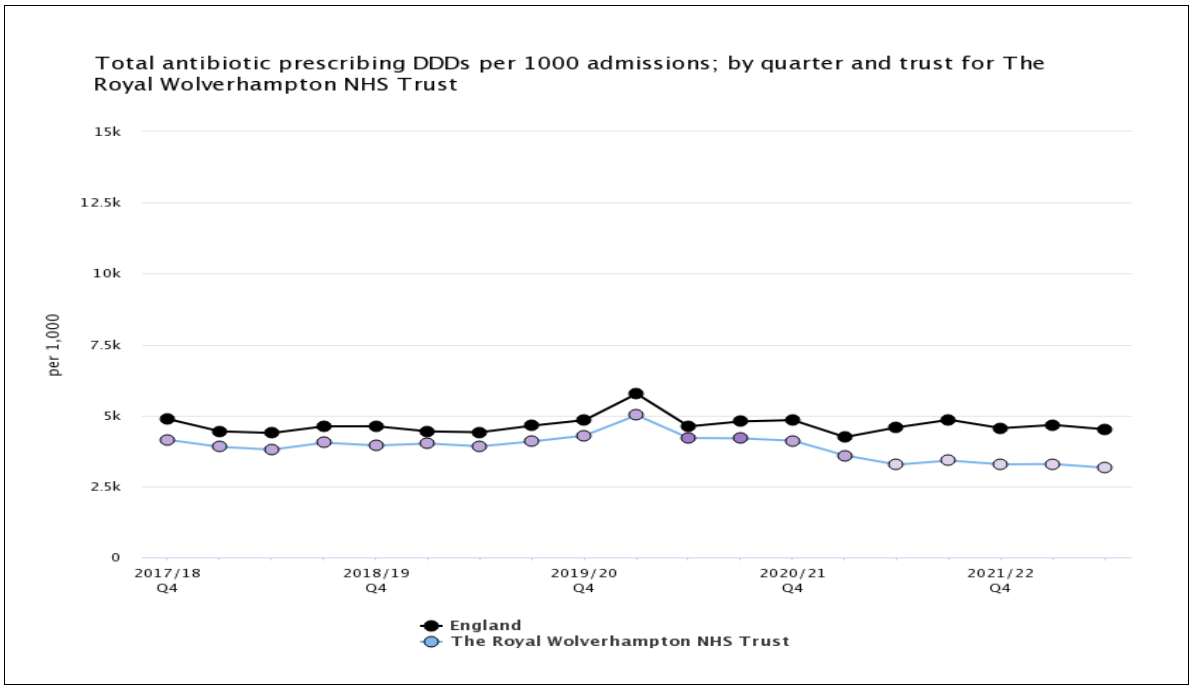
1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions.
2. Total usage (for both in-patients and out-patients) of carbapenems per 1,000 admissions.
3. The proportion of antibiotic usage (for both in-patients and out-patients) within the Access group of the AWaRe category.

The Access group of antibiotics includes: phenoxymethylpenicillin, nitrofurantoin, metronidazole, gentamicin, flucloxacillin, doxycycline, co-trimoxazole, amoxicillin, ampicillin, benzylpenicillin, benzathine benzylpenicillin, procaine benzylpenicillin, oral fosfomycin, fusidic acid, pivmecillinam, tetracycline and trimethoprim.

At the time of writing, data is available up to the end of quarter two for 2022/23. This data is in the public domain, accessible through UKHSA's 'Fingertips' Website:
https://fingertips.phe.org.uk/profile/amr-local-indicators

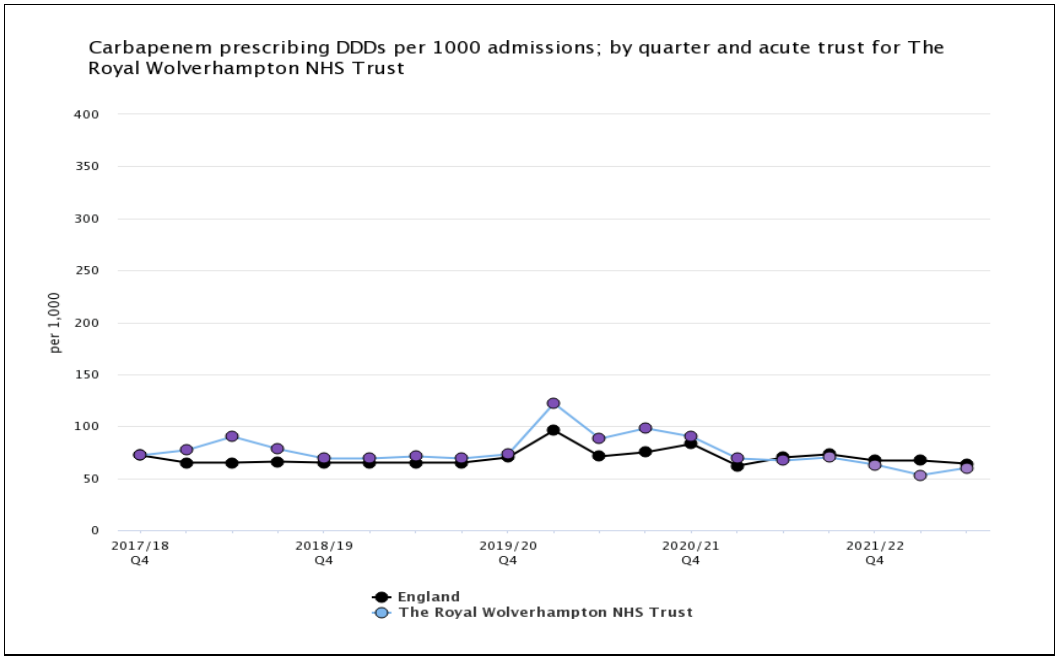
Total antibiotic usage

RWT's total antibiotic usage has consistently been lower than the average for England over the period shown with this trend becoming more pronounced over time.



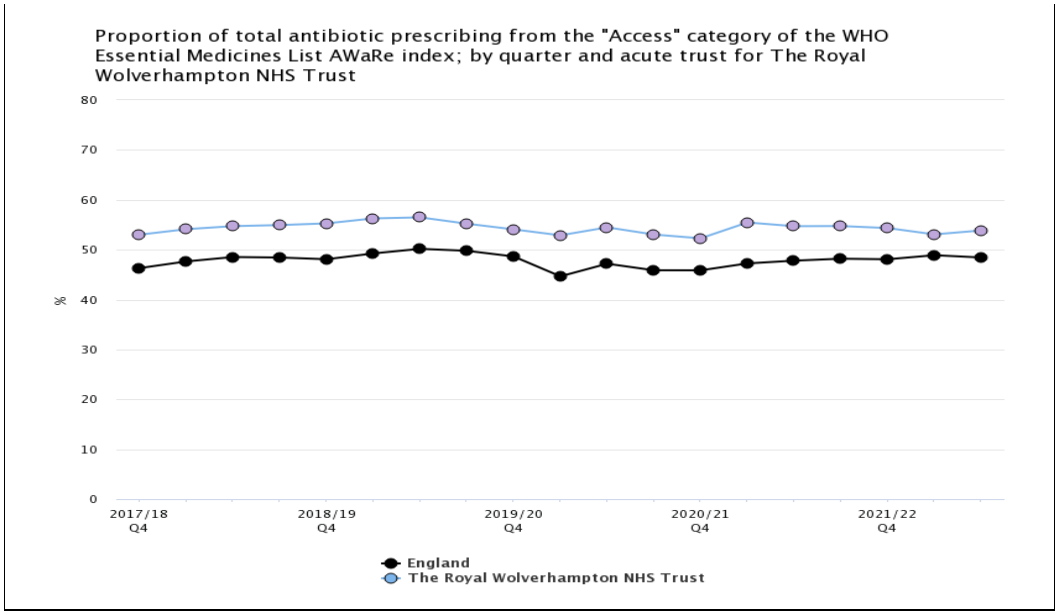
Carbapenem use

Carbapenems are very broad-spectrum antibiotics, often an agent of last resort. RWT has, in the past, prescribed more carbapenems than the average for England with a spike seen in quarter one 2020-2021, coinciding with the first wave of COVID-19. Since then, we can see a downward trend in prescribing with the last data point for RWT (60.0 DDDs per 1000 admissions) sitting below the average for England (64.0 DDDs per 1000 admissions).



Access Antibiotics

We aim to use a greater proportion of antibiotics from the WHO 'Access' group of antibiotics and a lower proportion from the 'Watch' and 'Reserve' groups. RWT is performing above average for England, with an average of 53.9% of antibiotics prescribed from the 'Access' group compared with an average of 48.4% for England in Q2 2022-23.



ANTIBIOTIC RESISTANCE

Resistance data is currently drawn from the UKHSA fingertips website. Resistance in *E. coli* is used to give an impression of resistance rates in Gram-negative enteric pathogens. In the past, RWT have had higher rates of resistance than the national average for gentamicin, cephalosporins and ciprofloxacin. Our Tazocin resistance rates have been lower than average.

The most recent data shows a significant departure from the trend and raises concerns about the accuracy of the most recent data. RWT antimicrobial Pharmacists do not think this large improvement in resistance rates has been seen in clinical practice at RWT. This will require further investigation, and Pharmacy colleagues plan to correlate locally generated data with the national data reported here.

% *E. coli* bacteraemia isolates resistant to antibiotic					
Antibiotic	RWT 2019	RWT 2020	RWT 2021	RWT 2022	Average for England 2022
Tazocin	7.5	7.7	11	10	10.5
Ciprofloxacin	29.4	30.4	34	21	18.6
Cephalosporins	19.1	18.1	19.0	15.0	14.3
Gentamicin	14.8	14.0	15.0	8.0	10.6

Table 1. Trend in E. coli resistance rates in RWT.

AMS TEAM ACTIVITIES

AMS Ward Rounds

As a team we continue to conduct weekly antimicrobial stewardship ward rounds. The AMS team consists of a microbiologist, a pharmacist, and an Infection Prevention nurse. The team alternate between surgical and medical wards each week, but also prioritise wards that have had recent outbreaks of hospital acquired infections such as *Clostridioides difficile.*

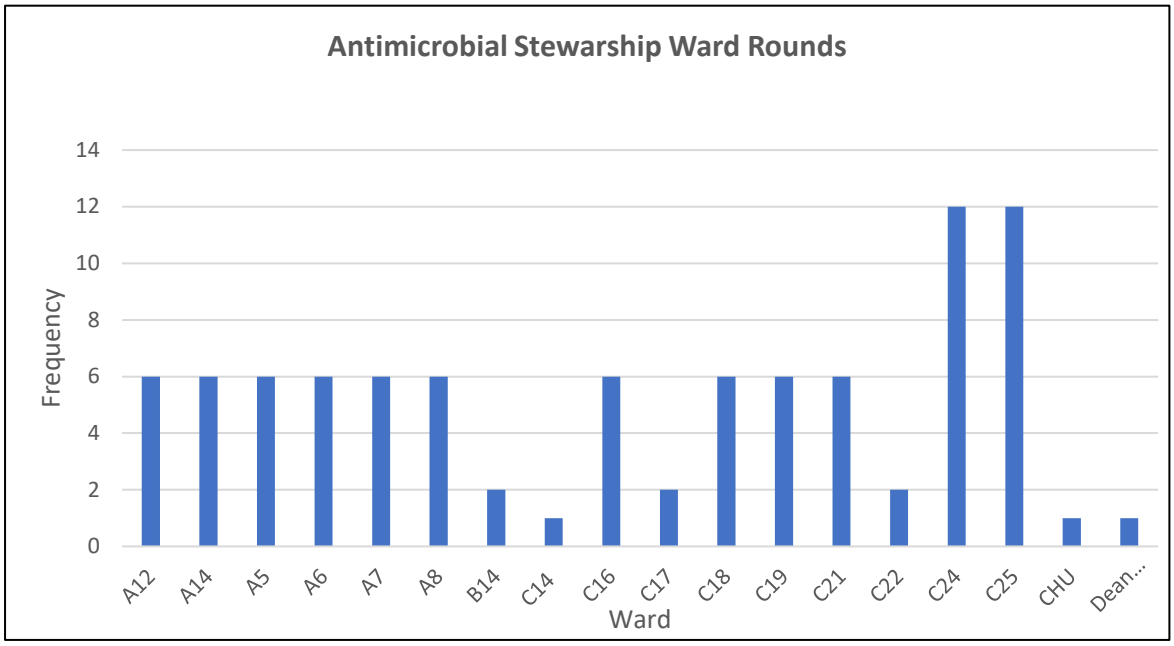


Figure 1. Distribution of AMS ward rounds

The team have conducted 93 ward rounds since August 2021 as shown in Figure 1. Within this period, the team have made 420 interventions with antimicrobials. Of the interventions made more than 75% were significant, resulting in optimisation of patient therapy, reduced antimicrobial usage, facilitation of patient discharge and economic savings to the Trust. Other expected benefits would include reduction or prevention of emergence of resistance which is one of the key mandates of an AMS team.

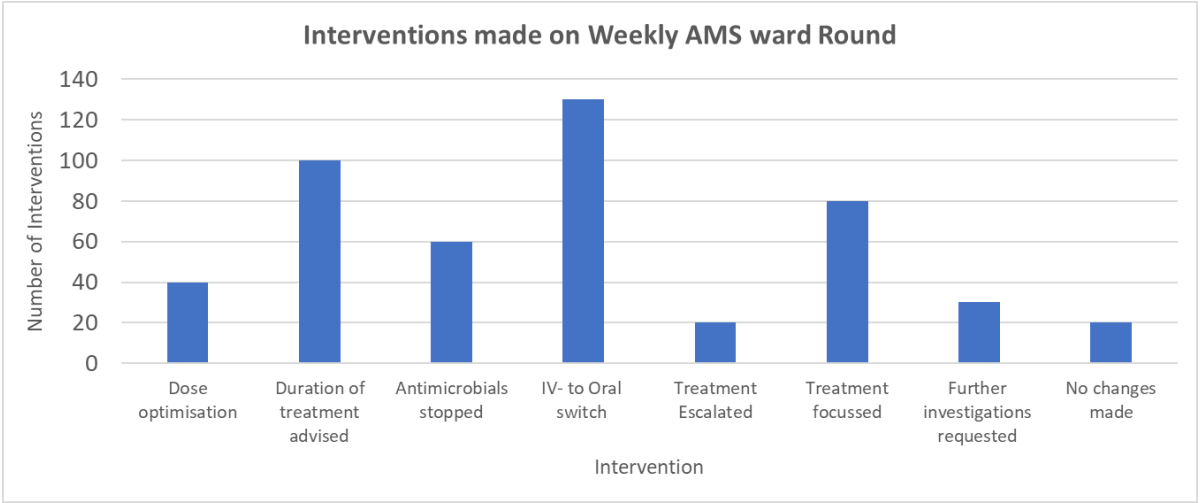


Figure 2. Interventions in AMS ward rounds

Figure 2 shows the range of interventions made:

- 27% of interventions made involved switching patients from intravenous to oral antibiotics.
- 23% involved a recommended duration of antibiotics to reduce extended courses.
- 12.5% involved stopping antimicrobial therapy.

The team intend to build on the momentum and continue to conduct weekly AMS ward rounds including having a presence at both West Park and Cannock sites.

AMS teaching

The team continue to conduct monthly AMS teaching with the junior pharmacists, focusing on Teicoplanin dosing, *C. difficile*, OPAT, prompting an IV to Oral switch, and antimicrobial sensitivities. The ward pharmacist is also able to join the AMS ward round which provides them with insight into the role of the AMS team and an opportunity to understand and learn from microbiologist and infection prevention nurses.

The team continue to encourage and upskill our junior pharmacists in prompting the medical and surgical teams to step down from IV to oral antimicrobials after 72 hours taking into consideration the clinical and physical signs that would indicate it is appropriate to switch. This has a cost implication for the Trust as oral preparations are significantly cheaper than Intravenous preparations as well as negating the need for an indwelling vascular device.

OPAT

The out-patient parenteral antimicrobial therapy (OPAT) service allows patients to receive IV antibiotic treatment at home or in an out-patient setting. 117 patients have received and completed a course of antibiotics via OPAT from January- December 2022, equating to 3231 bed days.

Currently we administer four once daily antibiotics via OPAT: Ceftriaxone, Daptomycin, Ertapenem and Teicoplanin. The service are working towards bringing in 24 hours OPAT infusion devices which would allow admistration of flucloxacillin, ceftazidime and Tazocin at home. This would facilitate discharge of patient who require these drugs, promoting patient flow and reducing length of stay.

Infection	Number of patients	Bed days
CNS and ENT infections	4	97
Endocarditis/cardiac infection	10	199
Lung infection	1	20
Intra-abdominal/pelvic infection	10	285
Bone and joint including spinal	64	2310
UTI/urological infection	9	109
Vascular	1	39
Bacteraemia	3	22
Cellulitis/SSTI	15	150
Total	**117**	**3231**

Table 2. Number of patients treated via OPAT and number of bed days.

Bone and joint infection make up a significant proportion of the OPAT workload. It should be noted this includes diabetic foot infection, septic arthritis, prosthetic joint infection, and spinal infection.

CQUIN

Description	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	
Numerator	Of the denominator, those who, at the point of audit, have already met the criteria for switching from IV to oral administration of antibiotics	
Denominator	Total number of adult inpatients (16+) with active prescriptions for IV antibiotics at the point of audit (sample size 100 patients per quarter)	
Exclusions	• Patients in ICU and HDU • Patients treated with intravenous antifungals or antivirals	
Data reporting and performance	Quarterly submission via e-mail to UKHSA. Refer to the AMR Programme Workspace in FutureNHS (link below) for details about auditing, data collection and reporting. Performance basis: Quarterly.	
Scope	Services: Acute	Period: All quarters
Payment basis	Minimum: 60% Maximum: 40% **Please note that for this indicator, a LOWER % = better performance**	Calculation: Quarterly average %
Lead contact	Kieran Hand england.amrprescribingworkstream@nhs.net	

For the coming year (2023-24) the Trust are participating in an antibiotic focused CQUIN03, prompt switching of IV to PO antibiotics.

Figure 3. National CQUIN03

Benefits of a timely IV to Oral switch of antibiotics:

- Length-of-stay reducing by 1-2 days, releasing vital bed capacity.
- Reduction of line-related adverse events e.g. phlebitis.
- Reduction in line infection and line associated bacteraemia.
- Improved patient experience.
- Nursing time released to care for patients.
- Carbon footprint significantly reduces e.g. IV ciprofloxacin carbon footprint is 60 times greater than oral.
- Reduction in dose calculation and dilution errors.
- Reduced overall antimicrobial exposure.
- Potential reduction in healthcare-associated infection (*C. difficile*) rates through reduced overall duration of antibiotic use.
- Reduced cost. A 10% reduction in IV antibiotic doses is estimated to save £77k/year for RWT.

A baseline audit conducted in April 2023 of 30 patients from medical and surgical wards showed **25%** of patients on IV antibiotics were past the point at which they met the PO switch criteria. All these patients were switched to oral antibiotics as an intervention in the AMS ward round.

Additional activities over the last 12 months

- There are two new antibiotic agents available for use in the Trust. IV dalbavancin (a long-acting glycopeptide for Gram positive infections) and IV cefiderocol (for multi drug resistant (MDR) Gram negative infections). Both agents are available under microbiology direction for specific indications.
- The AMS team participated in the ICB formulary harmonisation process which is soon to complete.
- The following antibiotic guidelines have been reviewed and updated. They can be referenced via the microguide app:
    - *C. difficile* guidance
    - Trauma and Orthopaedic (T&O) surgical prophylaxis guidance
    - Intra-partum Group B Streptococcus prophylaxis guidance

AMS team aims for the coming year

- Data return for the national IV to PO switch CQUIN. 100 patients audited per quarter.
- Review Trust mandatory AMS training
- Review and update the following antibiotic guidelines:
    - Gentamicin and teicoplanin prescribing guidance.
    - Empirical prescribing for infective endocarditis.
    - Intra-abdominal infection guidance.
- Continue to engage with ICB AMS regional work streams.

AUDIT

Primary Care GPs

All audits have taken place in Primary care General Practices in Wolverhampton including and 4 of the practices under RWT.

A specific audit tool, for RWT practices has been developed. Risks continue to be managed in line with RWT processes.

To date the following practices have integrated with RWT: Alfred Squire Road, Coalway Road, Lea Road, Oxley Practice, Penn Manor, Thornley Street, Warstones Surgery, West Park Surgery.

Policies and Audit

Infection Prevention policies have been reviewed accordingly during the year to ensure they reflect national guidance. There has also been a programme of policy audits undertaken to assure the Trust of compliance and to identify learning needs and actions required.

The current policy suite includes the following policies:

Policy number	Policy title	Policy reviewed	Policy audited
IP01	Hand Hygiene		x
IP02	Preventing Infection associated with the Built Environment		
IP03	Prevention and Control of MRSA, VRE and other Antibiotic Resistant Organism	x	x
IP04	Transportation of clean and contaminated instruments, equipment and specimens		x
IP05	Linen		x
IP06	*Clostridioides difficile*	x partial review	x
IP07	Viral Haemorrhagic Fever		
IP08	IP Operational Policy	x partial review	
IP09	Glove Policy		

IP10	Isolation Policy for infectious diseases	x	
IP11	IP Management of patients affected by common UK Parasites		
IP12	Standard Precautions	x	
IP13	Outbreaks of Communicable Infection/ Infection Prevention Serious Untoward Incidents		
IP18	Norovirus	x	
IP19	Blood and Body fluid spillage Management		
IP20	Urinary Catheter Policy		
IP21	Control and Management of TSE including CJD	x	

Compliance

Guidance released throughout the year has been appraised and incorporated into policy/ process where appropriate:

Guidance/Report/Alert	Recommendation/Action taken
COVID-19 guidance updated several times during the last 12 months	All recommendations and actions taken. Risks added to the Risk Register if unable to achieve. RWT/WHT joint respiratory virus risk assessment updated
Monkeypox guidance	All recommendations and actions taken. Action card and information circulated to emergency portals and Sexual health, and is available on the Trust intranet
National Infection Prevention and Control Board Assurance Framework (Version 1.0, 9 February 2023).	Contributed to the Consultation process facilitated regional NHSE.
Increase in invasive group A streptococcus (iGAS) infection 2022/098	All recommendations and actions taken. Information circulated to emergency portals
NHSE Midlands Region IPC Management of Influenza cases	RWT/WMH respiratory risk assessment updated
Public health control and management of diphtheria in England: 2022 guidelines. November 2022	All recommendations and actions taken. Information circulated to emergency portals
Good IPC practice for the cleaning and handling of incubators and other equipment in neonatal units. GOV.UK	Guidance reviewed, Trust practice bench marked against guidance.

Environment Audits

The Environment Audits of inpatient areas are conducted on a monthly basis by the clinical team and annually they are accompanied by IP, Estates and Hotel Service Supervisors. The audits are reviewed by the Clinical Leads, Infection Prevention and Hotel Services at the monthly Environment Group. Ad hoc audits have been conducted throughout the last 12 months due to COVID-19.

Infection Prevention Annual audits

The Infection Prevention team complete an annual audit for inpatient, clinical areas including theatres and Primary care. The tool has been added to My Assurance to support electronic reports and gives visual access to ward and department managers.

ESTATES PROGRAMMES

It is recognised that buildings must be safe to reduce the risk of infection through design and building works. The IP team have worked collaboratively with Estates (Capital and Maintenance) this year on a range of both small and large building projects to ensure patient safety is always maintained. The Environment Group receives a report from Estates on planned developments which ensures the IP team are informed of future projects.

INFECTION PREVENTION REPRESENTATION AT KEY MEETINGS

The IP team have maintained representation on numerous working groups this year as a method of ensuring appropriate IP advice is communicated and to ensure that infection prevention is built into design, policy and thinking across the organisation. These groups include:

Silver Command
PPE Group
Capacity meetings
Surge planning
Clinical Practices Working Group
Clinical Practices Ratification Group
Environment Group incorporating Waste
Health and Safety Committee
Inoculation Injury Group
Water Safety Group
Ventilation Safety Group
Medical Devices Group
Clinical Procurement Equipment Group (CPEG)
Theatre Procurement Equipment Group (TPEG)
Quality and Safety Action Group (QSAG)
Quality Governance Assurance Group (QGAC)
Matrons, Senior Nurses, Midwives and Health Visitors Group
COVID-19 and Influenza Vaccination Operational Group
COVID-19 and Influenza Vaccination Oversight Group
Infection Prevention and Control Group
Trust Management Committee
Trust Board
Decontamination Group
Fire Safety Group
Tenanted Buildings Working Group
Care indicators Approval Group
Antimicrobial Stewardship Group
C. diff Task & Finish Group
Catheter and Continence Group
Sustainability
Review of Covid 19 Restrictions - RWT/WHT Task and Finish Group

1. INTRAVENOUS RESOURCE TEAM

The IV Resource Team (IVRT) provides three key deliverables across the adult sector of the Trust – the insertion of long vascular access devices for the provision of a variety of intravenous therapies, the facilitation of an Outpatient Parenteral Antimicrobial Therapy (OPAT) service for patients requiring intravenous antibiotics at home, and work to reduce Device Related Hospital Acquired Bacteraemia (DRHAB) occurrence with the support of

Infection Prevention. The backlog in clinical activity resulting from the recent pandemic continues to place an increased demand upon the service.

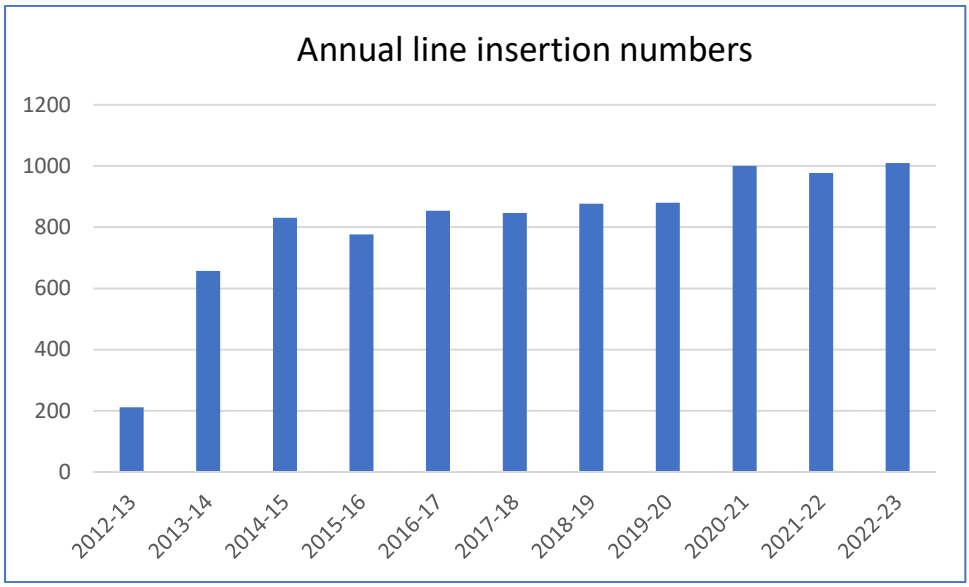
Long line insertion.

The continuing increased demand for oncology services has led to a continued increase in the number of long lines required for chemotherapy, with the provision of up to two peripherally inserted central catheter line insertions per weekday being enabled within chemotherapy outpatients. Other outpatient line insertions are provided for the respiratory centre and the endoscopy suite.

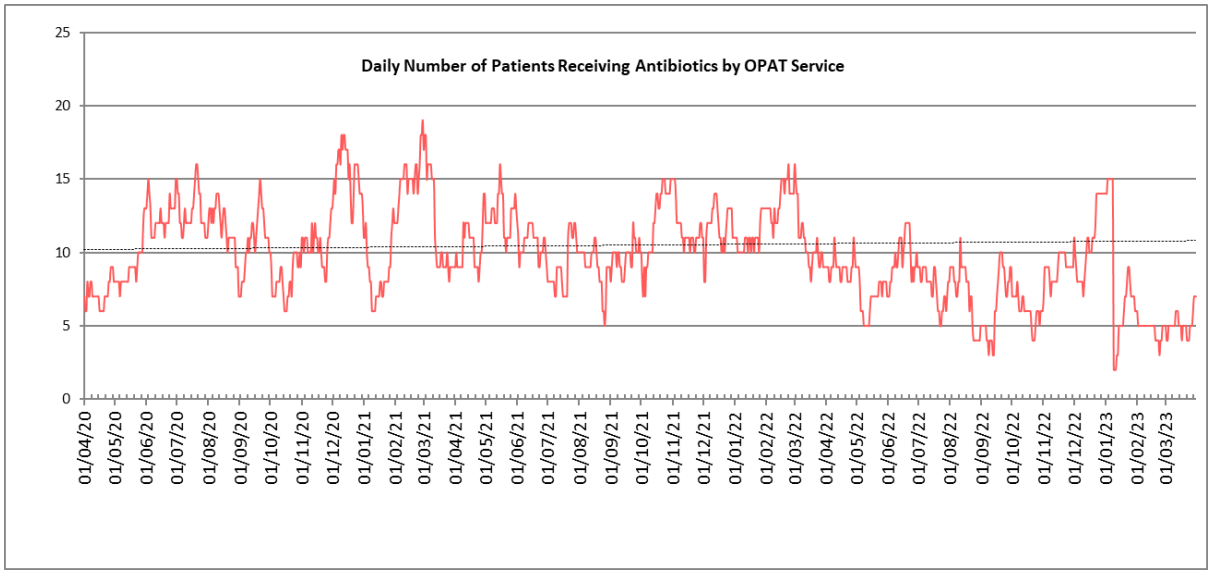
Despite these demands the IV Team continues to follow up all inpatients with long lines in situ daily, providing insertion site care and assessing for evidence of line associated complications and prompt removal at the end of treatment. Ongoing support which had previously been reduced to the Oncology and Haematology wards has also been reinstated to assist with the recruitment of large numbers of new and inexperienced staff to these areas.

The Team has now inserted a total of nearly 9000 lines and has inserted 1011 long IV lines this year – the highest annual insertions since the team commenced in 2012. This is a significant achievement as the team has been challenged with reduced staffing levels due to an experienced staff member leaving to further her career requiring replacement and challenges with administrative support. To increase efficiency, the service has introduced the application of surgical glue at insertion sites at the end of the insertion procedure. This reduces the need for traditional day one dressing change, and the risks of line related infection due to the bactericidal properties that the glue provides.

The outcome of a business case is awaited that aims to extend the size of the team to improve the speed of access to long term vascular access insertion and the introduction of arm ports. The team is also exploring collaborative working with Walsall Healthcare Trust, currently without a vascular access team, to improve vascular access provision across both sites.



Outpatients Parenteral Antibiotic Therapy (OPAT) service
The OPAT service continues to enable the safe discharge and monitoring of patients whilst receiving intravenous antimicrobial therapy by working with a variety of community nursing teams covering a wide area from Hereford and Worcester to west Shropshire. Appropriate long term vascular access devices are inserted prior to discharge and patients are screened against specific discharge acceptability criteria prior to referral to community teams. This work requires high levels of accurate and extensive communication to ensure safe patient governance between community services and the Trust multi-disciplinary team. This year OPAT has discharged 122 patients saving the Trust nearly 4,000 bed days, thus helping to reduce the pressure on inpatient services whilst improving patient experience by enabling them to return to the home environment.



The business case submitted last year to support the use of elastomeric pumps to enable the slow 24 hour delivery of certain antimicrobials to the Medicines Management Group has been amended and awaiting further consideration prior to approval. If accepted this will enable the realisation of potential cost savings due to the ability to use cheaper alternative antimicrobial choices without the need for frequent dose administration. This could demonstrate multiple benefits for both patients and to care delivery.

Device Related Hospital Acquired Bacteraemias (DRHABs)
Device related bacteraemia reduction continues to be challenging quality improvement work, with efforts continuing to be made to reduce these to pre pandemic levels. This continuing struggle is potentially explained by the large recruitment initiative achieved by the Trust and consequent increased new staff numbers, alongside the increasing workload of the team and consequent reduced ability to support education and training. The Team is to assist the twice monthly intravenous care education sessions which are being introduced by Nurse Education from April 2023 onwards, whilst also working with the Intensive Care Practice Education Facilitators and Nutrition Department to provide monthly half day Parenteral Nutrition and long intravenous line care study sessions which are keenly attended.

External opportunities
The Team continues to work with many other Trusts to further the development of quality improvement projects relating to vascular access. Of note is the development of a standardised benchmarking line infection surveillance system for use both across the NHS and further afield, which has been well received and is to be endorsed by NHS England. The

Team Lead has achieved silver winner status in the annual British Journal of Nursing awards for heading this work, which is planned for development into a freely accessible electronic app of benefit to healthcare services both within the UK and beyond from whom interest has already been received.

TUBERCULOSIS SERVICE

Tuberculosis (TB) is an infectious disease that is treatable and curable but continues to be a major public health issue. It is a serious, potentially fatal, disease that requires prolonged and complex treatment and is also an infection risk to close contacts, posing a significant burden on the patient, family and NHS. Those in under-served-populations (which include migrants, refugees, asylum seekers and those with social risk factors - homelessness, imprisonment, and drug use and alcohol misuse) are at higher risk of acquiring TB. The incidence of TB in England is higher than most other Western European countries. Nationally, the highest rates of TB are seen in London, with the West Midlands having the highest rates outside of London.

The activity of the TB service ensures that TB cases in Wolverhampton are well managed according to NICE guidance and reduce the threat of spread in the City. Where active (infectious) cases are identified there is a swift response to contact tracing with appropriate education (e.g. to work places and family members) to reduce anxiety.

Persons with latent TB infection are not infectious and cannot spread TB infection to others; however, it is known that approximately 10% of latent cases can progress to active TB disease which is transmissible. The TB team have actively sought to identify latent TB infection (LTBI) cases. This is supported by an on-going project working with the Refugee and Migrant Centre (RMC) in Wolverhampton. Through the project work the TB team screen appropriate individuals that access the RMC service. It has been found that from screening these groups during 2019 - 35% were found to be positive for LTBI and treatment is offered to these people. New Entrants screening began in 2020 with information provided from Flag 4 data. In 2021/22 the screening demonstrated an average positive rate of 20.79%, for the period 22/23 the LTBI positive rate is 26.1 % and treatment is offered to these patients.

The TB Service support all of the 3 local prisons Oakwood is the second biggest prison in Europe and operated by G4S, Featherstone is Category C men's prison and Brinsford is youth offenders operated by HM Prison Service. The TB Team support with any TB cases and contact tracing. Each prison has identified link nurses to enable a good working relationship. Support when possible TB cases are identified, is assisted with referrals, and guidance is provided. There is no initial screening program in place at present, however any prisoner that presents with a cough and any signs and symptoms are isolated and screened. Continued educational sessions are provided to prison Health care staff.

The BCG immunisation programme is a risk-based programme. The vaccine is recommended for individuals at higher risk of exposure to TB, particularly to protect against serious forms of disease in infants. Local pathways are agreed in the Trust for delivery of BCG vaccinations by Maternity from birth to the age of one New-born screening team. All targeted children from birth will have a severe combined immunodeficiency (SCID) blood spot test. The TB team has worked with local commissioners to facilitate BCG vaccination that was required for eligible children over one year old up to <18 years old.

SURGICAL SITE INFECTION SURVEILLANCE (SSIS)

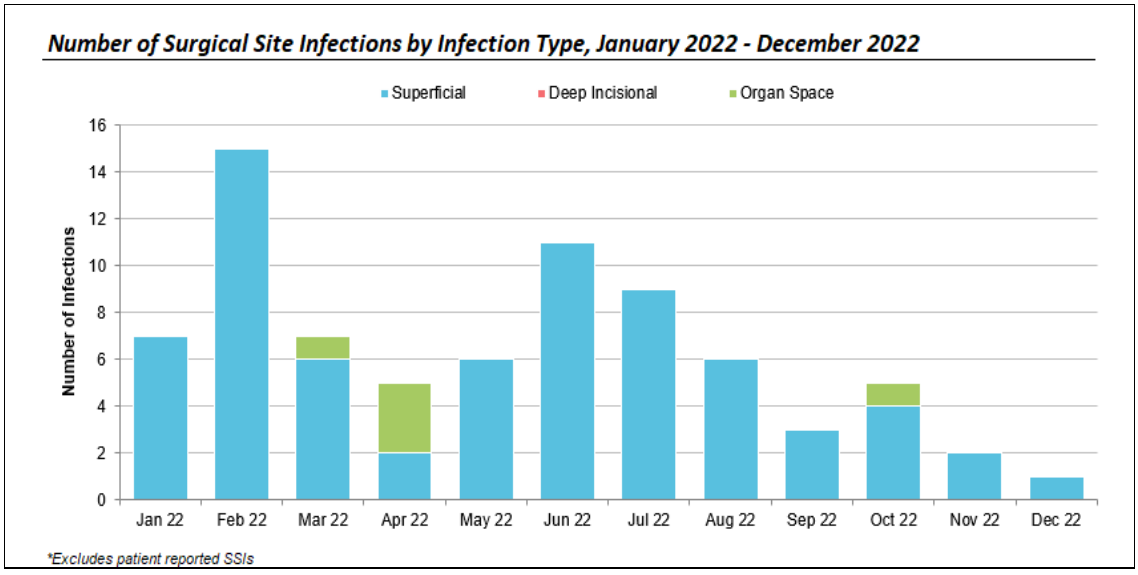
The SSIS Team consists of:

- Band 7 IPN with responsibility to operationally manage the team
- 1.0 WTE Band 6 SSIS Nurse
- 2.5 WTE Band 3 SSIS Co-ordinators
- 1.0 WTE Administrative support

The Trust has continued to collect and report on data around SSIS since 2012. The Trust currently undertakes data collection for all knife to skin procedures 365 days a year and we have a standardised approach using methodology set by U.K. Health Security Agency (Formerly Public Health England) to collect data across our inpatient facilities. This amounts to surveillance of over 1,000 procedures each month from both RWT and Cannock Chase Hospitals during a normal year. The past 2 years has had a reduced number of elective surgeries due to the Coronavirus pandemic. Some elective surgery has been undertaken at the Nuffield to assist in the prevention of a backlog.

The criteria for diagnoses of infections are set by U.K. Health Security Agency and differentiates between superficial, deep and organ/space infections.

The service currently follows up all patients at 30 days post operatively using telephone surveillance. All patients who have had surgery where an implant has been inserted are also followed up at 6 and 12 months.



An electronic based surveillance system is used by the SSIS team which ensures environmental friendliness and compliance with data protection legislation. The surveillance system used has an interface with Silverlink (theatre system used) allowing for accurate surgical data to be transferred. This system also allows for the SSIS team to complete and upload data to U.K. Health Security Agency for the mandatory reporting of hip and knee replacements and surgery for fractured neck of femur. Data is also submitted to U.K. Health Security Agency for Coronary Artery Bypass Graft (CABG) and valve replacement, totalling almost 3000 procedures per annum. In 2021 however only 2.064 were reported due to the restrictions on elective surgery.

This data is used to compare local rates of SSI over time and against a benchmark rate obtained from data published by all Trusts. This enables Trusts to inform and guide the review or change of local practice to improve the quality of care.

All other surgery data is collated for internal quality reporting. In total surveillance is normally performed for over 7,000 inpatient and over 5,000 day case procedures per annum.

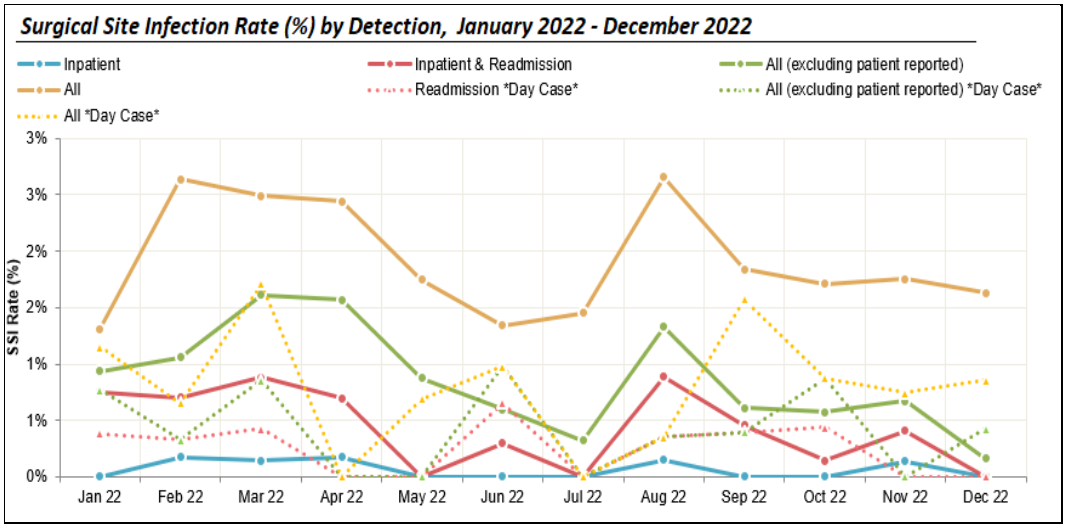
A local report is published monthly, this data is shared with the Divisional Surgical Director on a monthly basis. Consultants have their own personal code which allows them to identify their own rates and comparisons can be made within their speciality, it also means that the data is anonymised. This is used to drive further improvement.

Total Number of Surgical Site Infections and Rate (%), January 2022 - December 2022

Month	Plot Area / No. procedures	Surgical Site Infections				SSI Rate (%)			
		Inpatient	Readmission	Post Discharge	Patient Reported	Inpatient	Inpatient & Readmission	All (excluding patient reported)	All
January 2022	533	0	4	1	2	0.0%	0.8%	0.9%	1.3%
February 2022	568	1	3	2	9	0.2%	0.7%	1.1%	2.6%
March 2022	683	1	5	5	6	0.1%	0.9%	1.6%	2.5%
April 2022	573	1	3	5	5	0.2%	0.7%	1.6%	2.4%
May 2022	687	0	0	6	6	0.0%	0.0%	0.9%	1.7%
June 2022	672	0	2	2	5	0.0%	0.3%	0.6%	1.3%
July 2022	621	0	0	2	7	0.0%	0.0%	0.3%	1.4%
August 2022	677	1	5	3	9	0.1%	0.9%	1.3%	2.7%
September 2022	653	0	3	1	8	0.0%	0.5%	0.6%	1.8%
October 2022	701	0	1	3	8	0.0%	0.1%	0.6%	1.7%
November 2022	741	1	2	2	8	0.1%	0.4%	0.7%	1.8%
December 2022	614	0	0	1	9	0.0%	0.0%	0.2%	1.6%

Data is reviewed at the Infection Prevention and Control Group (IPCG) and the Infection Prevention Team surveillance meetings where new initiatives and directives are discussed by the team such as new NICE guidance NG125 and antimicrobial dissolvable sutures, which have been incorporated into practice.

The data set and system used is highly commended by other organisations and RWT continue to host visits from other Trusts to review our methods of data collection and reporting to see if it can be replicated to assist them in their service delivery.



New initiatives have been the development of a toolkit for all deep and organ/space infections to enable surgical teams to identify aspects of care that may have contributed to a SSI and can prevent future occurrences.

RWT has also collaborated with other Trusts in the region as part of a NHSE initiative for the reduction of avoidable SSI's. Primary drivers were to increase knowledge of SSI's and engagement among patients and staff. Task and finish groups were set up to focus on specific areas such as normothermia, skin prep, educational resources, and post discharge surveillance.

THE CONTINENCE CARE SERVICE (CCS)

In the last year The Continence Care Service (CCS) has continued to increase the impact and reach of it's service to people living with, or at risk of, incontinence. This has been undertaken collaboratively with patients, carers, and health professionals within Wolverhampton.

As the cost-of-living crisis has worsened, the CCS have been made aware that more and more people are unable to afford essential products to manage their incontinence.

Bladder and bowel continence disorders are common. 1 in 10 adults in the UK are affected by faecal incontinence. The issue is closely associated with advanced age, and it is estimated that 34% of women are living with urinary incontinence. Incontinence poverty is a growing issue where people cannot afford to buy the products, they need to manage the problem. This can lead to significantly lower quality of life for individuals and their families, as well as other physical and mental health problems.

The UK financial crisis has greatly impacted upon the CCS resulting in an increase in referrals from people who are no longer financially able to buy containment products independently. Contracted Product Suppliers have increased their contract prices as a result of the rises in the cost of fuel and raw materials.

The CCS's mission for 2022 was to continue to deliver a high-quality nurse led continence service, promoting rehabilitation and to maintain financial stability by providing cost effective evidence-based product provision.

The CCS has worked tirelessly to ensure that the people who are referred to the service receive continence assessments that have a focus upon promoting rehabilitation. The highly skilled nurses in the CCS have worked in collaboration with the patients and their families/ carers to create achievable plans to promote continence whilst maintaining upmost dignity. Only at the point that the patient has reached their optimal potential and if clinically indicated has a product been prescribed. Evidence based, cost effective prescribing has been strongly adhered to, consistent with ensuring that the patients clinical needs have been adequately met. This has been determined by thorough clinical assessment and pad weighing /analysis when required.

The CCS has continued with its mission to break taboo by raising awareness of bladder and bowel continence care for adults by maintaining their popular open Facebook group. This initiative has promoted discussion and education by the sharing of research on treatments and new technology pertaining to the specialist field. People have also referred themselves to the CCS after discovering the group.

In 2022/23 the CCS has continued with the success in maintaining their outstanding Team Stress Risk Assessment 'Green 'Score. The CCS have worked hard to ensure that staff have been abreast with all operational and clinical changes and have had daily communications.

The safety of the patients and the staff have been paramount in ensuring that the service has continued to function and maintain the high standards it aspires to achieve.

In conclusion the CCS have endeavoured to support, educate, to be proactive and reactive despite the hurdles. The provision of a high standard of patient centred dignified care has not been compromised by the challenges endured due to the commitment and positive efforts of the CCS working together with their RWT Colleagues.

INFECTION PREVENTION FUTURE PLANS FOR 2023/24

This is the fourth annual report that has been written during the COVID-19 pandemic, this historic event is something that will never be forgotten in the NHS or at least during our lifetime. As the World Health Organisation (WHO) downgraded the global health emergency in May 2023 the effects on health services continue as services strive to recover and adopt a pre pandemic, business as usual position.

The role of Infection Prevention has never been more important as we recover from the pandemic, we must support staff who are fatigued and consider the recruitment and retention issues we currently face in healthcare, these factors impact on the standards of cleanliness and compliance with hand hygiene and use of personal protective equipment. “Back to Basics” infection prevention education will continue to be a focus for 2023/24 as will the National “Gloves off campaign” as we learn to live with COVID-19. We will find different methods to communicate key messages and reach out to all healthcare staff with service situated training recognising the increase in occupancy and staffing challenges.

This is an exciting time for the IP team to collaborate with colleagues at Walsall Healthcare Trust to be able to learn from each other and to play an integral role in the national and regional IP collaboratives. We will continue to maintain and develop the important day to day activities provided by the IVRT, CCS and TB Team, surveillance of HCAIs, including the surgical site infection surveillance programme, the outbreak management in RWT hospitals and care homes across the city and support of care homes in the prevention and management of infection issues. The structure of the IP Team will enable us to scan the horizon for innovations to support both the reactive and proactive work in the future.

The importance of emergency preparedness has now been recognised and we will await the findings and recommendations from the National COVID-19 enquiry. Lessons learnt will be an important part of preparing for future pandemics. Close cooperative working with neighbouring health care partners and organisations is also crucial in ensuring RWT and the City are safe places to receive healthcare and live.

The IP team will continue to work towards reducing the numbers of patients discharged into the Community with a long-term catheter by working in collaboration with the multi-disciplinary teams across Wolverhampton Health Economy. Device Related Bacteraemia will be reduced by educating staff to manage devices appropriately. A reduction in Hospital Acquired Pneumonia (HAP), Ventilator Associated Pneumonia (VAP) and Catheter associated urinary tract infections (CAUTI) are the projects we will establish this year with the target to reduce the number of avoidable healthcare acquired infections.

Further plans over the next 12 months are to understand how behavioural sciences and human factors can support compliance with infection prevention practice and how we can use these sciences to support our messaging and educational frameworks to ensure that they are embedded into everyday practice.

Appendix 1

Quality Account 2022/23

The Quality Account

Why are we producing a quality account?

All NHS Trusts are required to produce an annual Quality Account, to provide information on the quality of the services it provides to patients and their families. [1]

The Royal Wolverhampton NHS Trust (RWT) welcomes the opportunity to be transparent and able to demonstrate how well we are performing, considering the views of service users, carers, staff, and the public. We can use this information to make decisions about our services and to identify areas for improvement.

[1] Quality Account (2009) Health Act

Statement on Quality from the Chief Executive

To be provided by Communications Team.

Vision and Values

Our vision is to 'To deliver exceptional care together to improve the health and wellbeing of our communities'. Our vision has been updated to reflect the closer working of our organisations and to focus on our core purpose of improving the health and wellbeing of our communities. A vision is more than a few words – it reflects our aspirations, helps to guide our planning, support our decision making, prioritise our resources and attract new colleagues.

Looking back 2021/22

Priorities for Improvement

The chosen priorities supported several quality goals detailed in last year's quality strategy as well as three key indicators of quality:

Patient Safety	Having the right systems and staff in place to minimise the risk of harm to our patients and being open and honest and learning from mistakes if things do go wrong.
Clinical Effectiveness	Providing the highest quality care with world-class outcomes whilst also being efficient and cost effective.
Patient Experience	Meeting our patients' emotional needs as well as their physical needs.

Progress in achieving our quality priorities were monitored by reporting to the relevant Quality Boards at the Trust.

Patient Safety		
PS 1 - COVID-19 minimising impact This priority supports the delivery of our Quality & Patient Safety strategy and builds on the work already undertaken to maintain best practice for the management of COVID-19 for inpatients, preventing the spread of infection and minimising the impact of COVID-19 to optimise service recovery to pre-COVID-19 position. Reduce indirect harm caused by COVID-19 by establishing systems to identify and monitor learning from related incidents.	**We said we would:** Minimise and manage outbreaks within national/regional guidance to maintain safety of staff and patients with minimal impact on service provision. Aim to provide high quality, safe services to pre-covid rates to meet national targets.	**How did we do?** **Looking back Infection Prevention 2022/23** This year has been extremely busy with the ongoing COVID-19 Pandemic but also returning to pre-COVID business as usual. During this period the Infection Prevention team (IPT) have been able to complete both reactive and proactive work though. The IPT have continued to work effectively with Wolverhampton Public Health to ensure COVID-19 guidance and all COVID, Flu and Norovirus outbreaks are managed in a timely manner, thus ensuring patient safety in care homes and other high-risk settings. A new contract has been agreed from April 2023. In the acute Trust; - • Carbapenemase Producing Enterobacterales (CPE) colonisation has continued to increase with 53 cases. • *Clostridioides difficile* is over trajectory with 72 cases, 14 over trajectory. • 2 MRSA bacteraemia attributed to RWT. • Environmental controls continue to be a top priority however not all areas have received a deep clean due to lack of decant facilities however all inpatient areas have received an enhanced level of cleaning throughout. • The bed cleaning service has resumed whereby empty beds are taken to an area and cleaned using steam and Hydrogen Peroxide Vapour (HPV). A clean bed is delivered to the ward ready for a new patient. • The Intravenous Resource team continues to deliver a high standard of line care with patients discharged on outpatient parenteral antibiotic therapy (OPAT) • Surgical Site Infection surveillance (SSIS) data is shared with Consultant Surgeons via a monthly dashboard. • Device related bacteraemia (DRHAB) has increased. This is an internal trajectory of 48 and there were 58 identified. • Outbreak management included COVID-19 x 87, Norovirus x 2, Influenza x 2. Ward based education has been completed including *Clostridioides difficile* awareness week, different wards each week, and back to basics.

		Looking back COVID-19 2022/2023 The Trust continues to identify all COVID-19 healthcare associated infections (HCAIs) in line with national definitions and to undertake investigations as indicated by national guidance. Outbreaks continue to be managed according to national guidance however there have been many variables which have impacted on the number of outbreaks such as visiting and the removal of all COVID-19 guidelines for the public. Outbreaks are reported and escalated to ensure learning is identified and corrective actions taken. Several changes in guidance occurred throughout the year such as patient's wearing face masks and a reduction in inpatient screening. Asymptomatic screening ceased and only patients who presented in ED or in an inpatient setting with symptoms were screened. All patients identified as Clinically Extremely Vulnerable (CEV) or were admitted to Intensive Care or were being discharged to a care home were also screened for COVID-19. Patients who had a positive result were isolated in a side room or nursed in a bay with other positive patients (cohort bay/ward) All COVID-19 HCAI deaths are reviewed by an individual case analysis and structured judgement review (SJR) with a full RCA completed where indicated. Themes identified were ventilation of the ward environment and patient/staff compliance with face masks. The Trust undertake Duty of Candour in a sensitive manner and in line with national guidance in all cases where moderate or severe harm or death has been caused by omissions in care.

PS 2 - Reduce harm by assessing, recognising, and responding to minimise patient deterioration This priority supports delivery of our quality strategic aim to deliver a safe and high-quality service and builds on the achievements of our 2021/22 quality and patient safety strategy priority to protect patients from unintended or unexpected harm.	**We said we would:** Continued focus on good governance processes for the deteriorating patient including: • Development of a dashboard for deteriorating patient and sepsis. • Critical care reviews and themes for learning and quality improvement • Learning from mortality reviews in relation to the deteriorating patient • Further collaboration and close working with resuscitation committee • Achieve the CQUIN in relation to recognition and response to deterioration of patients.	DPG dashboard development is ongoing. With input from the Information team, 'Observations on time' dashboard was developed and implemented. The dashboard provides real time data that clinical areas can interrogate to evaluate performance and support improvement. There has been an incremental improvement in the compliance with 'observations on time' which is a key safety metric. A similar approach will be used to develop other elements of the dashboard and we have plans to share it with Walsall Healthcare NHS Trust colleagues and work collaboratively on the deteriorating patient agenda. The Trust is committed to delivering the Commissioning for Quality and Innovation (CQUIN) relating to deteriorating patients and unplanned admissions to Critical Care Unit. It measures the recording of the National Early Warning Score (NEWS2), escalation time and response time for unplanned critical care admissions**.** The CQUIN goal is 20-60% and the Trust has performed consistently well above the national target (overall compliance was 83% for the last quarter of 2022/23.). The associated audit has demonstrated an improvement in escalation but challenges with documentation of the response time. Feedback is provided to ward teams when delay in escalation/response is identified. We have continued to contribute to the national cardiac arrest audit. An improvement has been noted in the 'risk adjusted' parameters such as ROSC (Return of Spontaneous Circulation) > 20 minutes and survival to hospital discharge. The overall 28-days in-hospital survival is similar to peer group and the national average. The Resuscitation Committee has set up a focus group to undertake further analysis of factors that impact on the risk-adjusted metrics and determine interventions to support improvement. Case ascertainment and data completion is also being explored and discussions are ongoing with the Information Technology team to develop an electronic form to improve data capture post event. Unexpected deaths following cardiac arrest is now an additional criterion to identify any missed opportunities regarding prompt escalation or whether Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) should have been in place.

PS 3 - Promote equality out of outcomes by routinely reporting user outcomes (reducing health inequalities) This priority supports the delivery of the national/regional (Integrated Care System - ICS) agenda to focus on access and health equity for underserved communities and our local Quality and Patient Safety Strategy to Promote equality of outcomes for all, including hard to reach groups.	**We said we would:** • Ensure of our current patient safety workstreams are dovetailed and support outcomes in line with Health Inequalities programme to maximise impact.	The Royal Wolverhampton NHS Trust have undertaken the following actions as part of the Health Inequalities agenda: <u>Governance and Education</u> - Introduced a Health Inequalities Steering Group which has representation from a wide range of stakeholders internal and external to the organisation including Local Authority, Public Health and One Wolverhampton. - Trust Board Reports and Development sessions. - Business case templates have a dedicated section which includes consideration of inequalities. - Equalities Impact Assessment (legal duty) now also includes consideration of other inequalities e.g. deprivation. - Successful bids for developing educational packages for the workforce to improve understanding of health inequalities for the population in which we serve. <u>5 National Themes and Our Initial Action Plan</u> 1. Inclusive services – breaking down data by deprivation and ethnicity - Maternity and early years data development and dashboards to steer focus - Equity audit of elective pathways and pilot work on DNAs 2. Mitigating against digital exclusion - Considering data protection concerns, equipment and data availability, digital skills in access to information and services, monitoring uptake 3. Ensuring datasets are complete and timely. - Meeting ethnicity completion target of 95%, flags for Learning Disability in place 4. Accelerating prevention programmes - Introduction of tobacco dependency service for inpatients, expansion of the Drug and Alcohol liaison team, primary care workstreams, recruitment of EDI midwife 5. Strengthening leadership and accountability - Board level buy-in, working towards distributed leadership through education and changing business-as-usual processes <u>Assessing Equity</u> - Analysis and qualitative data gathering and analysis to identify disparities focusing on patients that Did Not Attend (DNA) and a review of current processes focusing on a deep dive in high volume specialities in the first instance to establish the inequalities faced. An Equitable Recovery Programme pilot is currently underway within the Ophthalmology Department to proactively contact patients with outpatient appointments to identify any barriers they may face to attend their appointments.

		- Updating the Patient Access Policy to ensure that services are available to all patients and easily accessible.

PS 4 - We will aim to improve mental health care and treatment for all ages **PS 5 - We aim to review our services, work with our partners to deliver a flexible service to meet the needs of mental health patients** **PS 6 - As a registered provider of mental health, we aim to adhere to the law and legislation within the Mental Health Act 1983 and to ensure all patients are treated in a patient centred way** **PS 7 - We aim to support and deliver excellent care for some of our most vulnerable patients and their carers including children and those living with a learning disability, mental health issues and dementia** **PS 8 - We aim to deliver parity of esteem by having embedded mental health services and skills across the workforce** This priority supports the delivery of the national/regional (Integrated Care System - ICS) agenda to improve mental health services and services for people and our local Quality and Patient Safety Strategy to Strengthen governance and care systems related to the care of those with ill mental health.	**We said we would:** • Ensure the workforce is knowledgeable and skilled in meeting the needs of our mental health patients. • Embed a multidisciplinary approach to supporting mental health patients. • We will deliver a mental health steering group that will enable a trust wide approach to reviewing mental health care standards and to share experiences. The group will be a supportive group that aims to improve mental health care and standards throughout the organisation. • Work with partner agencies to support effective delivery of mental health care services that are delivered within the organisation. • Develop a mental health strategy • We will develop a process to support the use of Force Act 2018 and improve governance processes for auding mental health data.	**PS4** – The trust has developed systems where incidents and complaints can now be systematically reviewed to allow the organisation to have oversight. Regular data is available to support clinical areas to access appropriate care and treatment and support patient care. Systems and processes have been developed to support the adherence to the mental health act and therefore are able to support quality of care for patients who are detained under the mental health act ensuring their patient rights are adhered to and they have access to Independent mental health advocates when required. The trust continues to work with partner organisations who support our patients when admitted to the organisation. **PS5** – The trust liaises with partner organisations to agree pathways and services for our patients. The mental health team engages in transformational projects to develop the services available to patients whilst in the organisation. The executive team are working with partner organisations to develop clear service standards. **PS6** – A process has been embedded where the trust is aware of all mental health activity that takes place within the organisation. With this oversight, assurance has been gained that all patients have access to the correct legal process supporting MHA. The trust adheres to the mental health act 1983 and mental health Code of practice to support our patients who are detained to the organisation. Mental health act administrators are in post who support the process and education for the workforce. Enhanced mental health act training has been developed for the workforce to support their knowledge and understanding of the mental health act, to improve quality of care delivered to patients. **PS7** – Over the last year the mental health team has been able to learn and understand the services that are in place, working across the organisation to support all ages of mental health presentations. New working groups have commenced to develop services to support areas for improvement such as – paediatrics, inpatient wards and for older adults who may be presenting with Dementia. Close working is taking place with the learning disability team and support sharing of information to enable a joint approach and support the quality-of-care patients receive. The trust is working with our partner organisations to benchmark best practice and work in collaboration for the regional workstreams that are taking place.

		PS8 – The mental heal team continue to advocate for parity of esteem and are working with our partner organisations to fully embed this practice, understanding that there are challenges to ensure parity of esteem from the front door throughout the patient journey. Therefore, work continues in collaboration to ensure pathways are robust and services are delivered to meet the complex needs of the patients that attend the trust. It is envisaged with the completion of the ongoing workstreams, regional work and collaboration we will achieve parity of esteem in the future.

Clinical Effectiveness		
CE 1 - To ensure we improve and continue to have an appropriate workforce to support clinical effectiveness, patient safety and a positive patient experience	**Nursing Workforce** **We said we would:** • Continue our recruitment programme, utilising our lead recruiter Clinical Fellowship programme to attract and onboard international recruits to our workforce • Continue to increase placement opportunities for nursing students, supporting our local university's ability to educate more nursing students • Improve the work/life balance of our nursing staff by offering flexible working which will improve the organisations attractiveness to new staff and retention of current staff. • Continue to provide mechanisms to allow for personal and professional growth, whether from Clinical Support to Nursing Associate, Nursing Associate to Registered Nurse or Registered Nurse to Advanced Practice. • Seek to improve opportunities for all by supporting local recruitment programmes in partnership with local government, charities, and associations to address local inequalities that effect employment within our communities. • Complete the implementation of Safecare and safe staffing policy to fully realise the benefits of a responsive, acuity led staffing allocation and the governance of red flag alerts. • Improve the systematic review of staffing in the organisation using the new Safer Nursing Care Tool (SNCT) provided for both Emergency Departments and Community in late 2021 and early 2022.	**How did we do?** Nursing Workforce We have done: • Continued our recruitment programme, utilising our lead recruiter Clinical Fellowship programme to attract and onboard international recruits to our workforce • Continued to increase placement opportunities for nursing students, supporting our local universities ability to educate more nursing students • Improved the work/life balance of our nursing staff by offering flexible working which will improve the organisations attractiveness to new staff and retention of current staff. We have also relaunched the internal transfer programme with good results. • Continued to provide mechanisms to allow for personal and professional growth, whether from clinical support to nursing associate, nursing associate to registered nurse or registered nurse to advanced practice. Introduction of STAY events for registered staff and nuanced event for unregistered staff. • We improve opportunities for all by supporting local recruitment programmes in partnership with local government, charities, and associations to address local inequalities that effect employment within our communities. Success with recruiting through the Prince's Trust "Get Into" programme for 18-30 year olds. • Completed the implementation of safecare and safe staffing policy to fully realise the benefits of a responsive, acuity led staffing allocation and the governance of red flag alerts and report daily. • Improved the systematic review of staffing in the organisation using the new Safer Nursing Care Tool (SNCT) provided for both Emergency Departments and community in late 2021 and early 2022. Completed an external review from NHSE/I to ensure we are using the SNCT appropriately, which we are fully compliant with. We have also intorducted robust training for staff around the utilisation of the tool to ensure accurate data capture.

	AHP **We said we would:** • Continue to build upon our Health Education England-funded workforce programmes: supporting AHPs to return to practice; international recruitment into AHP posts through RWT's award-winning Clinical Fellowship Programme; increase attraction, reduce attrition, and improve retention of AHPs and the support workforce; enhance our resources to increase the number of AHPs undertaking apprenticeships at all levels; develop the AHP support workforce. • Continue to work with universities to offer an increased number of placements and attract students as our future workforce. • Focus on developing new roles and career progressions opportunities for our existing AHP workforce. • Ensure provision of attractive development programmes • Continue to strengthen our governance arrangements using our oversight reports to the Chief Nurse. • Expand our apprenticeship offer to the diverse population to widen potential future employment opportunities within healthcare for the young people in our local communities. • Continue to build a personalised plan to deliver more flexible working opportunities in all our roles and deliver on the promises made in the NHS People Plan.	The Chief Nurse has oversight for AHP recruitment and retention thorough monthly reports. Working with colleagues across the Black Country Integrated Care System (ICS), we promoted return to practice (RtP) across the ICS. The campaign resulted in 481 views on the RWT RtP website. This represents an increase in views of approximately 250% compared to previous months. International recruitment (IR) is ongoing, through the NHSE ICS programme for which RWT is the lead recruiter. Diagnostic Radiography have done particularly well, with 13 radiographers appointed to date. Two offers have been made for internationally recruited Podiatrists. Our first four Operating Department Practitioner (ODP) apprentices became registered ODPs in 2022, with a further six Theatre Assistant Practitioners starting their Level 6 apprenticeship in 2022. Within the Physiotherapy and Occupational Therapy (OT) Department there are currently three physiotherapy and four OT apprentices, with a further five apprentices due to start their apprenticeships in 2023. New apprenticeship opportunities for 2023 include radiography, dietetics and speech and language therapy. We are also exploring level 3 and level 5 apprenticeships for our AHP support workforce as well as level 7 opportunities for those already educated to level 6. We are hopeful that links developed with several universities during our clinical placement expansion programme 2021/22 project will lead to increased retention of local students recruited as new graduates. To support retention, during 2022 we saw the launch of our new ICS AHP preceptorship programme. A positive preceptorship experience is reported to result in newly registered graduates and international recruits having increased confidence and feeling valued by their employer. This, in turn, is linked to improved recruitment and retention. Other initiatives implemented to improve retention include 'stay and grow' conversations, the updated AHP Career Map and supporting flexible working. Temporary staffing arrangements are in place for vacancies where necessary to ensure services are appropriately staffed and targeted recruitment continues to proactively recruit to hard to fill posts. AHP vacancy levels overall are now meeting the Trust target over the last nine months, the first time since April 2020.

	Medical Workforce **We said we would:** **Consultants** • Continue to develop internally trained senior medical staff from fellowship programme. • Aim to strengthen links with neighbouring organisations where the national consultant resource is limited. • Develop pathway for long term locum consultants to be employed and supported to progress through CESR to a substantive appointment **Junior medical staff / fellowship** • Ongoing development and expansion of clinical fellowship programme. • Embrace and adopt required changes to training structure and supervision requirements • Explore options for digital fellowship programmes in collaboration with external stakeholders. **Medical students** • Consolidate Aston Medical School students into the Trust and continue to recognise this will be an important future source of junior and senior medical staff. • Continue to provide high quality training for University of Birmingham medical students.	The Clinical Fellowship Programme (CFP) CESR Faculty is an initiative supporting Doctors across The Royal Wolverhampton, Walsall Healthcare NHS Trust and Black Country Healthcare Foundation Trust. The Certificate of Eligibility Specialist Register (CESR) Programme is the alternative training pathway for doctors to join the GMCs Specialist Register to become UK Consultants. CESR is a lengthy process and requires a high level of commitment from the doctor combined with support from the CESR Faculty and a doctor's respective directorate to progress toward a successful application with the GMC. The Trust currently have: ➢ 16 CESR successes since 2018 ➢ 44 currently committed the pathway ➢ 18 anticipated submissions within the next 12 months ➢ Developed CESR Fellow posts - linked to "hard to fill" consultant vacancies with a view to attracting doctors from within the UK. **Clinical Fellowship Education and Enhanced Support Services** • Implementation of a 3-tier weekly teaching programme – aimed to support all levels of Fellows. SIMS training sessions • Educational Support Meetings during initial 6 months into tenure (running parallel to Educational Supervision) • Group Supervision Sessions with trained Educational Supervisor for initial 6 months into Tenure • Peer Led Enhanced Support Services sessions for portfolio, IT training, on call induction training • Peer Led Pastoral Programme - leads for Academic, Socio-Cultural and Early Support aiding our International Fellows

		with an easier transition into working in the NHS and adjusting to life in the UK. **Medical Students** • Aston Medical School (AMS) students have been well integrated into the organisation. The AMS inception cohort (intake 2018) will graduate this academic year, with every student having the entirety of their medical final clinical examination at RWT. • A quality visit from the GMC assessing AMS and their provision for OSCEs (Objective Structured Clinical Examinations) was excellent. The successful partnership between RWT and AMS resulted in an "impressive and well-organised" OSCE. (Source: General Medical Council team, 7.3.23). Quality metrics for University of Birmingham Medical school students remains high with the latest quality visit in Sept 2022, the feedback from the visit cited, 'throughout the visit it was evident to the Panel that the Trust have a genuine commitment to education. This was equally reflected within the student feedback whereby students perceived the RWT to be an excellent placement'.

CE 2 - To continue with our multi-professional Clinical Services Framework (CSF) to further enhance our ability to work as integrated teams and support our patient needs	**We said we would:** Continue to implement the Clinical Services Framework (CSF) and the elements outlined for 2022 under. • Right workforce • Excellence in care • Cultural and organisational structure • Communication • Education • Research	During 2022/23, the Trust continued to progress the priorities and milestones outlined in the Clinical System Framework for Nurses, Midwives, Health Visitors and Allied Health Professionals (AHPs), which was launched during 2021/22 as version 2. The Framework consisted of 6 pillars, including: Right Workforce; Excellent Care; Culture and Organisational Structure; Communication; Education and Research and Innovation. In total, there were 36 specific work-streams and 222 associated objectives for the 2-year period. Progress with delivering the agreed objectives was reported on a three-monthly basis and shared with senior leaders via the key forums and Trust Board, via the Chief Nursing Officer report. From the 222 set objectives, 157 were achieved, 73 were not achieved and 2 objectives were not reported against. Overall, the were many positive achievements, despite the extreme operational pressure caused by the Covid-19 pandemic. Examples of positive achievements include: • Recruitment/training of Professional Nurse Advocates (PNAs). 49 staff are now accredited as PNAs within the Trust. • Recruitment of Smoking Cessation Specialist Midwife to support smoking cessation. • Nurses, Midwives, Health Visitor and AHPs published 113 peer reviewed articles in 2022, as opposed to 39 in 2021, overperforming on the CSF objective set for both years. • The Care to Share magazine continued to be published to celebrate achievements as well as being a helpful communication tool. • 100% Care Certification was achieved for Healthcare Support Workers (HCSWs). • Progress with internal transfer process was achieved with a CNO Fellow appointed to progress the workstream in 2022. • International Nurse retention was positive and for 85 staff recruited during 2020, 85-90% remained at the Trust. • The 30, 60 and 90-day conversations were introduced to proactively monitor staff wellbeing and job satisfaction. • Success with the apprenticeship programme was achieved through proactive community scoping and

		collaborative working with the Prince's Trust and Health Education England. • The target of expanding AHP representation on Trust committees was met. • Co-production, clinician and patient workshops have been commenced and are now embedded. In terms of the objectives that were not achieved, this was due to a variety of reasons. For example, some of the national reporting mechanisms had changed which meant that some metrics were no longer collected or relevant. In addition, the extreme operational pressures caused by the Covid-19 pandemic and the need for re-prioritisation of key activities had negatively impacted on our ability to achieve all the objectives. A new framework for Nurses, Midwives, Health Visitors and AHPs, renamed as the Quality Framework, has been developed and launched in April 2023, following extensive consultation across both, the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. Some of the objectives not achieved during 2022/23 are included in this version. The Framework outlines key areas of focus for the next 2 years and includes focus on the same pillars as outlined in previous iterations, but now includes 5 separate plans for the following services: Paediatrics, Maternity, Acute Adult, Allied Health Professionals and Community. Quarterly progress updates will be provided via the Chief Nursing Officer/Director of Nursing reports.

Patient Experience		
PE 1 - To maintain and improve patient engagement and to continue to place patient engagement and involvement at the heart of decision-making driving forward improvements in delivery of care	**We said we would:** With our colleagues at WHT we will publish an Enabling Framework for 2022-2025. This will reinforce our collaborative working across both Trusts.	A variety of workstreams have been ongoing throughout the year to improve patient engagement and involvement and ensure this is at the heart of decision making. We have had an active Council of Members (patient participation group) where meetings are held bi monthly. Active members of the group have been involved in a variety of projects and initiatives including assessment of standards against the '15 Steps' challenge and 'Observe and Act' initiatives. This group have been rebranded and are now called Patient Involvement Partners (PIP's), which gives more clarity to the role. The Terms of Reference was also agreed, plus rebranding which will be going live in early 2023. The enabling strategy has been written following consultation with the patient groups and is currently being ratified. The Trust have trialled a feedback initiative called Mystery Patients, in our Paediatric areas. The model uses QR codes from posters displayed in clinical areas to give anonymous feedback of the services accessed. In January 2023, our PIP's helped co-design the RWT model of the initiative to prepare us for wider roll out. The PIP's group chose to call the RWT model '**Feedback Friend'** and discussed logo and what information needs to go onto the poster and be on the online form which is accessed by the patient. The end co-designed result should be rolled out in a phased approach across further clinical areas in RWT from April 2023. RWT has been working on co-design for the ward welcome information boards within this reporting period with final designs ready to go live in April 2023. We have worked with the following groups to identify what information patients and carers would like to see on the welcome boards: • Patient Involvement Partners (for adult wards) • Service users with Learning Disability in a specific focus group for both adult and paediatric wards • A local primary school for Paediatric Ward

		The Patient Experience team have met with one of the LD nursing team to begin scoping methods of feedback for patients with a learning disability. A video will be put together in the new financial year. **Patient Involvement in Quality Improvement -** The first task and finish group meeting was held in this reporting period, to develop a framework within RWT and WHT, of involving patients and carers within all Quality Improvement workstreams **15 Steps Patient Observation Initiative -** During this reporting period Patient Involvement Partners (PIP's) have been involved with supporting 15 Steps assessments in various clinical locations.
PE 2 - To continue to improve complaints responses to patients and ensure learning is identified and areas are provided with e-learning	Embed the PHSO Complaints Standards, and with our colleagues at WHT, we will continue to develop and implement the new PHSO Complaints Standards including e-learning training modules and tracking progress against each Trust's self-assessment	The Trust has implemented the Parliamentary Health Service Ombudsman (PHSO) Complaint Standards for complaint handling and became an early adopter of the initiative. The early implementation was successful, and this initiative has now been suggested to be used nationally by the PHSO. A self-assessment was undertaken as part of the requirements for the PHSO for being an early adopter of the scheme. A module has been written jointly between both The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust, and will be shortly available for wider accessibility. This incorporates the principles of the PHSO standards. However local training has been delivered for bespoke groups as and when required. There is an ambition to make this module mandatory for all those whose responsibilities are to deal with formal complaints. Part of the PHSO standards is to focus on the customer care element, and a project has been implemented over the last 12 months focusing on de-escalation of complaints resulting from aggression between the public and staff. This was piloted within the ED area for predominately receptionists, however has been widened out to clinical staff. The ambition for the forthcoming year is to deliver this training to other directorates. We have undertaken assessments periodically throughout the year with an independent panel in relation to our complaint handling. The current results are favorable with compliancy to process.

PE 3 - To build on the success of volunteer services	Identify strategic priorities for volunteering opportunities aligned with strategic priorities of the Trust • Increase recruitment of volunteers • Continue to explore career pathways for volunteers within the Trust and evidence case studies/ good practice • Expand volunteer opportunities based within Trust community services	We are still trying to form a strategic alignment of volunteer roles with the strategic Trust priorities. During the last year, many new roles were requested of volunteers including Endoscopy waiting room, ED and ARC, Discharge Lounge, and Surgery wards which we have been able to fulfil thanks to our adaptable approach with use of an app for volunteer rostering. To plan effectively for Winter Pressures 2023, we will be recruiting again in late summer, and meet with workforce leads to understand where volunteers could most effectively plug gaps in clinical areas. The recruitment of volunteers has increased, we still continue to hold quarterly recruitment projects with a minimum target of 50, and in addition, attend the Trust wide Recruitment events, and a wide range of community engagement events. We also spend quality time on volunteers retention initiatives, to hold the numbers of volunteers in place for longer. We continue to support volunteers with career explorations in the NHS, and to build upon their own skill development and to pursue job applications within the Trust if this is their choice. We have signed a partnership agreement with NHS Cadets, which is manged by NHSE and St Johns Ambulance, and trains and educates young people on the opportunities within NHS Careers, alongside a volunteer placement. Since forming the partnership, we have supported 9 young people through this route. We regularly collect case studies for use in social media and reports, and a case study of a particular volunteer who gained a Bank HCA position has been featured in two national campaigns through NHSE promoting HCA careers. The Deputy Head of Patient Experience with portfolio responsibility for volunteering also led a monthly 'NHS Volunteer Managers Forum' on recruitment of the clinical volunteers for Helpforce, which was live streamed on LinkedIn. Finally, we will explore volunteer opportunities within the community fully in 2023, as we have been awarded funding by NHS Charities Together, for a 2 year volunteer programme aiming to ease social isolation.

PE 4 - Patient Access Waiting Times: A focus on waiting times to improve 62-day cancer performance, a reduction in long waiting patients (+78 weeks) and elimination of 104 week waits	• Focus on cancer capacity and pathway times. This year has seen a sharp increase in referrals, however, our 2ww performance is improving which will in turn help the 62-day pathway times. Work is on-going to improve diagnostic waiting times with the inclusion of mobile units to increase capacity. • We recognise the need for capacity to be increased over and above pre-covid numbers to reduce waiting times. We continue to utilise virtual clinics where appropriate to ensure maximum capacity is available. • We will continue to work collaboratively with other local Trusts to offer and utilise mutual aid where appropriate to ensure the best outcomes for patients.	**How did we do** We have continued to prioritise the treatment of patients on a cancer pathway. There was a 22.7% increase in referrals in 2022/23 compared to pre-Covid which has impacted on all stages of the cancer pathway. Additional diagnostic capacity is in place to improve timeliness of diagnostic and mutual aid has been sought to increase treatment capacity further. The Trust has significantly reduced the number of patients waiting over 78 weeks, reducing the number of breaches to 85 at the end of March. Industrial action within March (which continued into 2023/24) impacted on the improvements the Trust could make beyond this. The Trust eliminated all waits over 104 weeks.

Looking forward 2023/24

Priorities for Improvement

How we chose our priorities

Each year the Trust is required to identify its quality priorities. We consulted on both the quality strategy and annual quality priorities. The draft priorities were shared with commissioners, Healthwatch, our governors, the Trust Management Committee, the executive teams within the divisions and directorate management teams. The final priorities for 2023/24 were agreed by the Trust Board.

The chosen priorities support several quality goals detailed in our quality strategy as well as three key indicators of quality:

Patient Safety	Having the right systems and staff in place to minimise the risk of harm to our patients and being open and honest and learning from mistakes if things do go wrong.
Clinical Effectiveness	Providing the highest quality care with world-class outcomes whilst also being efficient and cost effective.
Patient Experience	Meeting our patients' emotional needs as well as their physical needs.

Progress in achieving our quality priorities will be monitored by reporting to the relevant Quality Boards at the Trust.

The priorities detailed below have been identified and agreed in the Quality and Safety Enabling Strategy and the Patient Experience Enabling Strategy. These are the first joint strategies for The Royal Wolverhampton NHS Trust (RWT) and Walsall HealthCare NHS Trust (WHT). The strategies define in detail how we will strive to excel in delivery of care, which is one of the four strategic aims of the joint Trust Strategy.

Our key priority areas have been agreed based on the triangulation of information from various local, regional, and national sources, including recent engagement with our staff, patients, partners and the communities we serve.

The priorities identified below are specifically drawn from both above strategies.

The priorities are captured under the Quality & Safety Enabling Strategy overarching themes.

Our People

- ❖ Priority Area – The right workforce with the right skills in the right place at the right time

Embed a culture of learning and continuous improvement at all levels of the organisation.

- ❖ Priority Area – Quality Improvement
- ❖ Priority Area – Patient Safety
- ❖ Priority Area – Patient Involvement

Prioritise the treatment of cancer patients focused on improving the outcomes of those diagnosed with the disease.

- ❖ Priority Area – Cancer treatment

Deliver safe and responsive urgent and emergency care in the community and in hospital.

- ❖ Priority Area – Urgent and Emergency Care and patient flow

Deliver the priorities of the National Elective Care Strategy

- ❖ Priority Area – National Elective Care Strategy

Patient Safety	
Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority Area – Patient Safety**	**Key actions we will take.** • Transition to the Patient Safety Incident Response Framework (PSIRF). • Transition to Learn from Patient Safety Events (LfPSE). • Increase uptake of Level 2 syllabus training. **The aim for 2023/24** • Transition to PSIRF achieved by 30th September 2023. • 100% of incidents uploaded to LfPSE by 31st October 2023.

Deliver safe and responsive urgent and emergency care in the community and in hospital.
 	
Priority area – Urgent and Emergency Care and patient flow
	Key actions we will take.:
	• Working with partners from across the system, we will support the flow of patients through UEC, by:
	  ○ Expanding and maintaining the use of Same Day Emergency Care (SDEC) services to avoid unnecessary hospital stays.
	  ○ Expanding virtual wards, allowing people to be safely monitored from the comfort of their own homes.
	  ○ Working with partners to speed up discharge from hospital and reduce the number of patients without criteria to reside.
	
	The aim for 2023/24
	• Year on year improvement in the percentage of patients seen within 4 hours within A&E.
	• Reduce adult general and acute bed occupancy to 92%.
	• Consistently meet the 70% 2-hour urgent community response time.

Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority Area – Quality Improvement**	**Key actions we will take:** • Produce a gap analysis on how both Trusts rank against the 4 components of a Quality Management System (QMS) i.e., quality planning, quality control, quality improvement and quality assurance, and review how we triangulate data to understand priorities. • All Divisional and Care Group/Directorate triumvirates to attend one day QSIR fundamentals (sessions are being scheduled from January 2023). • Year-on-year roll-out plan for QI huddle boards across both trusts to targeted areas e.g., low evidence of improvement work, non-clinical areas. **The aim for 2023/24** • Completed gap analysis by end of 2023/24 • Increase in the number of staff trained following triumvirate training. • Introduction of 10 QI huddle boards per site/annum
Clinical Effectiveness	
The right workforce with the right skills in the right place at the right time **Priority Area – Our People**	**Key actions we will take:** • Recruit and Retain staff using targeted interventions for different career stages. • Improve retention using bundles of recommended high impact actions. • Develop and deliver the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models. **The aim for 2023/24** • To improve staff turnover by the end of 2023/24
Prioritise the treatment of cancer patients focused on improving the outcomes of those diagnosed with the disease **Priority Area – Cancer Treatment**	**Key actions we will take:** • Maintain focus on operational performance, prioritising capacity for cancer patients to support the reduction in patients waiting over 62 days. • Increase and prioritise diagnostic and treatment capacity for suspected cancer, including prioritising new Community Diagnostic Centre capacity. • Implement priority pathway changes for lower Gastrointestinal (GI), skin, and prostate cancer. **The aim for 2023/24** • Reduction in the number of patients waiting over 62 days for treatment and meeting the cancer faster diagnosis standard by March 2024. • 75% of patients who have been urgently referred by their General Practitioner (GP) for suspected cancer are diagnosed, or have cancer ruled out, within 28 days.
Deliver the priorities of the National Elective Care Strategy **Priority Area – National Elective Care Strategy**	**Key actions we will take.** • Deliver an increase in capacity through the Community Diagnostic Centre and theatre expansion programme. • Transform the delivery of outpatient services with the aim of avoiding unnecessary travel and stress for patients. • Increase productivity using the GIRFT (Getting it Right First Time) programme and improving theatre productivity. **The aim for 2023/24** • Eliminate waits of over 65 waits by the end of 2023/24 • Meet the 85% theatre utilisation expectation.
Review of GIRFT[i] & Model health system data[ii]	**Key actions we will take.** • Review model health system and getting it right first (GIRFT) data to guide relevant aspects of activity, quality, and safety

Patient Experience	
Embed a culture of learning and continuous improvement at all levels of the organisation. **Priority Area – Patient Involvement**	**Key actions we will take**: • The key priorities are outlined within the joint Patient Experience Enabling Strategy (2022-2025) these include: **Pillar one – Involvement** We will involve patients and families in decisions about their treatment, care, and discharge plans. **Pillar two – Engagement** We will develop our Patient Partner programme using the patient voice and input this provides to inform service change and improvements across the organisation. **Pillar three – Experience** We will support our staff to develop a culture of learning to improve care and experience for every patient.

Within the Quality and Safety Enabling strategy there are several priority areas identified under the overarching theme of **Fundamentals** which are based on internal and external priorities. The Trust will also be expected to deliver on the specific objectives linked to the strategy under this section.

Fundamentals – based on internal and external priorities.

- ❖ Priority Area – Prevention and management of patient deterioration
- ❖ Priority Area – Timely sepsis recognition and treatment
- ❖ Priority Area – Medicines management
- ❖ Priority Area – Adult and Children safeguarding
- ❖ Priority Area – Infection Prevention and Control
- ❖ Priority Area – Eat, Drink, Dress, Move to Improve
- ❖ Priority Area – Patient Discharge
- ❖ Priority Area – Maternity and Neonates
- ❖ Priority Area – Mental Health
- ❖ Priority Area – Digitalisation

The Quality and Safety Enabling Strategy also includes the following priority area, which is part of the Care strategic aim of the Trust Strategy:
Deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations.

- ❖ Priority Area – Financial sustainability and this is focusing on ensuring that we best utilise the finite resources available, including but not limited to people, physical capacity and finances and maximise opportunities offered through collaborative working between RWT and WHT.

Statements of Assurance from the Board

Mandatory Quality Statements

During the period April 2022 to March 2023, 60 national clinical audits and seven national confidential enquiries covered relevant health services that The Royal Wolverhampton NHS Trust provides.

During that period The Royal Wolverhampton NHS Trust participated in 93% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Royal Wolverhampton NHS Trust was eligible to participate in during April 2022 to March 2023 are as follows: See Tables 1 and 2

The national clinical audits and national confidential enquiries that The Royal Wolverhampton NHS Trust participated in, and for which data collection was completed during April 2022 to March 2023, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. See Tables 1 and 2

The reports of 22 national clinical audits were reviewed by the provider in April 2022 to March 2023 and The Royal Wolverhampton NHS Trust intends to take the following actions to improve the quality of healthcare provided: See Table 3

The reports of 117 local clinical audits were reviewed by The Royal Wolverhampton NHS Trust during April 2022 to March 2023. Of these, 76 demonstrated areas where actions could be taken to improve the quality of healthcare. Details are at Appendix 1.

National programme name	Work stream / Topic name	Participated 22/23	Data collection completed during period	% submission rate / comments
Breast and Cosmetic Implant Registry	–	Yes	Yes	100%
Case Mix Programme (CMP)	–	Yes	Yes	–
Elective Surgery (National PROMs Programme)	–	Yes	Yes	–
Emergency Medicine QIPs	Care of Older People (COP)	Yes	Yes	100%
Emergency Medicine QIPs	Mental Health self harm	No	–	–
Emergency Medicine QIPs	Pain in Children	Yes	Yes	100%
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	Yes	Yes	–
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	Yes	–
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Yes	Yes	100%
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes	–	No minimum dataset
Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	–	No minimum dataset
Inflammatory Bowel Disease Audit	–	Yes	Yes	100%

LeDeR - learning from lives and deaths of people with a learning disability and autistic people	–	Yes	–	–
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	Yes	–
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	Yes	Yes	–
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal mortality surveillance	Yes	Yes	–
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	Yes	Yes	–
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	Data collection still in progress	–
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Yes	–	–
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	Yes	Data collection still in progress	TBC
National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	Yes	–
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes	Data collection still in progress	–
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Data collection still in progress	–
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Yes	Yes	–
National Asthma and COPD Audit Programme (NACAP)	Pulmonary Rehabilitation Organisational and Clinical Audit	Yes	Yes	–
National Audit of Breast Cancer in Older Patients	–	Yes	–	–

National Audit of Cardiac Rehabilitation	–	Yes	Data collection still in progress	–
National Audit of Cardiovascular Disease Prevention Primary care	–	Yes	–	Data automatically extracted from GP records
National Audit of Care at the End of Life (NACEL)	–	Yes	Yes	–
National Audit of Dementia	Care in general hospitals	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	–	Yes	Yes	–
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Congenital Heart Disease Audit (NCHDA)	Yes	Data collection still in progress	–
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	Data collection still in progress	–
National Child Mortality Database (NCMD)	–	Yes	Yes	–
National Early Inflammatory Arthritis Audit	–	Yes	Yes	100%
National Emergency Laparotomy Audit (NELA)	–	Yes	Yes	100%
National Joint Registry	–	Yes	Yes	100%
National Lung Cancer Audit	–	Yes	Data collection still in progress	–

National Maternity and Perinatal Audit (NMPA)	–	Yes	Yes	–
National Neonatal Audit Programme (NNAP)	–	Yes	Yes	–
National Ophthalmology Database Audit (NOD)	Adult Cataract Surgery Audit	No	–	–
National Paediatric Diabetes Audit	–	Yes	Yes	100%
National Perinatal Mortality Review Tool	–	Yes	Yes	–
National Prostate Cancer Audit (NPCA)	–	Yes	Yes	–
Perioperative Quality Improvement Programme (PQIP)	–	Yes	–	–
Renal Audits	National Acute Kidney Injury Audit	Yes	Yes	100%
Renal Audits	UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	100%
Respiratory Audits	Adult Respiratory Support Audit	No	–	–
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	No	–	–
Sentinel Stroke National Audit Programme (SSNAP)	–	Yes	Data collection still in progress	–
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	–	Yes	Yes	–
Society for Acute Medicine Benchmarking Audit (SAMBA)	–	Yes	Yes	100%
Trauma Audit & Research Network (TARN)	–	Yes	Yes	100%
UK Cystic Fibrosis Registry	–	Yes	Yes	100%

UK Parkinson's Audit	–	Yes	Yes	–

National programme name	Work stream / Topic name	Participated 22/23	Data collection completed during period	% submission rate / comments
Child Health Clinical Outcome Review Programme	Testicular torsion	Yes	Data collection still in progress	–
	Transition from child to adult health services	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Yes	Yes	100%
	Crohn's disease	Yes	Yes	100%
	End of Life Care	Yes	Data collection still in progress	–
	Endometriosis	Yes	Data collection still in progress	–
	Epilepsy Study	Yes	–	–

Based on information available at time of publication.

National Audit Title	Actions to be taken by RWT

National Cardiac Rehabilitation Audit 2021/22 (2022/23)	Fully Compliant - no local actions.
Audit on Device Complications 2022/2023	No local actions - consistent growth of device implantations (except during the COVID period in line with national and international trends). RWT complications rates are lower compared to other centres in Europe There was no significant perforation or pericardial effusion or Tamponade. There was no fatality related to the procedure
National Cardiac Audit Programme (NCAP) 2021/22 data (2021/22)	Cardiac surgical mortality data is fully compliant with national standards with no identified local actions.
National Thoracic Surgery Audit (2021/22 DATA) 2021/22	No local actions - statistics for RWT continue to identify us as one of the top cardiac surgical centres for thoracic surgery in terms of measured outcomes.
National Emergency Laparotomy Audit (relates to 2020/21 submission of data). 2022/23	Consider direct admission to critical care for high-risk patients and promote multidisciplinary decision making.
National audit - Use of Negative pressure dressing in breast surgery (17/18)	This was a national study rather than a clinical audit and therefore no audit standards. There was no non-compliance to address. The study has highlighted that prophylactic use of negative pressure dressing in high-risk patients undergoing breast oncoplastic and reconstructive surgery is being used in routine practice at the Trust.
REspiratory COmplications after abdominal Surgery (RECON) (18/19)	This was a study to determine the impact of pulmonary complications on death after surgery both before and during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic. This study has helped understand the detriment of surgery taking place over COVID period and that we must do our utmost to protect surgical patient from contracting COVID-19
IbRAnet localisation study : SAVI SCOUT	This was a project to assess the use of the novel technology to see if this improves localisation of non-palpable lesions and improve the excision rate of these lesions. The study concludes that it is a safe and acceptable technique, provides flexibility in preoperative planning but introduces a significant cost.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) (2021/2022) 2022/2023	Overall 97.8% compliant with standard, however some improvement actions have been taken in certain areas. This includes differed cord clamping, temperature management and monitoring of newborn babies <32 weeks, parental consultation, additional funding for neonatal staffing, support and training around breastfeeding.
National Audit: National Maternity and Perinatal Audit (NMPA) (2018/2019) 2022/2023	Maternity & Neonatal services at RWT are developing an overarching action and improvement plan incorporating recommendations from several national requirements including 'Single Delivery Plan', Ockenden Immediate essential actions, CNST maternity incentive scheme, ICB / LMNS workstreams, Saving Babies Lives Care Bundle V3, MBRRACE, The East Kent Report, CQC, Baby Friendly Initiative standards amongst others. Local improvement actions have been split into key objectives
MBRRACE (Maternal, Newborn and Infant Clinical Outcome Review) Audit- Perinatal Mortality Surveillance Report-UK Perinatal Deaths for Births (2020/2021) 2022/2023	

National Audit - Perinatal Mortality Review Tool (PMRT) (2021/2022) 2022/2023	around personalised care, equity, working with services users to improve care, growing and retaining workforce, investment in skills, patient safety culture, learning, support and oversight, standards to support best practice, data and use of digital technology.
MBBRACE-UK (Maternal, Newborn and Infant Clinical Outcome Review Programme)- Perinatal Confidential Enquiry- Stillbirths and neonatal deaths in twin pregnancies (2018/2019) 2022/2023	
MBBRACE (Maternal, Newborn and Infant Clinical Outcome Review) Saving Lives Improving Mothers Care- Maternal mortality surveillance and confidential enquiry (2018-2020) 2022/2023	
National Joint Registry (NJR) Annual Report (2020/2021) 2022/2023	The service is meeting or exceeding the national average in all areas. However some improvements have been applied locally including compliance with consent and linkability for Neck of Femur THA patients. This has been added into the patient information booklet.
Corona Virus in Hip Fracture - CHIP2 National Study: Is vitamin D associated with increased mortality from COVID-19 infection in a hip fracture population- National Observational Study 2020 data (2022/2023)	National data only - none of the recommendations were applicable to RWT.
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Hip Fracture Database (2021) 2022/2023	Service is meeting or exceeding the national average in all areas including all the requirements of Best Practice Tariff. No local actions.
National Joint Registry (NJR) Annual Report (2021)) 2022/2023	RWT performed well above national average - no local actions.
National Audit British Spine Registry (2021) 2022/2023	National data only - none of the recommendations were applicable to RWT.
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Inpatient Falls (2021/2022) 2022/2023	There has been increased education and teaching regarding tagging to help prevent falls. Embedded to all staff including therapy teams, junior doctors, flow co-ordinators and pharmacy staff. Practice Education Facilitator providing training and support.
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder (MITRE) Audit (2022/2023)	RWT performed well above national average - no local actions.
National Prostate Cancer Audit (2020/2021) 2022/2023	National data only - none of the recommendations were applicable to RWT.

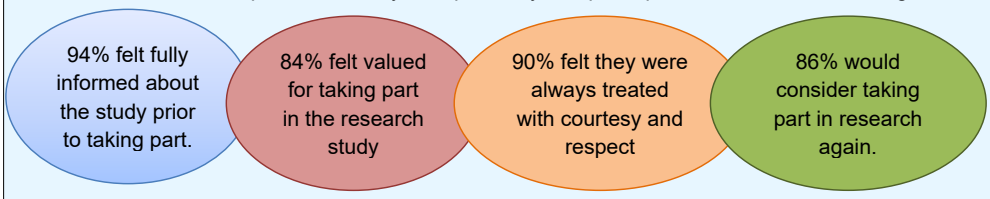
Participation in Clinical Research

Please add any further information below and/or graphs/tables etc.

National studies have shown that patients cared for in research active NHS Trusts have better clinical outcomes. Ensuring patients are given an option to participate in clinically appropriate research trials is a national and local target and identified by patients as an important clinical choice.
The Royal Wolverhampton NHS Trust's performance in research continues to be on a par with the large acute Trusts within the West Midlands region.

The R&D Directorate team have focused on delivery the recovery, resilience and growth programme for research following the disruption caused by the pandemic. 42 new studies were opened during 2022/23. Participants have taken part in research projects across a wide breath of services provided by the Trust including Oncology, Haematology, Rheumatology, Cardiology/Cardiothoracic, Obstetrics, Surgery, Paediatrics, Gastroenterology, Respiratory, Diabetes, Ophthalmology, Renal, Stroke/Neurology and Primary Care.

Our 2022/23 research experience survey, completed by 133 participants, showed the following:



For your consideration:
Providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven-day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement. Further information can be found at https://improvement.nhs.uk/resources/seven-day-services/.

Use of the CQUIN payment framework

A proportion of Royal Wolverhampton NHS Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between The Royal Wolverhampton NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for April 2022 – March 2023 and for the following 12-month period are available electronically at NHS England » 2022/23 CQUIN.

Statements from the Care Quality Commission

The Royal Wolverhampton NHS Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions or restrictions'.

The Care Quality Commission has not taken enforcement action against The Royal Wolverhampton NHS Trust during 2022/23.

The Royal Wolverhampton NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Statement on relevance of Data Quality and your actions to improve your Data Quality

The Royal Wolverhampton NHS Trust submitted records during 2022-23, (current data available up to Month 11 April 2022 – February 2023) to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 99.9% for outpatient care and
- 99.2% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

The Trust continually monitors data quality by external and internal Data Quality Dashboards and reporting suites. Identifying any areas that may require further focus.
External reports are used to monitor Data Quality within the organisation via Secondary Uses Service (SUS) Data Quality Dashboards, Data Quality Maturity Index (DQMI) and University Hospitals Birmingham Hospital Evaluation Data tool (HED)

The corporate Data Quality team continue to provide assurance to support the improvement of Data Quality within The Royal Wolverhampton NHS Trust which helps to underpin the provision of excellent services to patients and other customers.

- First point of call, answering and resolving thousands of queries and helping to support teams in ensuring all data is recorded accurately, timely, Completely, meeting all standards.
- Support for IT projects continued with testing, validation and systems expertise provided by the team.
- Promote compliance to Data Quality within the Trust and getting the data right at point of entry.
- Creation new Data Quality dashboards to show both good compliance and areas of improvement.
- Encourage good Data Quality beyond our usual KPIs, this includes audits into additional information such as Ethnicity.
- A Data Quality Forum was established in 2017. There are TOR for this group and the chair is the Head of Clinical Coding & Data Quality.
- The Data Quality department are responsible for monitoring and recording data quality issues identified in the Organisation and for ensuring action plans are in place to address issues identified. The Dept review the issues and prioritise them on the DQ issues log, hold action plans for DQ issues and manage progress against these action plans.
- Compliance is checked against indicators to assess the quality of the information on our PAS systems in relation to patients.
- The Trusts Data Quality policy is in place and was reviewed in October 2022

NHS Number and General Medical Practice Code Validity

Clinical Coding Error Rate

The Royal Wolverhampton NHS Trust was not subject to the Payment by Results clinical coding audit during 2022-23 by the Audit Commission.

The Royal Wolverhampton NHS Trust has taken the following actions to improve data quality:

The annual external Data Security & Protection Toolkit (DSPT) clinical coding audit took place during 2022/23, achieving an overall 'Standards Exceeded' rating in all areas of the audit.

A programme of continuous improvement audits on Clinical Coding is in place and monthly audits take place The Trust has a robust 2 year training programme for trainee coders and existing staff undertake coding training workshops yearly. In addition, all mandatory national training is completed yearly, ensuring all coders are compliant with training requirements.

Key Achievements in 2022/23:

- Achievement of 'Standards Exceeding' for DSPT
- In depth speciality and clinical coder based audits improving quality from the previous year,
- Continued engagement with Consultants and clinical teams
- Improved depth of coding

Clinical Coding/Data Quality reports are in place to ensure quality of coding is maintained and continually improved - examples include HED Report, SHMI and DQMI.

Data security and protection toolkit

SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2022-2023.

The table below details the incidents reported on the NHS Digital incident reporting tool and to the Information Commissioners Office (ICO), within the financial year 2022-2023. Any incidents that are still being investigated for the period 2022-23 are not included. The incidents listed below are for the Royal Wolverhampton NHS Trust and GP partnerships that have joined the Trust as listed below.

Date incident occurred (Month)	Nature of incident	No. of data subjects	Description/ Nature of data involved	Further action on information risk
August 2022	Cyber incident	None affected	Ransomware attack against Advanced Health and Care Limited (Advanced). Advanced act as a data processor for Royal Wolverhampton NHS Trust and provide services the Trust which were impacted. No data is known to be compromised but the systems were unavailable for a period of time whilst the supplier was investigating.	Technical remediation were put in place before system was made available again. During this time business continuity plans were enacted to maintain service provision.

Incidents classified at lower severity level - Incidents classified at severity level 1 are aggregated and provided in table below. Please note this is not all incidents, just level ones against the below listed categories:

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2022-23		
Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	5
B	Disclosed in Error	107
C	Lost in Transit	3
D	Lost or stolen hardware	1
E	Lost or stolen paperwork	16
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	5
H	Uploaded to website in error	1
I	Technical security failing (including hacking)	2
J	Unauthorised access/disclosure	12
		152

Data Protection and Security Toolkit Return 2022 - 2023 – final submission.

The Royal Wolverhampton NHS Trust RL4 Standards Met

Alfred Squire M92002 – Standards Met
West Park Surgery M92042 – Standards Met
Thornley Street M92028 - Standards Met
Lea Road M92007 - Standards Met
Penn Manor M92011- Standards Met
Coalway Road M92006 - Standards Met
Warstones M92044 - Standards Met
Oxley Surgery M92014 - Standards Met
Tettenhall Road Medical Practice M92640- Standards Met

An internal audit of the DSP toolkit in March 2023 had provided adequate assurance of the processes and evidence that is in place to support the DSP toolkit submission.

Looking forward to 2023/24 Data security and Protection

The Trust continues to monitor patterns and trends of data security incidents and implementing measures to reduce these to the lowest level practicable. Current risks include continued and increasing risk of external threats in relation to Cyber security, particularly via email phishing. Other risks to data security include disclosure in error via various means, and this is attributed to the ways of working in health, with increased remote working.

The Trust remains focused on embedding principles of privacy by design into Trust processes, from procurement to digital innovation and service redesign. This program of work will be monitored though the committees below.

- The Trust has several committees dedicated to reviewing assurance in relation to DSPT and GDPR, chaired by senior board members.
- The Chief Medical Officer is the Trust's trained Caldicott guardian, and is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that Trust satisfies the highest practical standards for handling patient identifiable information, and Chairs the IG Steering group.
- The Chief Financial Officer is the Trust's Senior Information Risk Officer (SIRO) and is responsible for monitoring the Trust's overall information risk, ensuring we have a robust incident reporting

process for information risks. The SIRO reports to the Trust Board and provides advice on the matter of information risk. The SIRO is also a member of the IG steering Group and co-chair of the GDPR implementation group.

- The Trust has an assigned Data Protection Officer who acts independently to ensure compliance with the GDPR as well as monitoring its application across the Trust. The DPO has a reporting line into the Caldicott Guardian through to the Trust board.
- The Trust is in the process of implementation a robust asset management system and defining establishing clear responsibilities for Information Asset Owners across the Trust to facilitate robust and timely escalation of information risk escalation to the SIRO.
- All trust staff receive appropriate annual training to ensure data security and protection principles are embedded within their understanding.

Seven Day Services

The Clinical Audit Team are now picking up the 7 Day Service audit as part of the Clinical Audit Programme at the Royal Wolverhampton NHS Trust. The 7 Day Service Audit is currently ongoing

Core Quality Indicators - Summary Hospital Level Mortality Indicator (SHMI)

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

The Summary Hospital-Level Mortality Indicator (SHMI) is the most commonly used indicator to compare the number of deaths in the Trust with the number expected on the basis of average England figures, taking particular characteristics e.g. age, co-morbidities and diagnosis profile into account. The score includes the deaths in hospital as well as those that occur within 30 days of discharge over a rolling year.

Where it is suspected that a death could have been prevented, an investigation is conducted via root cause analysis to understand the reasons and draw up robust action plans.

Indicator	September 2021 to August 2022	October 2021 to September 2022	November 2021-October 2022
SHMI RWT	0.938	0.935	0.928
SHMI England	1	1	1

The SHMI is lower compared to 2021/22. The Trust has been categorised as being “within the expected” range for the past year. The improvement in SHMI is as a result of both an increase in expected deaths and a decrease in the observed deaths.

The Royal Wolverhampton Trust has a robust mortality governance process underpinned by Learning from Deaths programme.

- The Trust continues to have reporting and investigation mechanisms for the SHMI, overseen by the Mortality Review Group (MRG). Diagnosis groups with a higher-than-expected SHMI are investigated by a data quality review followed by a case note review where indicated with results reported at the MRG and action plans developed.
- SHMI on its own is not a quality metric. the Trust continues with a key programme of work designed to scrutinise clinical care, provide assurance that gaps in care are identified and acted upon, gaps in quality of documentation are identified and corrected and systems of care provision are developed to the benefit of individual patients and the wider population.

This programme of work has developed over the last 12 months and included, the following:

- Further strengthening the process of scrutiny and review of deaths in hospital via the Medical Examiner and Mortality Reviewer processes.
- Successful expansion of the Medical Examiner Service to undertake reviews of deaths in the non-acute (community0 setting.
- Expansion of the Mortality Reviewer process to the vertically integrated primary care network (PCN) – RWT PCN to capture learning across the entire patient pathway
- Focus on specific diagnostic groups including assurance of clinical pathways and developments of resultant action plans
- Improving the quality of coding and documentation
- Learning from deaths, including listening to the bereaved families and carers and involving them in key processes
- Provision of end-of-life care in patients’ homes and care homes with an emphasis on admission avoidance where appropriate
- A programme of continuous quality improvement.

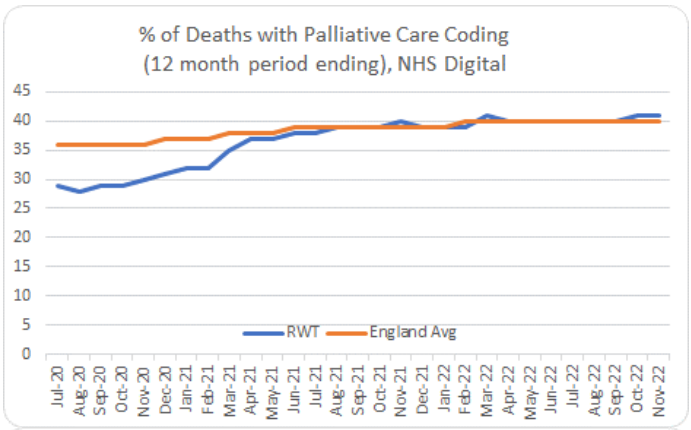
Progress against the agreed actions and the mortality improvement plan is monitored by the relevant quality boards. In addition, mortality associated reports are regularly presented to the Trust Board.

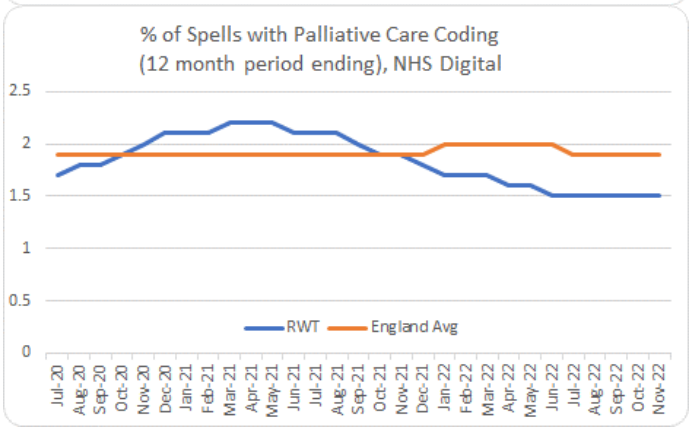
Core Quality Indicators – Summary of Patient Death with Palliative Care

Table: Percentage of deaths with palliative care coding are either diagnosis of specialty level for the Trust for

the reporting period:

	RWT	England Avg
% of Spells with Palliative Care Coding	1.5	1.9
% of Deaths with Palliative Care Coding	41	40
% of Spells with Covid-19 Coding	3.8	4.8





The Royal Wolverhampton Trust intends to take/have taken the following actions to improve this, and so the quality of its services in 2023/24 by:

- Business case submission for expansion of the Specialist Palliative Care Team in view of increased referrals.
- Ongoing development and expansion of Supportive Care Virtual ward, to include Amber and Red patients in partnership with Community Services and Compton Care.
- PRADA – Proactive risk-based assessment tool to identify patients in last year of life facilitating earlier intervention and advance care planning.
- Collaboration with RWT community and Compton Care

Core Quality Indicators – Learning from Deaths

	Prescribed information	Form of statement
A	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During April 2022 and March 2023, 2157 adult patient hospital deaths were recorded at the Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period: - 520 in the first quarter - 489 in the second quarter - 579 in the third quarter - 569 in the fourth quarter
B	The number of deaths included in item A which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By the 31st March 2023, **2074** case record reviews (ME Assessments followed by SJRs in selected cases based on the criteria) and 14 investigations (RCA) have been conducted in relation to 2157 of the deaths included in item A In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was conducted was: - [500 ME assessments/SJRs + 1 RCAs] in the first quarter - [458 ME assessments/SJRs + 5 RCAs] in the second quarter - [553 ME assessments/SJRs + 3 RCAs] in the third quarter - [563 ME assessments/SJRs + 5 RCAs] in the fourth quarter Please note: 19 Structured Judgement Reviews stage 1 (SJR1) remain outstanding across 2022/23 which are actively being progressed. It is also important to note that cases that have been through Medical Examiner (ME) process are included in the above figures.
C	An estimate of the number of deaths during the reporting period included in item B for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	A total of 4 cases [representing 0.14% of the adult patient deaths] during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: - [0%] 0 cases for the first quarter - [0.61%] 3 cases for the second quarter - [0%] 0 cases for the third quarter - [0%] 0 cases for the fourth quarter These numbers have been determined using evidence from the Root Cause Analysis (RCA) investigations involving deaths that were subject to review under the serious incident framework. (The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated).
D	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C.	Learning from the reviews/investigations of those adult patient identified in item C are as follows: Themes that have emerged from reviews of deaths at the Trust include. - Delay in treatment. - Communication.
E	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item D).	Actions to address the above thematic issues are as follows: **Delay in treatment** Action completed: - To make the process of acting on abnormal results telephoned from Clinical Chemistry more robust and Auditable. - The need for clinicians to be systematic in all aspects of their review of patients.

		- Dropping hemoglobin levels should prompt investigation and management for GI hemorrhage including PPI prescription. - In-reach Gastro team attend to assess patients' needs before bringing them up to the ward. **Communication** Action completed: - RCA should be discussed at Governance meetings for Acute Medicine and Cardiology. Wider dissemination to all medical Governance meetings. - Escalation of treatment should be based on clinical findings and the management plan needs to be clearly communicated to nursing staff on the ward with information regarding the timings and expectations for review of the patient. - To continue with the implementation of the 'PUSH' model to ensure that patients from ED and AMU are transferred at set times in the day (10:00 and 12:00). Staff on receiving ward to review risk assessments to ensure that patients' safety needs are being met.
F	An assessment of the impact of the actions described in item E which were taken by the provider during the reporting period.	A key impact of the actions has been to continue full implementation of the mortality improvement programme and the associated plan which is underpinned by the Mortality Strategy. In addition, the focus will remain on ensuring that the learning identified though the Trust's mortality review process is systematically implemented.
G	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item B in the relevant document for that previous reporting period.	24 case record reviews and 10 investigations completed after 1st April 2022 which related to deaths which took place before the start of the reporting period.
H	An estimate of the number of deaths included in item G which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0.18% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
I	A revised estimate of the number of deaths during the previous reporting period stated in item C of the relevant document for that previous reporting period, taking account of the deaths referred to in item H.	0.18% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Core Quality Indicators – Summary of Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMS) assess the quality of care delivered to NHS patients from their perspective, regarding the health gains for the following two surgical interventions using pre- and post-operative survey questionnaires:

• Hip replacement surgery
• Knee replacement surgery

The questionnaire does not differentiate between first time intervention or repeat surgery for the same procedure.
The table outlines the post-op score by procedure based on the EQ-5D Index.

	April 2019 - March 2020	April 2020 - March 2021	April 2021-March 2022
Hip Replacement Surgery	0.79	0.84	
Knee Replacement Surgery	0.75	0.73	

Commented [KM(RWNT1]: No data available, please see statement below from NHS digital……

"In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known."

Core Quality Indicators – Re-admission Rates

Adult readmission rates remain largely unchanged from previous years.

Work within the Trust to deliver the right care at the right time and the right location continues to be a focus. For a number of patients this means safely avoiding a patient's admission or facilitating an earlier discharge with ongoing support and monitoring at home. Key areas of work include:

- Work to deliver Same Day Emergency Care within Medicine, Frailty, Gynecology, Head and Neck and Surgery
- Further development and use of Virtual Wards
- Ongoing expansion of the huddle tool to support timely discharge
- Flow initiatives including Criteria Led Handover and Criteria Led Discharge

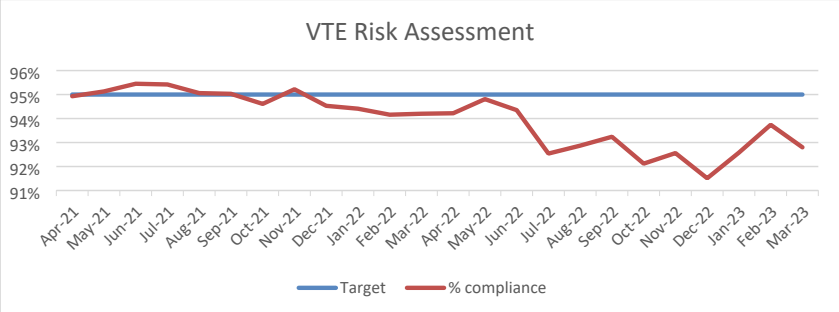
Readmissions in RWT
All data from PAS, using the national definition of a readmission 2015/16 – 2022/23

Readmissions									**Grand Total**
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	
Aged 4-15	440	505	423	359	428	269	348	443	3,215
16yrs and over	5,966	5,443	5,165	5,677	6,018	4,051	7,967	8,659	48,946
Grand Total	6,406	5,948	5,588	6,036	6,446	4,320	8,315	9,102	52,161
Total Admissions									**Grand Total**
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	
Aged 4-15	5288	5429	5117	4,668	4,813	2,899	4,078	4,592	36884
16yrs and over	115288	118585	117355	117,669	120,049	90,876	136,824	147,554	964200
Grand Total	120576	124014	122472	122,337	124,862	93,775	140,902	152,146	1001084
Percentage Readmissions									**Grand Total**
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	
Aged 4-15	8%	9%	8%	8%	9%	9%	9%	10%	9%
16yrs and over	5%	5%	4%	5%	5%	4%	6%	6%	5%
Grand Total	5%	5%	5%	5%	5%	5%	6%	6%	5%

Core Quality Indicators – Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) or blood clots, are a major cause of death in the UK. Hospitalisation on its own is a significant risk factor. The risk of hospital associated blood clots can be reduced by assessing an individual's pre disposing risk factors for blood clots, reason for admission and then administering preventative measures. The national target is that 95% of all patients over the age of 16 have a VTE risk assessment completed on admission. Our data reports all patients who recieved an individual VTE risk assessment within 24 hours of admission or met the criteria for a low risk COHORT group.

The graph below illustrates the Trust's compliance over time.



National data submissions to NHS digital have remained suspended since March 2020 due to the COVID-19 pandemic therefore there is no national data currently available for benchmarking purposes.

We believe our performance:-

- Demonstrates that the Trust has a robust process in place for collating data on venous thromboembolism risk assessments completed within 24 hours of admission.
- Refects the challenges of increased activity and impact on our compliance as a result of the VID-19 pandemic and associated recovery plans.

Despite the challenges of the last 2 years and the pasue in national data submission, we have continued to internally monitor our VTE risk assessment compliance.The timeliness of VTE risk assessment has been below our expected criteria and we continue to work with clinical areas to identify service improvement opportunities. Patient safety and effective care remain our priority and improving VTE risk assessment completions within 24 hours is our key target for the coming year, as is ensuring that patients receive care ein line their VTE risk assessment and individual needs. We continue to explore ways to improve compliance, including digital solutions and are currently preparing an applciation to apply for a VTE Exemplar Buddy which will allow us to work with an organistaion with Exemplar status in order to learn and share best practice.

Core Quality Indicators – Clostridium difficile

	2018-19	2019-20	2020-21	2021-22	2022-23
Trust apportioned cases (hospital and community onset cases)	45	43	46	57	72
Trust apportioned cases hospital onset only (excludes community onset cases)	37	33	35	44	58
Trust bed days (calculated using hospital onset cases and rate)	289063	289728	289017	289093	269777
Rate per 100,000 bed days (hospital onset cases only)	12.80	11.39	12.11	15.22	21.5
National average (hospital onset cases only)	14.00	15.38	14.09	17.30	22.21
Best performing Trust (hospital onset cases only)	0	0	0	0	0
Worst performing Trust (hospital onset cases only)	90.04	66.47	69.27	79.43	81.3

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons: The Trust collates numbers monthly and submits to UKHSA. Figures for apportioned cases, apportioned cases (hopsital onset only), rate per 100,00 bed days and national figures have all been taken from the UKHSA Healthcare Associated Infection Mandatory Surveillance Data Capture System. Bed days have been calculated using the apportioned cases (hospital onset only) and the rate per 100,00 bed days.

The Royal Wolverhampton NHS Trust has implemented a *C. difficile* action plan, to include ongoing weekly *C difficile* and antimicrobial stewardship ward rounds, education of ward staff, *C. difficile* toolkits monthly to assess cases, thematic review of cases and the annual deep clean programme.

Core Quality Indicators – Incident Reporting

2021/22 (Full Year Data)			2022/23 (Full Year Data)		
Incidents	% Resulting in Death	% Resulting in Severe harm	Incidents	% Resulting in Death	% Resulting in Severe harm
12538	0.4% (45)	0.3%(35)	16356	0.2% (29)	0.2% (36)

The Trust defines severe or permanent harm as detailed below:

Severe harm: a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

Permanent harm: permanent lessening of bodily functions; including sensory, motor, physiological or intellectual. It is harm directly related to the incident and not related to the natural course of a patient's illness or underlying condition.

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

- The Trust has a well embedded reporting culture as evidenced by benchmark comparisons within the National Learning and Reporting System (NRLS).
- It promotes the reporting of near miss incidents to enable learning and improvement and undertakes data quality checks to ensure that all patient safety incidents are captured and appropriately categorised to submit a complete data set and to enable wider learning from adverse events.

Core Quality Indicators – National Inpatient Survey

CQC National Adult Inpatient Survey 2021 published results from CQC September 2022

The 2021 Inpatient Survey was part of a National Survey Programme run by Care Quality Commission (CQC) to collect feedback on the experiences of inpatients using the NHS services across the country. The results contribute to the CQC's assessment of NHS performance as well as ongoing monitoring and inspections. The programme also provides valuable feedback for NHS trusts, which they can then use to improve patient experience.

Patients were eligible to take the survey if they were 16 years or older, had spent one night in hospital during November 2021 and were not admitted to maternity or psychiatric services. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January and May 2022.

The survey is spilt into 8 categories- ED, Waiting list and planned admissions, the Hospital and ward, Doctors, Nurses, Care and treatment, Operations and procedures, Leaving hospital.

There are 5 questions highlighted as 'CQC questions'- areas of focus that the CQC were particularly interested in. The results of these questions and comparable results between 2020 and 2021 are shown in the table below.

Category	Question	2020	2021	% increase/ decrease from 2020
The hospital and ward	Did the hospital staff explain the reasons for being moved in a way you could understand?	59.0%	62.0%	+3%
The hospital and ward	If you brought your own medication with you to hospital, were you able to take it when you needed to?	79.0%	76.0%	-3%
The hospital and ward	Were you offered food that met any dietary needs or requirements you had? This could include religious, medical or allergy requirements, vegetarian/vegan options, or different food formats such as liquified or pureed food.	80.0%	79.0%	-1%
Leaving hospital	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	60.0%	63.0%	+3%
Overall views of care and services	During your hospital stay, were you ever asked to give your views on the quality of your care?	9.0%	7.0%	-2%

Nationally, gaining views on quality of care is always a low scoring question. The Trust have revisited it's various posters for patient feedback for updating and distribution. Placemats have been amended to seek views.

Most improved Scores

Improvements picked up over 5 % increase. Both questions relate to leaving hospital.

Category	Question	2020	2021	% score increase from 2020
Leaving Hospital	Did a member of staff explain the purpose of the medicines you were to take home in a way you could understand?	48%	54%	+6%
Leaving Hospital	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	74%	81%	+7%

Medication features in a couple of questions although there was a reduction in score which was worse than what was expected from 79% to 74% for the following:

'If you brought medication with you into hospital, were you able to take it when you needed to?'

Results – Deteriorating Scores

The table below details those questions where there was a statistically significant change in score. Communication, as always, features quite highly as a common theme and for this survey, specifically about the patient not being able to understand. This applied to communication by both doctors and nurses.

The Trust can see that the other two questions specifically relate to capacity issues. In particular, waiting to get a bed on a ward and also notice when being discharged.

Category	Question	2020	2021	% Score decrease from 2020
Waiting to get a bed on a ward	From the time you arrived at the hospital, did you feel that you had to wait a long time to get a bed on a ward?	74%	67%	-7%
Doctors	When you asked doctors questions, did you get answers you could understand?	89%	84%	-5%
Nurses	When you asked nurses questions, did you get answers you could understand?	88%	84%	-4%
Leaving Hospital	Were you given enough notice about when you were going to leave hospital?	72%	66%	-7%

Obtaining feedback from patients is vital for bringing about improvements in the quality of care and this is an excellent way for inpatients to directly influence services locally. Heads of nursing have been compiling an action plan to address areas where improvements can be made.

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care is 73.5%[2] against a national score average of 74.5%. This is an improvement of 6% when compared to 2019-20.

The Adult Inpatient Survey 2022 provisional results are due to be received by the Trust in June 2023. However, the official CQC results will not be released until September 2023 (date to be confirmed) and will

feature in next year's Quality Account.

Core Quality Indicators – Patient Friends and Family Test (FFT)

Patient recommendation to friends and family

The Friends and Family Test (FFT) is a nationwide initiative which is a simple, single question survey which asks patients to what extent they would recommend the service they have received at a hospital department to family or friends who need similar treatment. The tool is used for providing a simple, headline metric, which when combined with a follow up question and triangulated with other forms of feedback, is used across services to drive a culture of change and of recognising and sharing good practice.

Results of these surveys are received monthly and shared at Directorate, Divisional and Trust Board level in the form of divisional dashboards.

We believe that patient recommendation to their friends and family is a key indicator of the quality of care we provide. We believe our performance reflects that:

- the Trust has a process in place for collating data on the Friends and Family Test
- data is collated internally and then submitted on a monthly basis to the Department of Health and Social Care
- data is compared to our own previous performance, as set out in the table below

The friends and family test recommendation scores are illustrated in the tables below. These include percentage changes on 2021/22 and the 2022/23 response rates. The Trusts overall average recommendation score for 2022/23 was 83%. When looking at the different touchpoints, there is a fluctuation of 8% with scores ranging between 77% and 85%. The Trust's overall response rate has varied between 15% and 20%.

	Apr -22	May -22	Jun-22	Jul-22	Aug -22	Sep -22	Oct-22	Nov -22	Dec -22	Jan-23	Feb -23	Mar -23
Trust Overall Score Rec Rate	83 %	84%	83 %	84 %	84 %	85 %	82 %	82 %	77 %	85 %	86 %	84%

	Apr -22	May -22	Jun-22	Jul-22	Aug -22	Sep -22	Oct-22	Nov -22	Dec -22	Jan-23	Feb -23	Mar -23
Trust Overall Score - Resp Rate	18 %	18%	18 %	18 %	18 %	19 %	20 %	18 %	16 %	18 %	18 %	15%

In terms of the overall touchpoints for national reporting, the Trust's average quarterly reports are shown below with the comparison of the score against the 2021/22 year.

Friends and Family Test	Inpatients and Day case (consolidated)				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2022/23	92%	92%	91%	92%	93%	93%	94%	94%	71%	71%	65%	72%	90%	87%	90%	91%
2022/23 Comparison against 2021/22	-1	=	-1	+1	+12	+17	+12	+24%	-4%	+3%	-3%	=	-3%	-3%	-2%	=

Friends and Family Test	Antenatal				Birth				Postnatal Ward				Postnatal Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2022/23	77%	89%	78%	86%	91%	95%	90%	93%	80%	82%	84%	87%	86%	82%	83%	82%
2022/23 Comparison against 2021/22	-19%	+22%	-3%	+5%	-5%	+1%	-3%	=	-6%	=	-1%	+4%	+3%	-3%	-3%	-2%

* Q4 data subject to change inline with March 2023 data submissions for FFT being after reporting date.

The below table illustrates the percentage difference between the Trusts recommendation score for each

touchpoint and the local STP and National results. The Trust scores higher for all of the touchpoints for the Black Country and West Birmingham STP with the exception of Community. Comparisons with national scores indicate that Outpatients and Birth are above national scores however all of the other touchpoints are below.

	Inpatients	Outpatients	ED	Community	Antenatal	Birth	Postnatal Ward	Postnatal Community
Trust overall	94%	69%	73%	92%	88%	95%	88%	77%
Compared to STP*	+3%	+4%	+2	-2%	+1%	+6%	+4%	+5%
Compared to National*	-4%	+3%	-5	-3%	-7%	+3%	-1%	-6%

* The Black Country and West Birmingham STP and National scores as at 28 February 2022.

Core Quality Indicators – Supporting Our Staff

The Trust is one of the largest employers in its local community, employing 10,652 people. The Trust has several ways of engaging staff to improve employee engagement and to support staff to continuously strive for excellence in patient care. The efficacy of the Trust's staff engagement approach is measured principally through the annual national NHS Staff Survey and the Quarterly Pulse Survey.

National NHS Staff Survey

The Trust has again undertaken a full census of the national NHS Staff Survey, whereby all our staff have been invited to provide feedback on their workplace experience. The results have, for the second time, been measured against the seven people promise elements and 2 themes staff engagement, and morale. The specific words that make up the NHS People Promise have come from people in different healthcare roles – all making it clear what matters most to them and what would make the greatest difference in improving their experience in the workplace. The NHS People Promise elements are:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

The Trust response rate was 34% , a 5% decrease, although proportionate due to the increase in the workforce establishment. For the first time bank workers were also invited to participate in the national NHS Staff Survey, that yielded a 12% response rate out of (1195) people.

The Trust scored higher than average for acute and community trusts in four of the People Promises:

- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We work flexibly.

We also scored higher than average in themes:

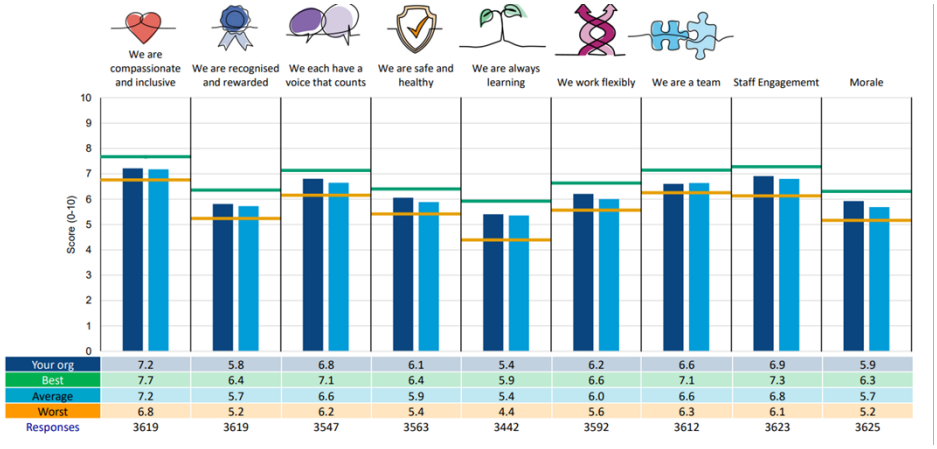
- Staff engagement
- Morale

Our scores are in line with the average for three People Promises:

- We are compassionate and inclusive
- We are always learning
- We are a team

Whilst all scores are above, or in line with the sector average, they do show a decline from our 2021 Staff Survey results, with the exception of People Promise: We work flexibly, which has remained the same. This is likely in response to the Trust continuing to support agile and flexible working.

The Table below shows the results for 2022 for each of the 7 People Promise Elements and the 2 themes and are scored on a 0-10 point scale, where 10 is the best score attainable



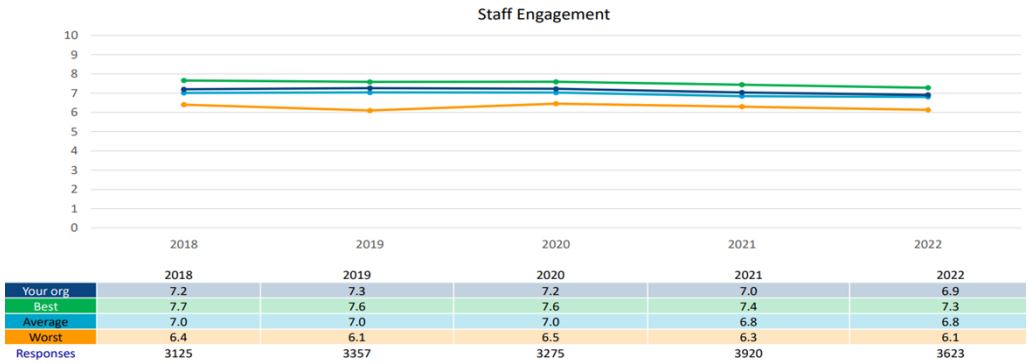
Quarterly pulse Survey response rate has shown a steady increase during 2022.

Q4 2021/22	Q1 2022/23	Q2 2022/23	Q4 2022/23
150	81	225	576

	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q4 2022/23
Engagement	7.00	7.23	6.71	6.20
Advocacy	7.3	7.49	6.99	6.33
Involvement	6.6	6.91	6.54	6.02
Motivation	7.1	7.27	6.60	6.26

Staff Engagement

The graph below provides a comparison for each year from 2017 to 2022 and staff engagement levels within RWT have remained consistent over the last five years and are above average for the comparator group.



The Royal Wolverhampton NHS Trust takes the following steps to develop and oversee continuous improvements in the staff survey:

- The results are shared across the Trust through the management structure to all local areas
- Results are discussed at monthly governance meetings.
- Themes are identified at a Trust, division and directorate level for priority action, and initial action plans developed. These action plans will be monitored through the organisational and divisional governance structures.
- Updates for assurance are provided at the Trust's People and Organisational Development Committee (PODC).

The Royal Wolverhampton Trust intends to take the following actions to improve this, and so the quality of its services in 2023/2024 by:

The key objective is to improve overall employee engagement. This will be measured by benchmarking ourselves against our peers with the aim to show continual improvements, in response to key questions related to staff engagement. Identified priorities for 2023/24 include:

- Compile local/divisional /corporate action plans- to drive further improvements in the national staff survey results.
- Divisions utilising a range of methods to communicate with and engage and involve staff local in implementing improvement actions.
- Engage with the Trust's Employee Voice Groups in sharing and gaining feedback on survey results and plans.
- Robust systems in place to evidence actions and improvements for under performing areas.

Supporting Staff through Speaking Up

The Royal Wolverhampton NHS Trust (RWT) has been committed to its Freedom to Speak Up (FTSU) journey and the Guardian role since October 2016, following on from the recommendations made by Sir

Robert Francis QC's report "The Freedom to Speak Up" (2015). The FTSU Guardian is an independent role and focuses on creating an open and honest reporting culture, enabling staff to talk about anything that could compromise good patient care. The Trust Board have shown their full commitment and support to embed FTSU within the organisation, placing emphasis on creating a culture where speaking up becomes business as usual.

Supporting Staff to Speak Up

All staff have the option of raising concerns to their line manager in the first instance or to the next level of management if they feel unable to speak with their line manager. If staff feel unable to do this, for whatever reason, they can approach HR for advice, a Trade Union Representative or they can contact the Freedom to Speak Up Guardians. Two types of referral are available:

Identified Speaking Up Contact Form

Anonymous Speaking Up Contact Form

Other enquiries are emailed to: rwh-tr.freedomtospeak@nhs.net

When staff request an appointment, they can expect to:

- Talk through their concern in a safe space
- Have their concern kept confidential (within the set limits of confidentiality)
- Discuss the options of support available
- Be signposted to support from other staff in the Trust if appropriate
- Be offered support that is impartial and objective
- Receive practical and non-judgmental advice.

Staff are routinely sent an email following their first appointment with a summary of next steps/ actions points, which includes how any issues that have been raised will be addressed. Staff are given the opportunity to feedback and have a follow-up call. Any agreed actions are monitored by the Guardian and feedback is given to the staff member as and when appropriate.

Within follow-up calls/ discussions, the Guardian will monitor the impact of raising concerns on the staff member, ensuring they do not feel at a disadvantage. If detriment is experienced, this is followed up by the Guardian to explore further, and to prevent further detriment where possible.

Review of Quality Our performance in 2021/22

OVERVIEW OF THE QUALITY OF CARE BASED ON TRUST PERFORMANCE

As part of the standard NHS contract, the Trust is required to monitor and report performance against a set of key metrics. These indicators are all reported to the Trust Board monthly.

Our performance for 2021/22 is shown below. COVID-19 pandemic clearly had a significant impact on our performance, large elements of the Trusts planned programme were suspended or curtailed to care for the surge in COVID-19 patients. Even when these suspensions were not in place, the performance measures below reflect the loss in productivity from working within a COVID-19 environment.

Commented [KM(RWNT2]: Tim Shayes happy with the narratives from last year to be used this year.

Performance against the National Operational Standards:

Indicator	Target 2022/23	Performance 2022/23	Performance 2021/22	Performance 2020/21
Cancer two week wait from referral to first seen date	93%	**80.91%**	81.87%	86.85%
Cancer two week wait for breast symptomatic patients	93%	**84.29%**	36.66%	51.42%
Cancer 31 day wait for first treatment	96%	**75.83%**	83.25%	86.03%
Cancer 31 day for second or subsequent treatment - Surgery	94%	**54.67%**	63.80%	76.02%
Cancer 31 day for second or subsequent treatment - Anti cancer drug	98%	**82.36%**	96.56%	97.92%
Cancer 31 day for second or subsequent treatment - Radiotherapy	94%	**82.32%**	84.96%	92.61%
Cancer 62 day wait for first treatment	85%	**38.22%**	47.36%	55.49%
Cancer 62 day wait for treatment from Consultant screening service	90%	**37.17%**	48.66%	58.33%
Cancer 62 day wait - Consultant upgrade (local target)	88%	**54.96%**	67.07%	68.87%
28 Day Fast Diagnosis	75%	**69.16%**	71.42%	
Emergency Department - total time in ED	95%	**76.51%**	81.55%	85.56%
Referral to treatment - incomplete pathways	92%	**59.85%**	68.42%	65.26%
Cancelled operations on the day of surgery as a % of electives	<0.8%	**0.29%**	0.43%	0.34%
Mixed sex accommodation breaches	0	**0**	0	0
Diagnostic tests longer than 6 weeks	<1%	**45.93%**	31.76%	45.27%

Performance against other national and local requirements

There are a number of other quality indicators that the Trust uses to monitor and measure performance. Some of these are based on the National Quality Requirements and others are more locally derived and are more relevant to the city of Wolverhampton and the wider population we serve.

Like the National Standards, these metrics are also reported to the Trust Board alongside a range of other organisational efficiency metrics. This gives the Board an opportunity to have a wide-ranging overview of performance covering a number of areas.

Indicator	Target 2022/23	Performance 2022/23	Performance 2021/22	Performance 2020/21
Clostridium Difficile	58	**72**	57	46
MRSA	0	**2**	1	2
Referral to treatment - no one waiting longer than 52 weeks	0	**3,653**	1,697	2,404
Trolley waits in A&E longer than 12 hours	0		523	169
ED waits >12 hours	<2%	**7.82%**		
VTE Risk Assessment	95%		94.84%	93.57%
Duty of Candour - failure to notify the relevant person of a suspected or actual harm	0	**0**	0	1
Stroke - 90% of time spent on stroke ward	80%	**88.99%**	83.30%	91.88%
Maternity - bookings by 12 weeks 6 days	>90%	**86.90%**	89.60%	92.00%
Maternity - breast feeding initiated	>64%	**77.80%**	75.90%	71.50%

ENGAGEMENT IN THE DEVELOPING OF THE QUALITY ACCOUNT

Prior to the publication of the 2022/23 Quality Account, we have shared this document with the following:

- Our Trust Board, including combination of Non-Executive and Executive Directors
- City of Wolverhampton Council Health Scrutiny Panel
- Wolverhampton Clinical Commissioning Group
- Trust staff
- Healthwatch
- Council of Members

In 2023/24 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

We would like to thank all the patients, community representatives for their feedback and members of staff who gave their time to help us select our priorities and ensure that the document is clear and accessible.

Statement from Black Country & West Birmingham Integrated Care Board

Black Country West Birmingham (BC&WB) statement on The Royal Wolverhampton NHS Trust (RWT) Quality Account 2022/23

Statement to be added once received (Head of Communication facilitating)

CITY OF WOLVERHAMPTON COUNCIL

Statement from City of Wolverhampton Council Health Scrutiny Panel

Statement to be added once received (Head of Communication facilitating)

Statement from Healthwatch

Commented [KM(RWNT3]: For Hannah Murdoch to update.

healthwatch Wolverhampton

Statement to be added once received (Head of Communication facilitating)

Statement of Director Responsibilities in respect of the Quality Account 2022/23

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the annual reporting manual and supporting guidance Detailed requirements for quality reports.
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2022 to March 2023
  - papers relating to quality reported to the board over the period April 2022 to March 2023
  - feedback from commissioners dated XXXXXX
  - feedback from local Healthwatch organisations dated XXXXXX
  - feedback from overview and scrutiny committee dated XX/XX/20XX
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/06/2022
  - the 2021 national staff survey
- the quality report presents a balanced picture of the trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

.....Date.....Chairman

.....Date.....Chief Executive

Statement of Limited Assurance from the Independent Auditors

NHS England/Improvement have confirmed in the Quality Accounts requirements for 2022/23 that there is no national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account.

Appendix 1 – Local clinical audits reviewed by the Trust in 2022/23 with actions intended to improve the quality of healthcare

Local Audit Title	Actions to be taken by RWT
Audit of Calibration Compliance at West Park (20/21)	Raise awareness with staff and address documentation errors with calibration sheets
Audit of Compliance with Visual Reinforcement Audiometry Guidelines and procedures (22/23)	Reminder to clinical staff re documentation and cross checks of journal entries.
Evaluation on the effectiveness of BAHA service (22/23)	Provide training to improve and ensure the process that patients are seen in MDT and then referred for surgery, plus need to fully complete post-fitting questionnaires.
Audit of New Paediatric Hearing Therapy Appointments (Tinnitus/Hyperacusis) (22/23)	Communication to PHT team and relaxation therapist to request that the specific leaflet handed out is recorded. Develop a new hot key for appointments to improve continuity of care when the child is seen by other team members.
Melatonin ABR (22/23)	MDT meetings introduced and current pathway altered for difficult to assess patients (complex needs patients)
Audit of Completed ABRs (Re-audit) (22/23)	Reminders to staff to: Ensure that Peer review requirements are added to the system and reviewed within timeframes. Check flags, parameters, risks, codes and outcomes and update accordingly. Give appropriate literature at appointments
Audit of Paediatric Hearing Aid fittings and Reviews 2022 (22/23)	Consider options to use hotkeys as reminder to record when REM is under target at high frequencies. Reminder to all staff to check new parameters and update on each visit.
Use of PPI with DAPT in patients with acute coronary syndrome - (Re-Audit) 2022/23	New ACS ward guideline to improve prescribing. Potential area to to create posters for the cardiology ward for cardiology SHOs on-call especially during clerking. Education re ACS treatment to the non-cardiology trained juniors/ new juniors rotating on cardiology regarding order-sets.
LocSSIp- Chest Drains (2020/21 DATA) 2022/23	Minor non-compliance so reminders to staff re importance of checklist completion.
Audit of diabetic patients having operations in June 2021 (covering New Cross and Cannock) 2021/22 (2022/2023)	Theatre list to document diabetes and allocate patient first on list unless other patient takes clinical priority.
Improving communication between physicians and patients' relatives in the Intensive Care Unit (ICU) 2022/23	Informing doctors and ACCPs in ICU to update their patients' relatives at least twice a week. Posters on ICU and plan to include relative updates as part of the ward round plan.
Arterial Line 2022/23	Disseminate results and recirculate sticker information. Designated drawer for all compulsory stickers. All stickers mentioned in Doctor's In Training Induction pack. Checking of relevant prescriptions on ward rounds. Education for new nurses regarding site monitoring. Propose flush-bag change to be 48 hourly.
A Quality Improvement Project to understudy the difficult intravenous access service provided by the Directorate of Intensive and Critical	Organisational training in USS guided IV cannulation for hospital doctors, and designing a protocol for borrowing USS machines from theatre.

Care 2022/2023 (Part 1)	
HTM01-05 - Infection Prevention (21/22)	Business case for refurbishment is awaiting approval at the time of this audit. Temporary repairs in meantime and risk managed via risk register.
RADQA reaudit (21/22)	In-house training of staff in new grading guidance and introduction of RINN holders, create new log book and risk assess the likely doses received and liaise with radiation advisor.
RADQA reaudit (22/23)	In-house training of staff and introduction of RINN holders
HTM01-05 - Infection Prevention Reaudit (22/23)	Refurbishment planned. On Directorate risk register.
Improving the surgical ward round: a quality improvement project	Creation of ward round proforma and education of the team via clinical governance meeting.
Do we follow GMC guidelines for intimate examination and chaperone use? (22/23)	Posters in surgical ward areas about guidelines for intimate examination, consent and chaperoning and exploring introducing a stamp to meet the RCS standards of documentation on intimate examination, consent and chaperoning.
Evaluation of General surgical Operations Notes according to the Royal college Guideline and Good Surgical Practice (22/23)	Development of a new proforma for operation notes, Consideration of including general standards for documentation in the induction for new starters.
National Audit - Project assessing the Management of Endometrial Hyperplasia - pre and post 2016 Green Top Guideline (2021/22) 2022/2023	Developing Trust guideline with clear algorithm for the management of EH and AEH. Explore feasibility of developing database and recall system to maintain timeline for biopsy follow up. AEH should be discussed with MDT / ? MRI before medical treatment. Adopting holistic approach in the management of EH and addressing high BMI and weight reduction measures.
Audit of ovarian cancer investigation and management over a 5 year time period (2022/2023)	Documentation of RMI at initial review Recommend BRCA testing and document as routine at initial oncology review.
Retrospective review of management of Endometrial Hyperplasia (2022/2023)	Developing Trust guideline with clear algorithm for the management of EH and AEH. Explore feasibility of developing database and recall system to maintain timeline for biopsy follow up. AEH should be discussed with MDT / ? MRI before medical treatment. Adopting holistic approach in the management of EH and addressing high BMI and weight reduction measures.
QIP- E-Discharge in Gynae Oncology (2022/2023)	Raise awareness via discussion at Gynae Care Group re importance of specifying follow-up, duration of hospital supplied medications and whether the patient had a procedure/diagnosis/plan discussed with them during their inpatient stay.
QIP- Post Coital Bleeding (2022/2023)	This project delivered further teaching and learning to junior doctors around the subject.
Improving the safety and effectiveness of the gynaecology emergency handover Audit (2022/2023)	Improvements to handover including ensuring all relevant staff attend, that it is completed face to face, covering all aspects of care and takes place at a specific location.
QIP-'Gynaecology post op Ward Round Audit (to review attendance to see	Develop a simple department guideline for post-op rounds and develop and expand on standards. Emphasize/feedback on detailed documentation.

elective gynaecology patients daily) (2022/2023)	Survey - record of discussions with Nurse in charge after rounds.
Minimal access rate for patients under the age of 50 undergoing hysterectomy for benign reasons Service Evaluation (2022/2023)	Plan to offer women minimal access hysterectomy i.e; either vaginal or laparoscopic route wherever feasible. Training clinicians to use morcellation technique to perform hysterectomy of a large fibroid uterus laparoscopically. Encouraging consultants to refer patients to their colleagues if they have surgical skills to perform the procedure through minimal access route.
Re-audit Antibiotic prophylaxis in daycase dentoalveolar surgery (22/23)	Update induction pack and produce poster for Anaesthetic room.
An Audit of Time to CEPOD Theatre for Patients admitted under OMFS with Acute Cervicofacial Infections. (22/23)	Review of CEPOD theatre lists to aim to reduce the time to theatre and reduce any delays, leading to reduced length of stay and improved patient care.
Assessing the effectiveness of a new analgesia protocol on re-presentations amongst paediatric post-tonsillectomy patients (22/23)	Ensure clear communication and documentation between surgical team, anaesthetic team, nursing staff and parents regarding optimal use of analgesia prior to and post-tonsillectomy. Ensure adherence to prescription using proposed proforma for all components of the analgesia protocol. Encourage use of tonsillectomy pain management home diary to ensure optimal analgesia is delivered.
A quality improvement project for post-operative pain management of osteotomy patients (22/23)	Implementing a standardised post-operative pain management protocol for inpatient and outpatient medication and to complete a post-operative pain review at the follow up appointment.
Black Country Head and Neck Cancer Pathway - an Audit and a Service Evaluation (22/23)	Further discussion of findings at the head and neck cancer MDT meeting.
Thyroidectomy Audit (22/23)	To improve clinician education on BAETS guidelines relating to the peri-operative care of patients undergoing Thyroidectomy.
ENT Handover sheet audit (22/23)	The audit has reminded clinicians on safe and adequate handover and reinforced the need for a more robust system which will be introduced with the rolling out of Careflow Connect.
Compliance with glandular fever screening in patients admitted with acute tonsillitis (22/23)	Further data is being collected on differential white cell count. If this is predictive of acute glandular fever infection, the Trust guidelines will be reviewed so that glandular fever screening should be considered but is not mandatory.
Operation Notes Audit (22/23)	Clinicians were reminded of the Royal College of Surgeons "Good Surgical Practice" guidelines for documentation of operation notes via presentation of the audit results and email circulation.
Hypoglycemia QIP	Ensure that haemolysed samples are repeated and send urine sample as per guidance
Low Cord PH Audit (2022/2023)	Education of Junior doctors and midwives.
NICE CG129 & QS46 Multiple Pregnancy Audit-Caearean Sections (2021/2022) 2022/2023	Good compliance with NICE guidance - improvement actions around documentation on mode of delivery (MOD) discussion.
Saving Babies Lives Element 4- Intrapartum care for healthy women and babies- CTG	Consultant Fetal Monitoring Lead and Fetal Monitoring Midwife will ensure all medical and new midwifery staff have been allocated to a Fetal Monitoring Study Day and reallocate non-attenders.

Compliance (2022/2023)	
Major Obstetric Haemorrhage (MOH)/ Post partum haemorrhage (PPH) (primary and secondary) Audit (2021/2022) 2022/2023	Improve documentation from theatre cases / recovery area, risk discussion in the briefing of elective cases and prophylactic measures. Low threshold for use of TXA. Encourage PPH Proformas
Consent in Obstetrics Audit (2021/2022) 2022/2023	To introduce standardised procedure specific pre-printed consent forms with risks outlined as per RCOG advice. Antenatal counselling: to provide information about operative vaginal delivery to women on BadgerNet app ,so the women can go through it and get background information about instrumental delivery in the antenatal period. Intrapartum Counselling: to develop patient information sheets/infographics in partnership with patients and midwifery staff to be available for intrapartum counselling of women on labour ward.
Saving Babies Lives: Element 3- Reduced Fetal Movement Monitoring Audit (2022/2023) 2022/2023	Ensure awareness amongst all maternity staff including midwives & doctors regarding the importance of RFM at the induction. Ensuring all maternity / medical staff have recorded given / discussed the Tommy's leaflet recorded on the Badger net. Ensure that the RFM checklist is completed fully prior to discharge home.
NG25 and Saving Babies Lives Element 5: Preterm Labour and Birth (to include data on MSU) (2022/2023)	Learning for staff re: UTI positive growth must be treated according to the culture and sensitivity in a timely fashion. Good practice to document the name of the antibiotic prescribed. Results of MSU must be reviewed and filed in the system by all doctors as evidence that the results were acknowledged and acted accordingly. A repeat MSU must be sent after completing treatment to confirm the clearance of infection
Saving Babies Lives: Element 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR) (2022/2023) - incorporating requirement of CNST quarter audit of a minimum of 10 cases delivered <3rd centile after 37*6 weeks	Include data on SBL dashboard Raise awareness amongst staff to update each patients risk assessment following review.
Ockenden Report Audit: Intrapartum Risk Assessment Re-Audit (2022/2023)	Reminde to all staff by using visual aid with an additional column on Induction unit and Delivery Suite white board ensuring continuous intrapartum RA is being done. Highlight need for risk assessment during mandatory EFM training.
Ockenden Audit: Audit of Handover process on Delivery Suite (2022/2023)	Re-audit results demonstrates considerable improvement in hand over-process. Increase awareness of handover times and the hospital guideline.
Ockenden Audit: Audit of Maternity Inpatient Review by Consultants (2022/2023)	Consultant buddy teams to have rota for ward cover Reg / SHOs have been clustered into teams to improve ward cover. More direct contact with Registrars during week through texts / emails to discuss cover for the week. Use of blue spots for visual reminder of who hasn't been seen. Agreed escalation plan for patients not seen.
Saving Babies Lives Element 4- CNST- 4.2 - Are all staff who care for	Improve documentation of reasons why maternal pulse or auscultation may be missed or delayed.

women in labour required to undertake annual training and competency assessment on and use of auscultation every 12 months? February 22 (2022/2023)	
Saving Babies Lives: Element 1- Reducing smoking in pregnancy (2022/2023)	Outcomes are above threshold required but not yet at 100%. Ongoing work adied by the Smoking Cessation team alongside continued efforts of midwifery and support staff at each stage of the woman's journey.
MLU audit 3rd/4thDegree Tears Audit (2022/2023)	Ensuring documentation is more detailed in birth position, particularly in water Ensuring new midwives to are supported at time of birth (where possible) for a number of births before supporting women independently
Saving Babies Lives Element 4- CNST- 4.2 - Re-Audit- Are all staff who care for women in labour required to undertake annual training and competency assessment on and use of auscultation every 12 months? February 2023 (2022/2023)	Staff learning around need to document reason why auscultations are delayed/omitted, also to ensure that maternal pulse is palpated and documented hourly in 1st stage and quarter hourly in 2nd. Ensure time on Badgernet is adjusted to reflect time of auscultation rather than time of entry to avoid appearance of delayed auscultation.
CNST Safety Action 4: Roles & Responsibilities of the Obstetric Consultant Compliance Monitoring (2022/2023)	Continue to follow the Consultant attendance monitoring process.
Local ECV Service Evaluation (2022/2023)	Updating ECV leaflet in line with RCOG leaflet
Efficacy of WHO Surgical Safety Checklist for Cataract Surgery 2022/23	Set local guidelines for documentation in biometry sheet and patient notes.
'Going green' in Ophthalmic theatres (22/23)	A table has been created with the help of the waste management team to raise awareness for theatre staff of which bags different waste gets placed in.
Assessment and Management of Paediatric Supracondylar Humeral Fractures at New Cross Hospital, Wolverhampton (2022/2023)	Proforma for easy documentation of assessments (pre-op and post-op). Updated operation note template. Discharging clinician to ensure all patients have a documented post-op assessment before discharge. Continue the excellent compliance with x-ray post op, long term follow up and wires removal.
Door-to-clexane time in trauma patients (2022/2023)	Changes and improvement around clexane plan including on electronic prescribing system, clerking and handover documentation. Reviewing ED and ward doctor involvement.
Effect of pre-operative dexamethasone on post op pain relief, PONV and length of stay in lower limb arthroplasty patients (2021/2022) 2022/2023	Results inconclusive due to small numbers, but having an agreed recommendation and protocol for the Trust may help to standardize as per best practice.
Re-audit of compliance with surgeon operated mini c-arm standards (2022/2023)	Electronic form - prompts user to complete all pertinent sections. Negates issue of missing radiology request forms and allows for better analysis. Standardised font makes information more legible.
VTE Re-audit (2022/2023)	Document diagnosis clearly, including the anatomical side of pathology. Whilst patients may already be on VTE prophylaxis when presenting for

	cast modification, indicate this clearly – this is also an opportunity to catch any initially missed cases. Document weight bearing status . Emphasise the importance of doing and documenting a VTE risk assessment on the plaster room sheet.
Assessment of the workload assigned to General Practices within one month of discharge post elective orthopaedic surgery (2022/2023)	Clinic for clip removal +/- BP check / blood samples / wound review. Proforma given to patient to give to GP ie with BP documented. GP can then make further decisions about medications etc GP can also action results of blood tests in community.
Bone bank transportation-from consent to green freezer re-audit (2022/2023)	Improvements around flagging patients who are rescheduled to have fresh set of pre-op bloods, improve documentation where bone graft not taken for donation, meausures to minimize contamination of samples, improved labelling and documentation of entry time to freezer.
Safe use of Intra-operative tourniquets in Trauma and Orthopaedics (2022/2023)	Improvements in documentation of exsanguination, padding and method of isolation, compliance with tourniquet pressure. Raising awareness of guidance via posters in theatres.
Emergency Spinal MRI Services QIP(2022/2023)	Aiming for improved access to MRI services for cauda equina syndrome, and implementing a local pathway for cases of back pain with suspected cauda equina syndrome.
Re-Audit of Documentation in Medical Records-consent form 4 for neck of femer patients (2022/2023)	Include next of kin discussion in medical clerking checklist Involve NOF nurses Prompt underneath the AMTS
Post-operative urinary retention (POUR) in lower limb arthroplasty patients (2022/2023)	Improve compliance with bladder scan protocol
Outcomes of Platelet Rich Plasma Injections In Early arthritis of The Knee. Comparison between a single injection Vs Course of Three Injections	Consider establishing PRP clinics once a month to improve theatre efficiency.
QIP: Improving Discharge Summaries for Arthroscopic Procedures (2022/2023)	Poster will be included in induction pack for Junior doctors. Awareness raised for discharge summaries of all day case procedures.
An audit of the investigation and management of shoulder dislocation in New Cross Hospital against BESS guidelines (2022/2023)	Improved awareness via presentation of audit findings and posters in fracture clinic. Gatekeeping of slots on acute shoulder instability clinic lists.
Re-Audit of Compliance of Antimicrobial prophylaxis in Trauma and Orthopedic surgery (2022/2023)	Learning incorporated into junior doctor induction and nurse teaching around antibiotics to be given to maintain optimal plasma level for 24 hours, per Trust guidelines.
NICE-related audit: Review of the outcomes for patients with fast track referrals for possible testicular cancer (2022/2023)	Results highlighted the importance of reviewing the ultrasound scan before fast track referrals. Considering whether primary care could access USS results prior to fast track referrals. Two fast track USS slots to be allocated every week.
QIP: Day Case TURBT Project (2022/2023)	Development of TURBT stickers to distinguish day case suitability easily and drive decisions re suitability at time of booking, aiming to reduce default position of overnight stay.

CEPOP Theatre Utilisation pre and post merger of Walsall and New Cross Emergency Urology (2022/2023)	Continued monitoring of CEPOD use and if necesssary to procure extra radiographer support in theatre.
Group & Save Samples for Robotic-Assisted Laparoscopic Prostatectomy Service Evaluation (2022/2023)	Routine pre-operative G&S samples is likely unnecessary & stopping this may lead to increased efficienty and sustainability. To be sampled and cross-matched on a case by case basis.

How to give comments

We welcome your feedback on this Quality Account and any suggestions you may have for future reports.

Please contact us as indicated below:

The Royal Wolverhampton NHS Trust
New Cross Hospital
Wednesfield Road
Wolverhampton
WV10 0QP

[i] Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

ii The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity.

Freedom to Speak Up Annual Report 2022/23

1.0 Introduction- Freedom to Speak Up (FTSU) Annual Report

- The Royal Wolverhampton NHS Trust has been committed to its Freedom to Speak Up (FTSU) journey and the Guardian role since October 2016. The FTSU Guardian is an independent role and focuses on creating an open and honest reporting culture, enabling staff to talk about anything that could compromise good patient care. The Trust Board have shown their full commitment and support to embed FTSU within the organisation.

2.0 FTSU Strategic Objectives

RWT set out the below five objectives to achieve a well- led speaking up organisation;

1. Raise the profile and develop a culture where speaking up becomes normal practice to address concerns
2. Develop mechanisms to empower and encourage staff to speak up safely
3. Ensure that the Trust provides a safe environment for employees and others to raise concerns and speak up
4. Ensure that concerns are effectively investigated and the Trust acts on its findings
5. Ensure shared learning amongst local/regional/national Networks

3.0 FTSU Updates

For the financial Year 2022/ 2023, The FTSU Guardian Team have prioritised recommendations made to the Trust Board in 2021, including: creating a FTSU Standard Operating Procedure, updating our Freedom to Speak Up Policy, creating more accessible ways for staff to access the service and refreshing the Speak Up Champion role.

The FTSU function was internally audited in August 2022, and recommendations made have been prioritised. For example, the introduction of a new processes for learning from cases. The FTSU Guardian Team have worked closely with colleagues in the Human Resources (HR) and Oragnisational Development (OD) Teams to take a multi-disciplinary approach to creating a healthy workplace culture that promotes compassionate leadership, restorative and just culture and civility and respect. We will continue to contribute to staff and management training in this area.

4.0 FTSU Data

The Trust FTSU data has been recorded for the Financial year 2022/23. This will be reported to the Trust Board and to the National Guardians Office (NGO) as an independent non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC and NHS England and Improvement.

4.1 Case Data

Table 1: Total number of FTSU cases for 2022/ 2023 compared with total cases for 2021/ 2022

	Quarter 1 2022/ 2023	**Quarter 2 2022/ 2023**	**Quarter 3 2022/ 2023**	**Quarter 4 2022/ 2023**	**Total for 2022/2023**	**Total for 2021/2022**
Total number of cases brought to Freedom to Speak Up Guardians and Champions	110	52	49	52	263	123
Number of cases raised anonymously	16	17	6	11	50	14
Number of cases with an element of patient safety/quality	70	21	18	14	123	23
Number of cases related to bullying/harassment	48	14	23	21	106	77
Number of cases where people indicate that they are suffering detriment as a result of speaking up	21	8	17	5	51	23
Number of cases with an element of worker safety or wellbeing	71	26	16	7	120	Not previously recorded
Number of cases relating to inappropriate attitudes and behaviours of staff	96	27	42	38	203	Not previously recorded

There has been an increase in the number of cases being reported to the FTSU Guardian Team compared with FTSU cases for 2021/ 2022. The FTSU Guardian Team have taken a more proactive approach to staff engagement, by offering regular drop-ins within departments and walk-arounds. This has provided greater opportunities for staff to speak up.

Whilst 263 new cases have been recorded, staff often have concerns that fall into multiple categories, which is reflected in the data for each case category. New categories for recording cases were added by the NGO, including cases with an element of worker safety or wellbeing and cases where staff raise concerns relating to inappropriate attitudes and behaviours of staff. Whilst the number of cases with an element of bullying and harassment remain high, the addition of a category for recording inappropriate attitudes and behaviours has been useful to reflect the high number of staff experiencing or witnessing this.

Figure 1 provides a snapshot of quarterly FTSU case numbers and themes. This shows that whilst all four quarters have similar numbers of reports overall, the theme which does not appear to show improvement is the number of concerns around bullying and harassment which remains fairly stable.

Figure 1: Number of quarterly FTSU cases broken down by themes

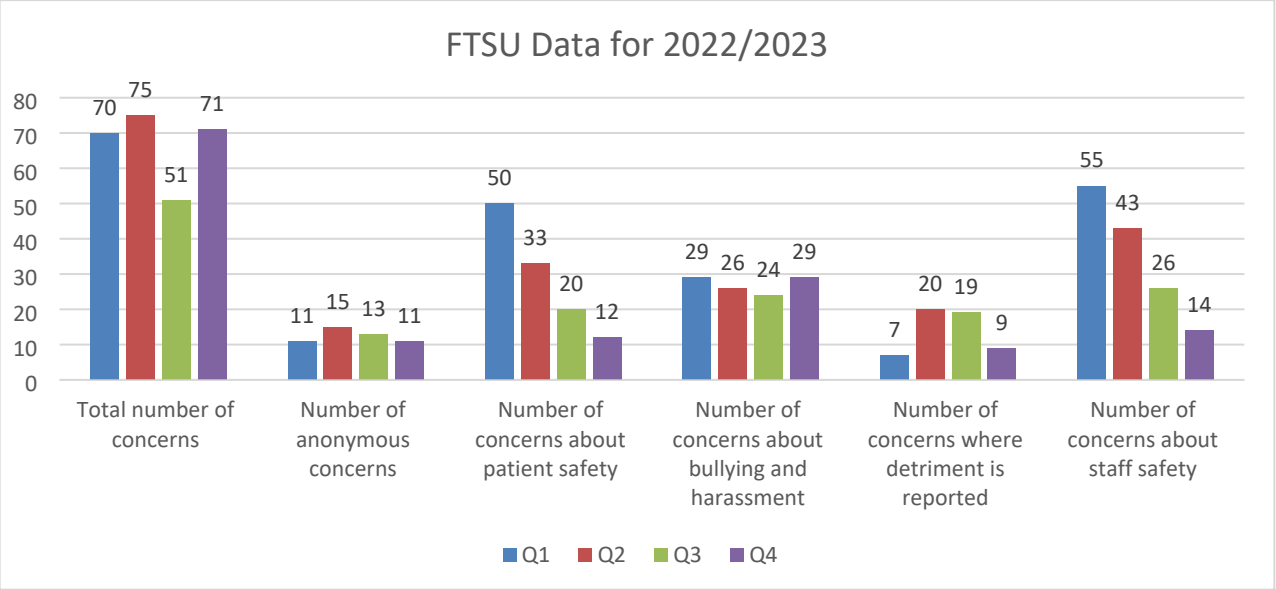
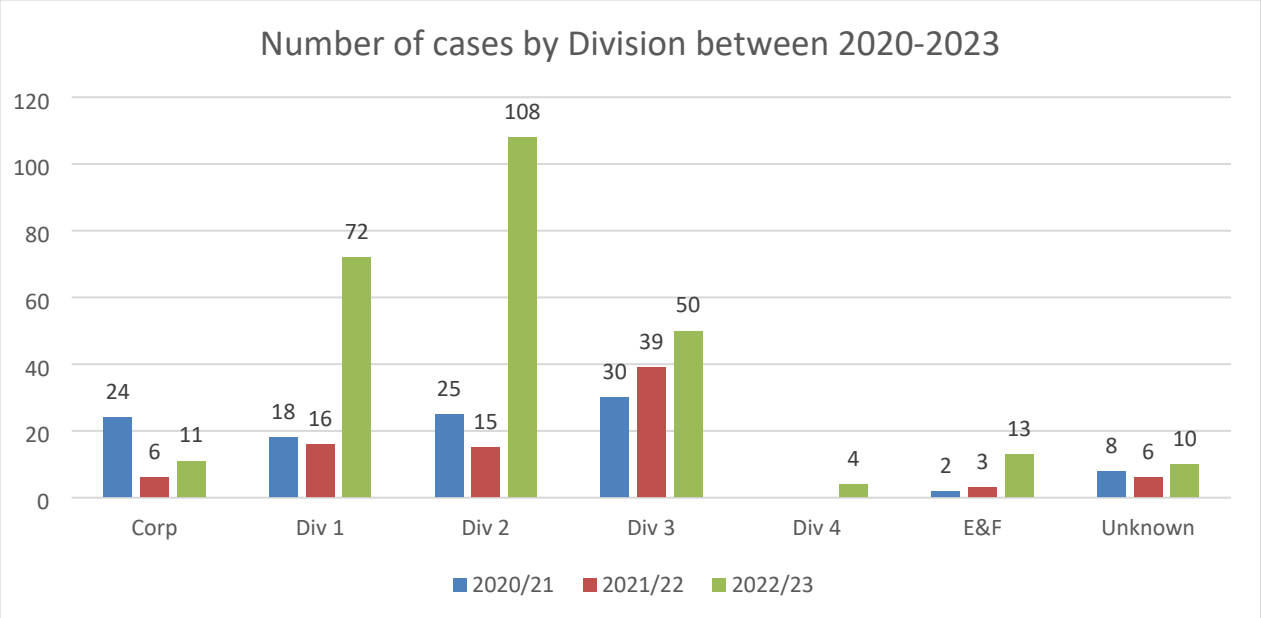


Figure 2 shows the number of staff contacting the Guardian from each Division across 3 financial years. There is a considerable increase in concerns in Division 1 and 2 and figures rising in all Divisions from last year. Division 4 has not previous been reported due to the minimal reports.

Figure 2: Number of FTSU Cases by Division between 2020 -23



Looking at the number of FTSU cases by department. The five areas with the highest number of FTSU reports are:

- Respiratory & Gastroenterology
- Pathology
- Emergency Services
- Acute & Community Care
- Adult Community & Primary Care

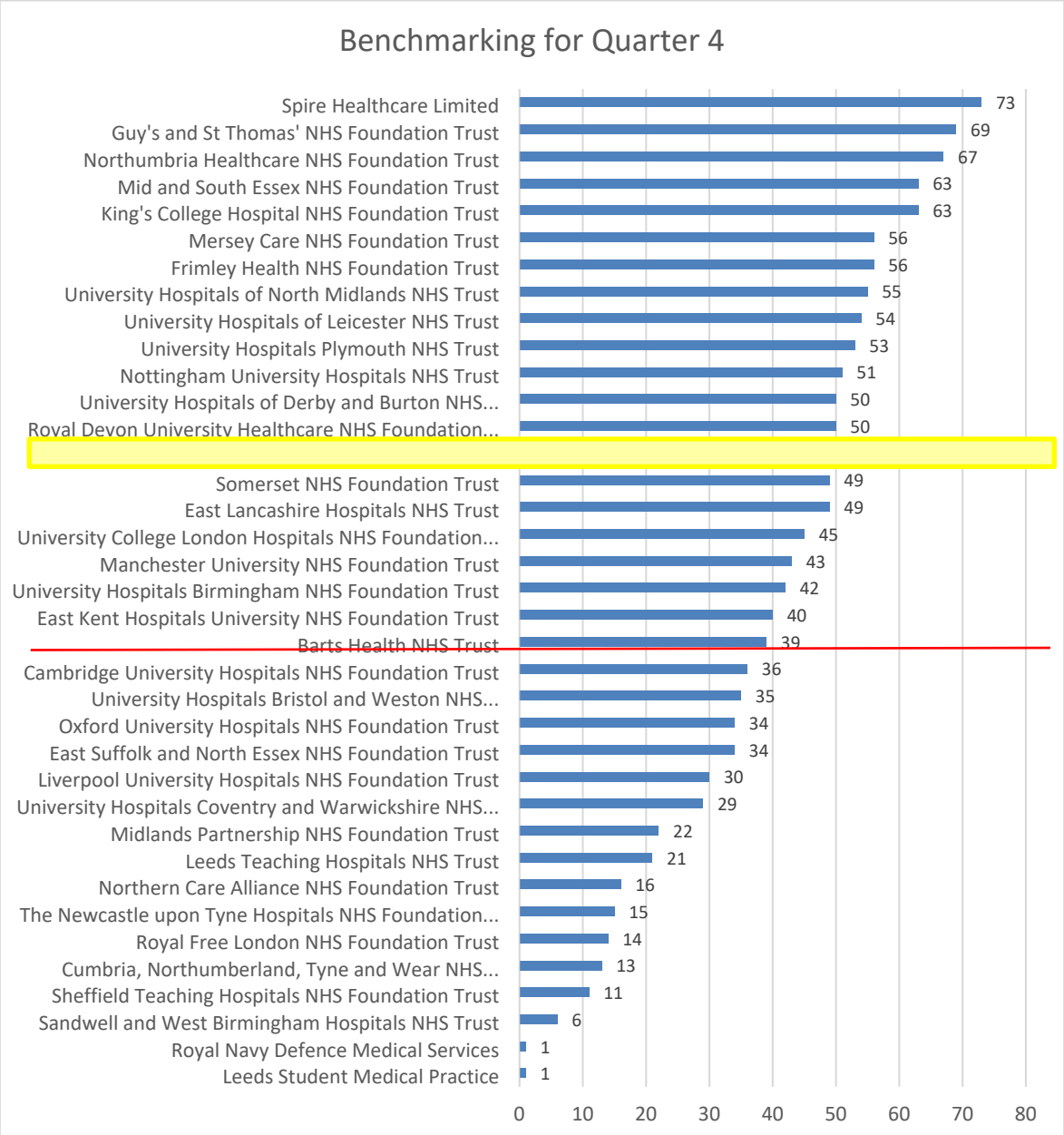
Table 2: Number of FTSU Cases broken down by Professional Group

Professional Group	**Number**
Additional Clinical Services	27
Additional professional scientific and technical	10
Administrative and Clerical	36
AHP	20
Estates and Ancillary	13
Healthcare Scientists	5
Medical and Dental	30
Nursing and Midwifery registered	85
Students	2
International Nurses	2
Other	14
Not known	41

Table 2 shows that a large majority of FTSU cases come from Nursing and Midwifery Registered staff with an increase from 19 last year to 85 this year. Unfortunately, due to a number of our concerns being raised anonymously, a significant portion of this data remains missing.

Figure 4 provides a benchmarking pointer for Organisations Nationally who have more than 10,000 employees. This data is purely for Quarter 4 as the NGO have not yet released the full years figures.
Yellow shows where RWT were at the end of Q4
Red shows where the average number of reports sits (38.75 reports)

Whilst the number of reports for RWT is higher than average, this could be due to several things such as the amount of WTE now allocated the FTSU, a higher profile for FTSU than ever before, multi-disciplinary working and constant publications from our communications team.



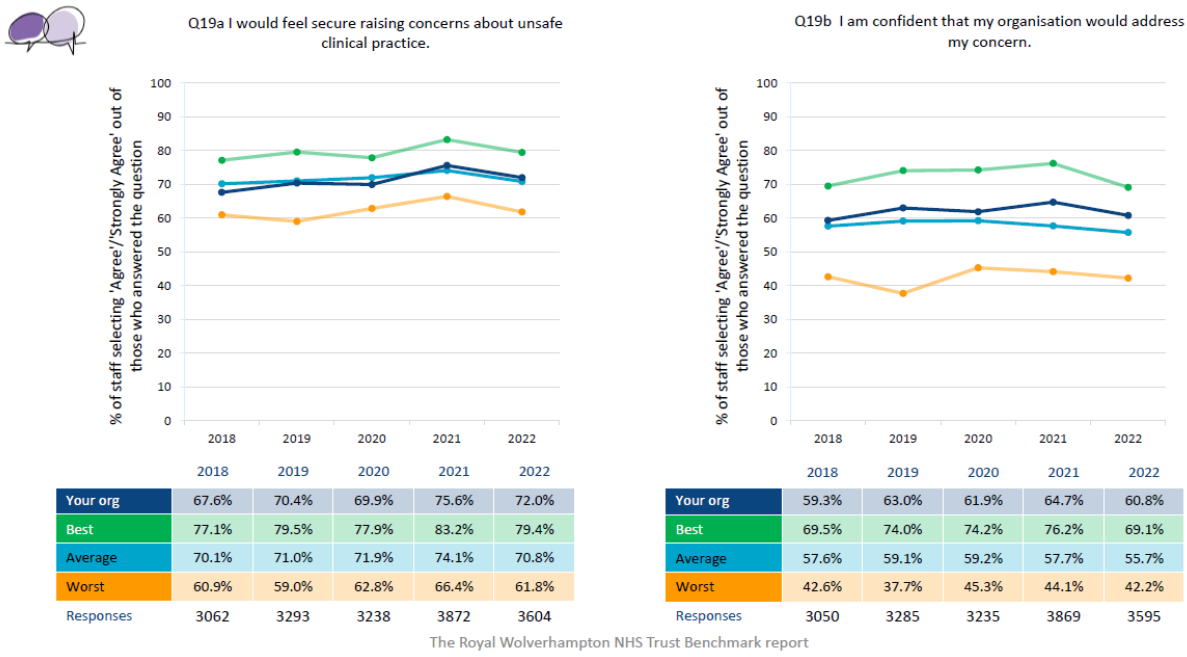
4.2 FTSU Index Update and Staff Survey Data

Figures 5 and 6 show the staff survey results for FTSU related questions.

This data shows that there has been a reduction in the number of staff who agree with the statement that they feel safe to speak up about anything that concerns them, and only 53.3% said they were confident that the organisation would address their concerns.

There has been a decrease in the number of staff who said they would feel confident to raise concerns about unsafe clinical practice and also in the number of staff who felt confident that the organisation would address these concerns.

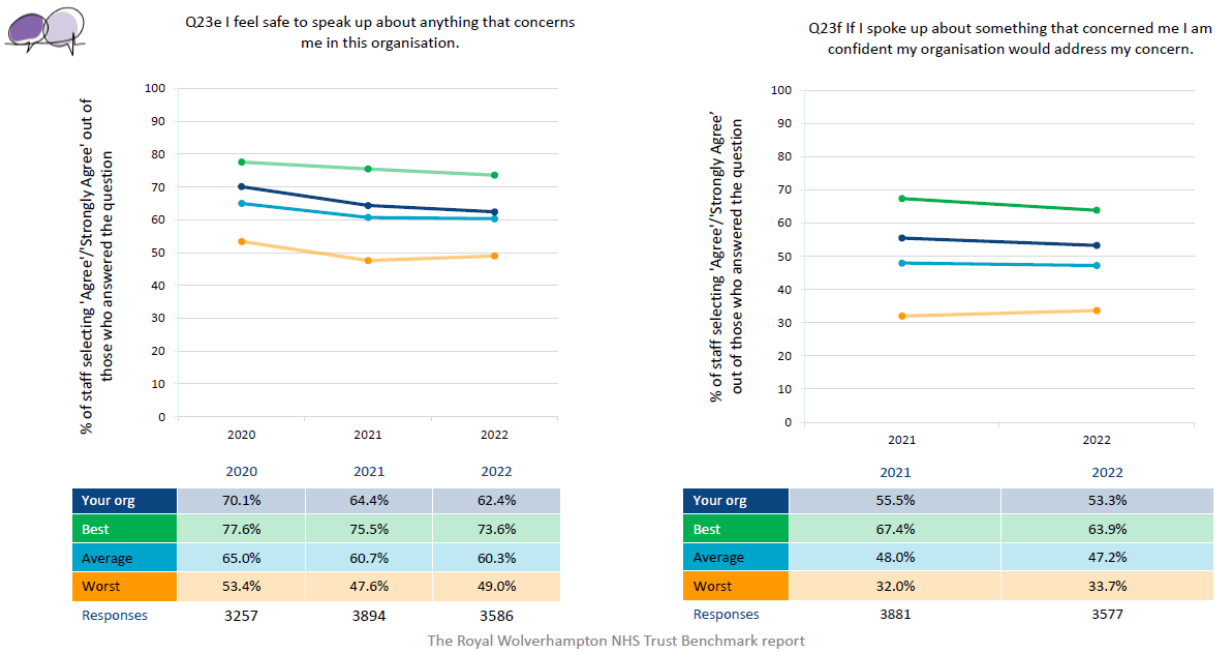
Figure 5: Staff Survey results for clinical practice speaking up related questions



	2018	2019	2020	2021	2022
Your org	67.6%	70.4%	69.9%	75.6%	72.0%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	3062	3293	3238	3872	3604

	2018	2019	2020	2021	2022
Your org	59.3%	63.0%	61.9%	64.7%	60.8%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	3050	3285	3235	3869	3595

Figure 6: Staff Survey results for general speaking up related questions



	2020	2021	2022
Your org	70.1%	64.4%	62.4%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	3257	3894	3586

	2021	2022
Your org	55.5%	53.3%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	3881	3577

4.3 FTSU Data Analysis

There is a theme within the data showing that workplace culture remains a challenge for staff and there also appears to be a link to inappropriate behaviours and bullying within the workplace.

Whilst the figures for RWT have decreased this year, the Trust remains above the national average for all of the questions relating to FTSU within the Staff Survey.

Our Organisational Development Team are working on Culture within the organisation, so along with the FTSU role continuing to have a high profile around the Trust and a third team member also starting to work within the FTSU team in July 2023, it may be that staff begin to feel more comfortable raising and speaking about concerns.

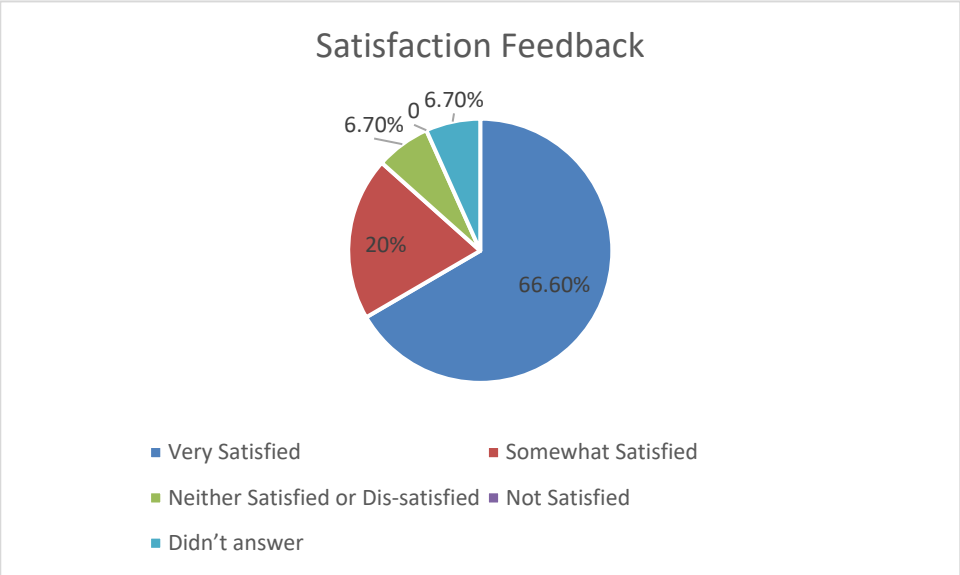
5.0 FTSU Service Feedback

Each quarter feedback is collected from all staff who have spoken up via an online questionnaire. From the feedback collected anonymously.

- 66.6% said that they were very satisfied with the way that they were dealt with by the FTSU Team
- 20% said they were somewhat satisfied with the way that they were dealt with by the FTSU Team
- 6.7% said that they were neither satisfied or dis-satisfied
- 6.7% did not answer this question
- 0% said that they were not satisfied

This feedback shows the majority of staff who respond to the survey are satisfied with the service they receive through the Guardian, that their needs were met and therefore be likely speak up again.

Figure 7:percentage of people who were satisfied with the FTSU service



6.0 FTSU Training

An excellent package of online training presentations continue to be delivered ant these include presentations on:

- Why speak up
- Barriers to speaking up
- Trust values and behaviours
- Equality Diversity & Inclusion

These training packages have been delivered in addition to the online E-Learning FTSU modules Speak Up and Listen Up, which are available through My Academy.

“Speak Up” is mandatory for all staff to complete

“Listen Up” module is mandatory for managers at all levels

“Follow Up” module for Senior Leaders, including Executive and Non-Executive Directors. So far 229 of our senior leaders have completed the Follow Up training – we will continue to share the requirement for this to be completed throughout the Trust.

7.0 Next Steps

Close working with key leaders and stakeholders has enabled the Trust to continue meeting our FTSU objectives. However, further improvements are required to ensure RWT is meeting and sustaining its local set objectives and those of the National Guardians Office (NGO) and NHS England & Improvement (NHSEI).

The key priorities for this year will be to continue working closely with colleagues in HR, OD and EDI, with a focus on triangulating case themes to help address workplace culture issues. The FTSU Guardian Team will also work collaboratively with the FTSU Guardian Team at Walsall Healthcare Trust to align our processes and procedures, helping to create a consistent FTSU offering across both Trusts. We need to look at data from exit interviews, leavers from the Trust and triangulate this with staff survey results and also the number of FTSU concerns from areas to establish if there are any key areas to work on.

The data from the past 12 months will help us to initiate our next steps. We will continue to closely monitor cases relating to workplace culture, bullying, harassment and poor attitudes and behaviours of staff and will start to breakdown the data further, to see whether individual's protected characteristics are felt to be a causal factor for the behaviour they experience or observe. The NGO continues to expand its reporting facility to allow people to elaborate more on their concerns to help to give a clearer picture.

From the staff survey results, it is clear that staff are still facing their own concerns about speaking up and barriers about conversations with management. Our OD team are doing some work around Civility and Respect along with their focus on Restorative and Just Culture and Compassionate Leadership approaches which may have a positive impact on the areas of concern in this report.

From the data there are some areas where the numbers have increased dramatically from the previous years figures, we will therefore be looking at the reasons behind this to see if there are any other trends, pattens or reasons for this.

We continue to work with our Speak up Champions across the sites to share knowledge about FTSU and to educate our staff as sadly there are still some people who do not know that the role of FTSU Guardian exists or what it is for. Pop up stands, drop in sessions, walk about times and other staff integration will continue and we will also be doing some work with our own IT team regarding an anonymous reporting system which will allow our Guardians to still make contact with the reporter to obtain more information about their reported concern and also to offer them updates despite them being anonymous. In Trust's where similar systems have been devised, feedback is good and they believe that staff are more confident to report if they can remain anonymous.

8.0 Summary

Freedom to Speak Up continues on its journey at The Royal Wolverhampton NHS Trust. There is a clear indication that some of the impact of this work is positive, as the number of staff approaching the Guardian increases year on year and, on the whole, many staff have said they would speak up again. However, further action is required to embed FTSU within the organisation to improve speaking up culture. Doing this effectively should have a positive impact on workplace culture as a whole, which is a clearly identified area for improvement in this report.

Executive Summary Workforce Report

The Royal Wolverhampton NHS Trust

Trust Board
6th June 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.

Three of the six workforce indicators are meeting the agreed targets/ thresholds mandatory training, vacancy rates and 12 month retention. Appraisal compliance, turnover and sickness absence are rated amber.

- Normalised turnover is 10.95%, improving slightly in month and for the the forth consecutive month. The retention rate is now reported as 12 month retention and is meeting the agreed standard.

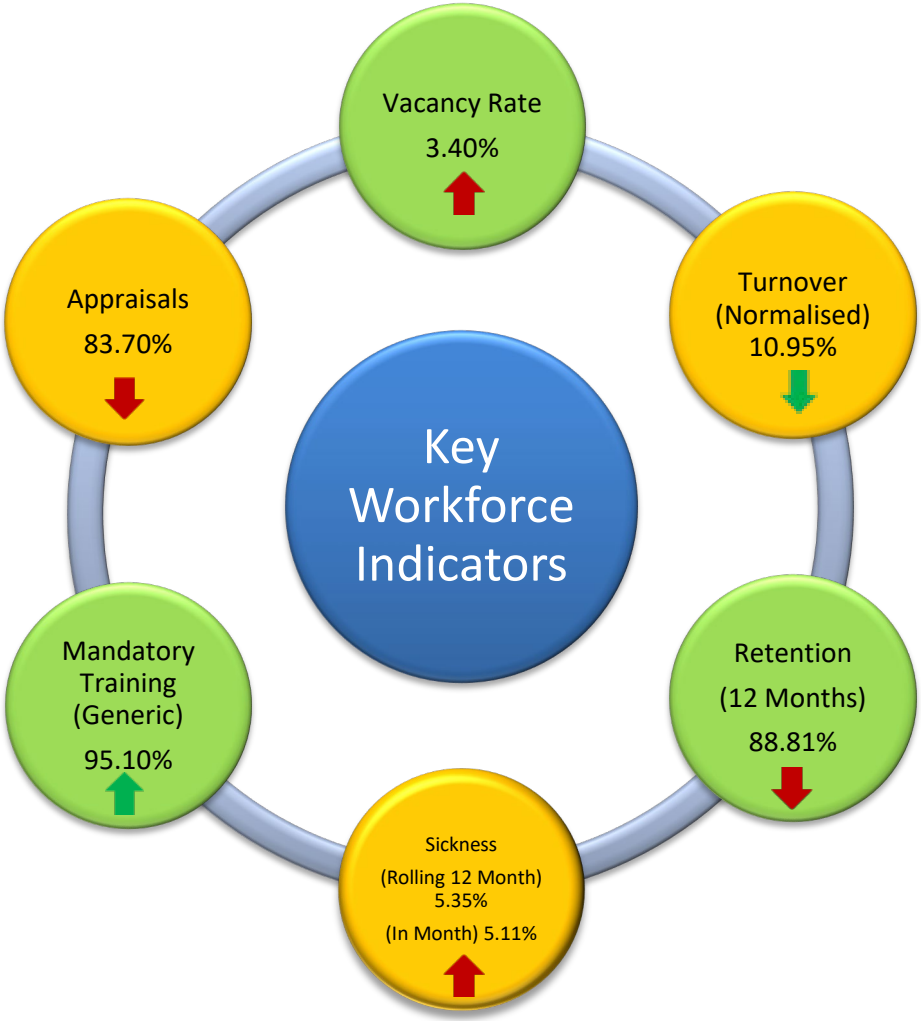
- The vacancy rate has worsened slightly in month, however, continues to meet the target at 3.40%. Over the last month the number of staff employed has remains largely stable with an increase of 2.80WTE over the month. The vacancy rate has increased as the number of established posts has been increased by almost 59WTE. Recruitment continues to outpace turnover. There are 111.60WTE newly qualified/ international nurses working towards their pin.

- Attendance levels have worsened in month over March. The in month performance for this indicator is above the target at 5.11%. Levels of absence as a result of COVID-19 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 5.35%.

- Performance in relation to generic Mandatory Training continues to meet the external target of 85%. Current performance is unchanged at 95.10%. Role specific mandatory training compliance also remains unchanged at 94.30% and above the target. In relation to appraisal, compliance rates have worsened slightly over the last month to 83.70%. This indicator is again rated amber and below the target of 90%.

- The fill rate through the bank in April was 70% for registered nursing staff and 84% for healthcare assistants. The medical bank fill rate was 85% exceeding the new target of 70%.

Key Workforce Metrics



Three of the six workforce indicators are meeting the agreed targets / thresholds; vacancy rate, retention rate and mandatory training compliance. Sickness absence, turnover and appraisal compliance are rated amber.

Turnover has improved slightly to 10.95%. Turnover performance is now meeting the standard only for Medical and Dental staff groups with elevated levels particularly in AHP and Healthcare Scientist staff groups.

The vacancy level has worsened in month, however, continues to meet the target. It is above target for medical staff only as the establishment has increased to a greater extent than the number of staff in post, with almost 4 additional doctors were in post at the end of April when compared with the end of March.

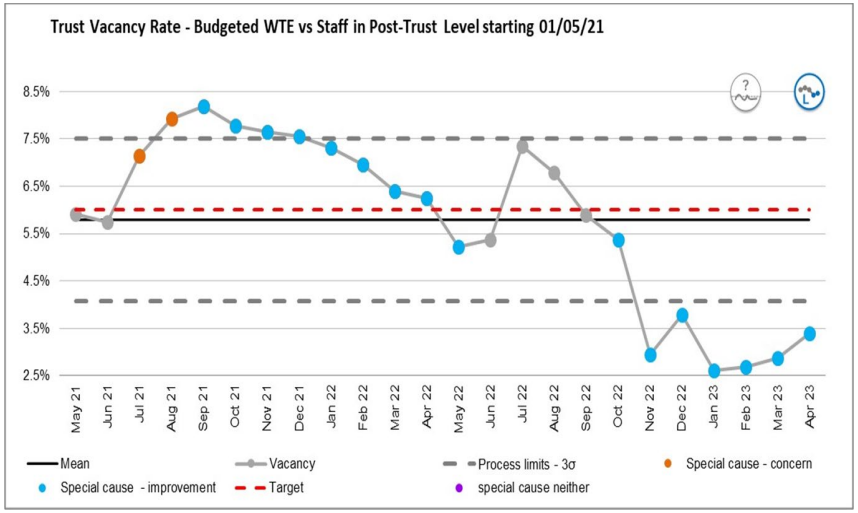
In month absence levels remain high following the impact of COVID-19 with a similar trend shown in relation to rolling 12 month attendance levels. Both indicators continue to exceed the target following elevated levels of absence as a result of COVID-19 and seasonal absence.

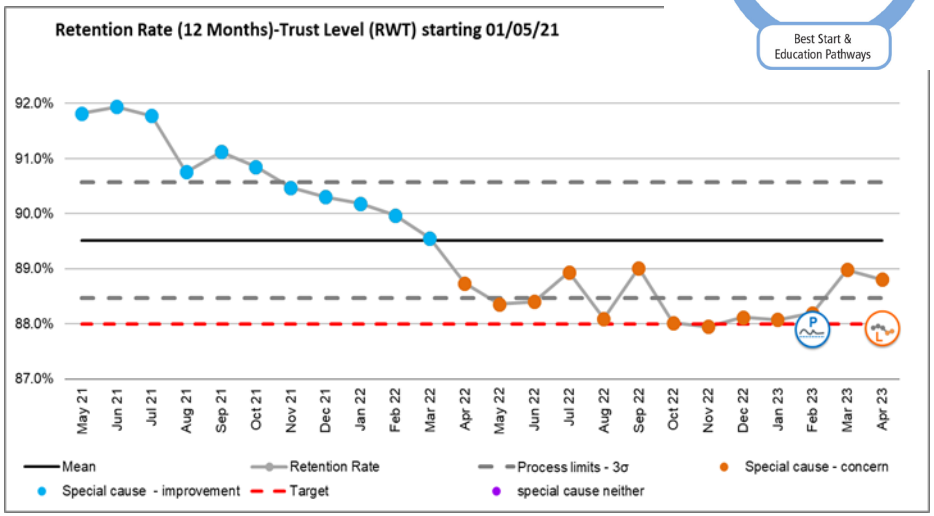
Mandatory training (generic) compliance rates have improved, and continues to exceed the 85% target.

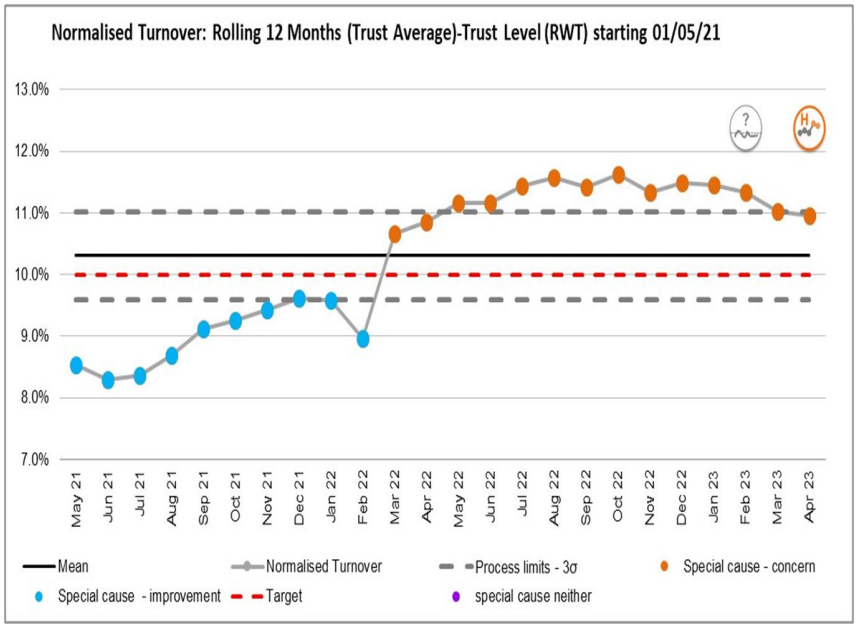
Appraisal compliance has worsened slightly and is not meeting the Trust target of 90%.

Attract, Recruit & Retain

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better







Key Issues & Challenges

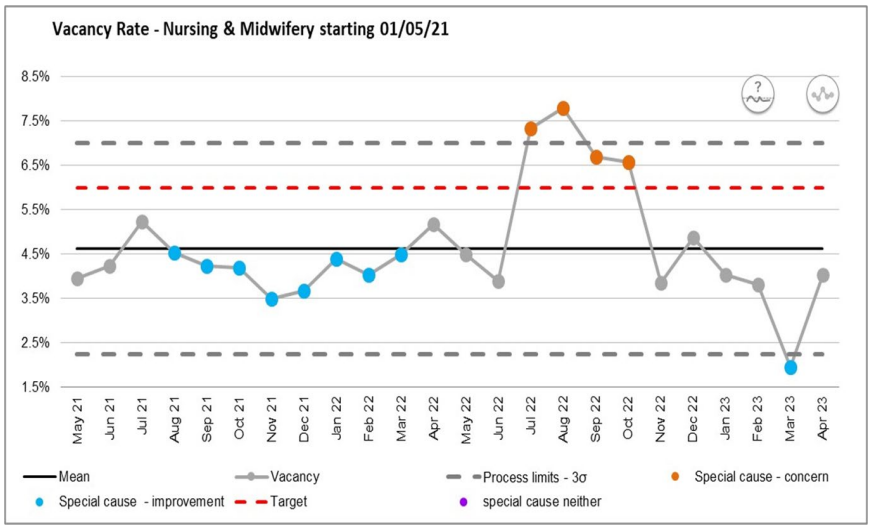
- The Retention Rate at 12 months is meeting the 88% target at 88.81%. Turnover exceeds the target at 10.95%.
- The vacancy rate remains elevated for medical staff only following an increase in the number of established posts for this staff group.
- Whilst the vacancy levels are performing well overall, there continues to be hotspots and 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.

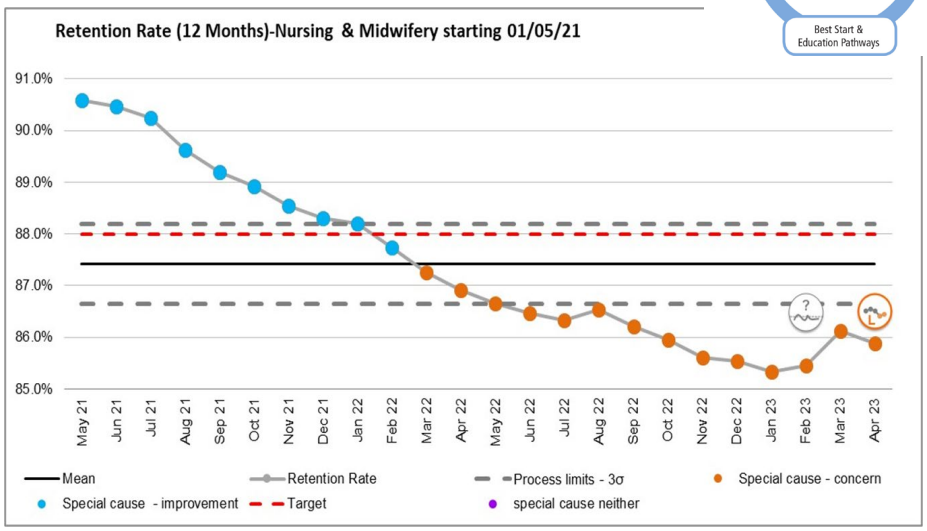
Key Actions & Progress

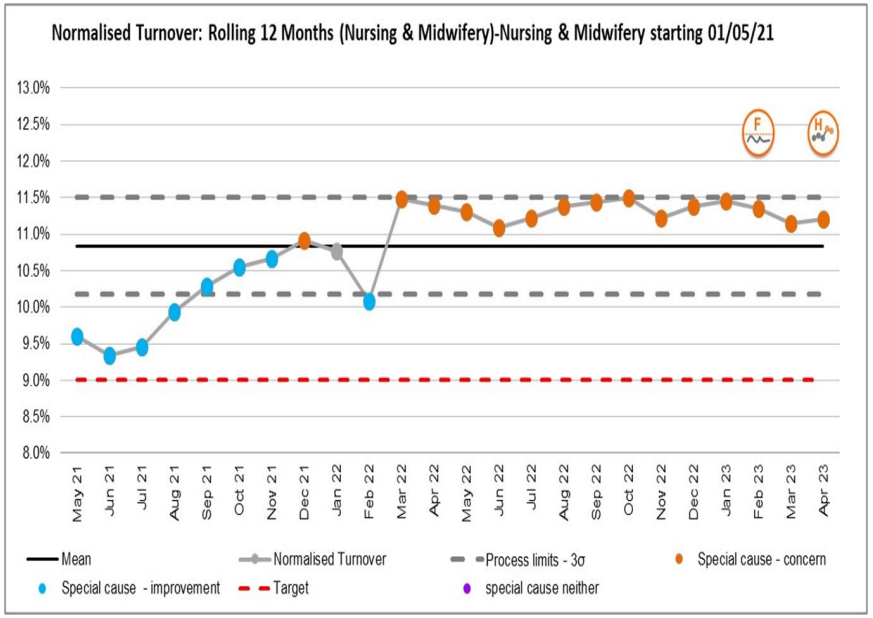
- The vacancy rate is now meeting the target consistently
- Active work continues to identify hard to fill posts and this will also focus on AHP, and Healthcare science posts where there have been improvements in month.
- Starters continue to outpace leavers with an increase in medical staff, nursing staff, admin and estates overall.
- 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

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better







Key Issues & Challenges

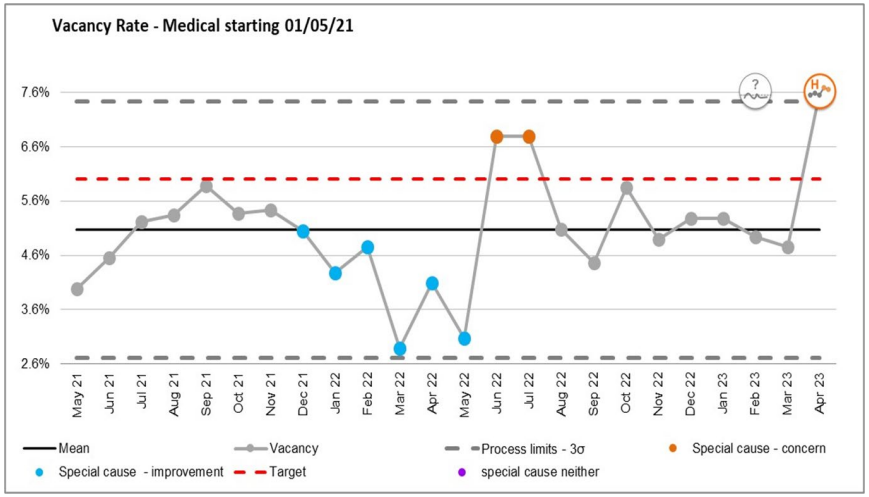
- Nursing turnover is above target at 11.21%, increasing slightly from the prior month. Work life balance is a key driver of turnover. Increased turnover is also driven by staff who deferred retirement/ may otherwise have left in prior years now leaving the service/ Trust in an increased number. Wider review of this suggests it is a rebalancing and is likely to stabilise in the near term, however, this will need close monitoring.
- Additionally, it should be noted that whilst nursing turnover has increased within the Trust, this is a general trend in provider and peer organisations and details of model health system data has been reviewed by the People and Organisational Development Committee.

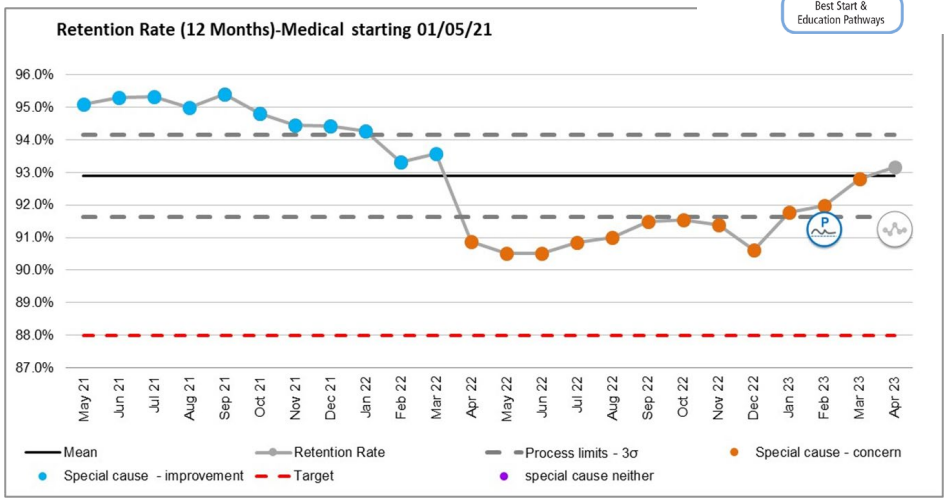
Key Actions & Progress

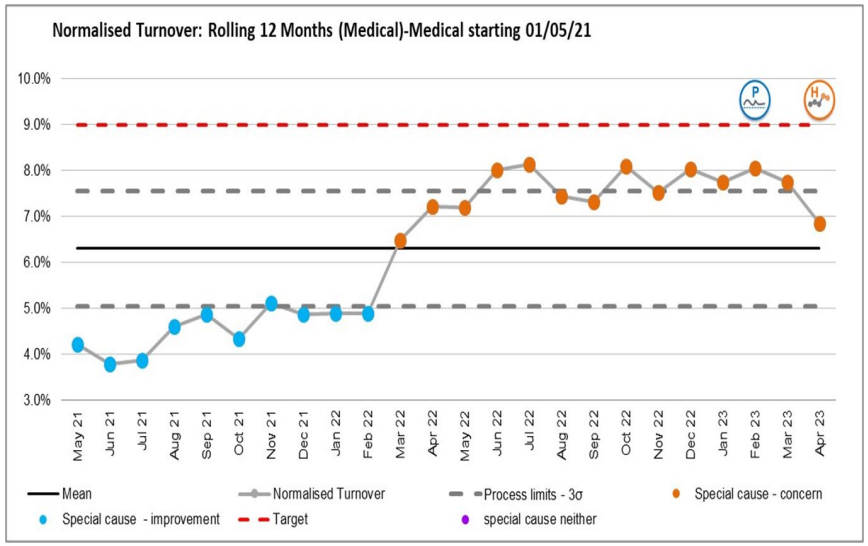
- Recruitment continues at pace for this staff group with a net increase of just over 2 WTE in month and a further 112WTE staff working towards their NMC registration.

Attract, Recruit & Retain

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better







Key Issues & Challenges

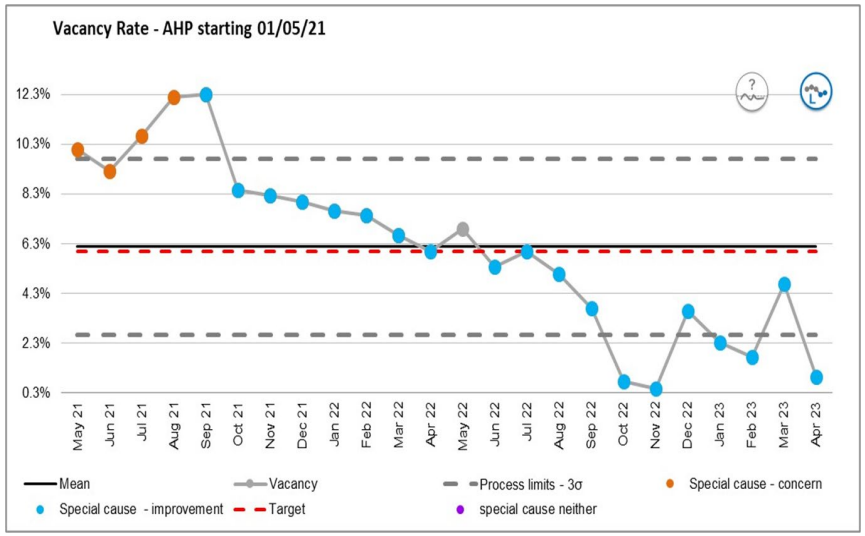
- The vacancy rate has risen as the number of established posts has been increased in month.
- Whilst the overall position is hugely positive, there are some hotspots in key services where vacancy levels give cause for concern, such as in clinical oncology, emergency medicine and microbiology.

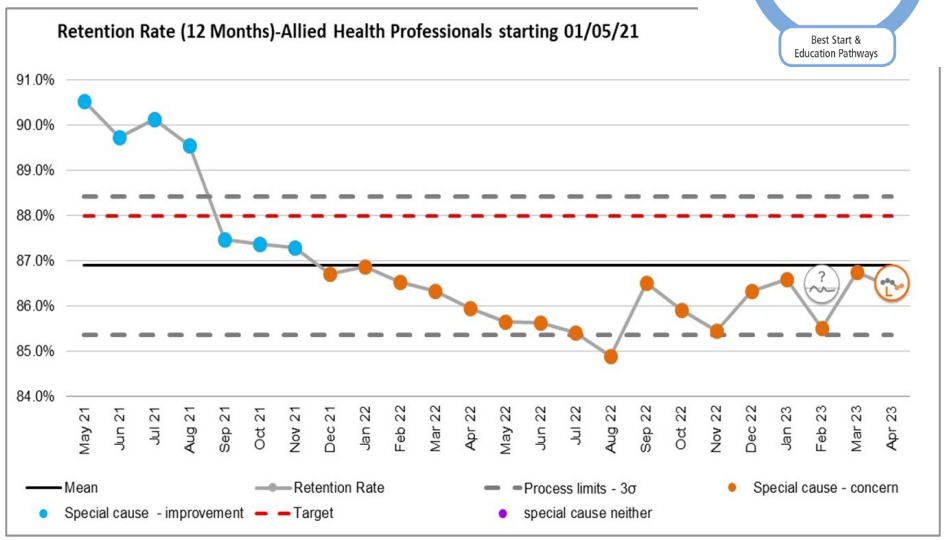
Key Actions & Progress

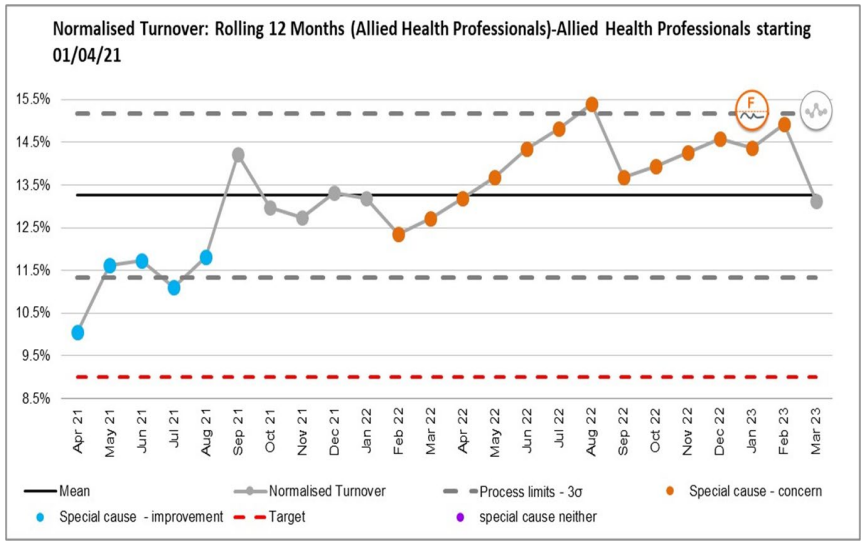
- All recruitment and retention metrics for medical staff are being met.
- There has been successful Consultant recruitment in Cardiology, Histopathology, Urology, Emergency Medicine, Respiratory, Diabetes, Gastroenterology and Acute Medicine. A CESR post has been developed in Microbiology where the Consultant post has been previously advertised without success.

Attract, Recruit & Retain

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better





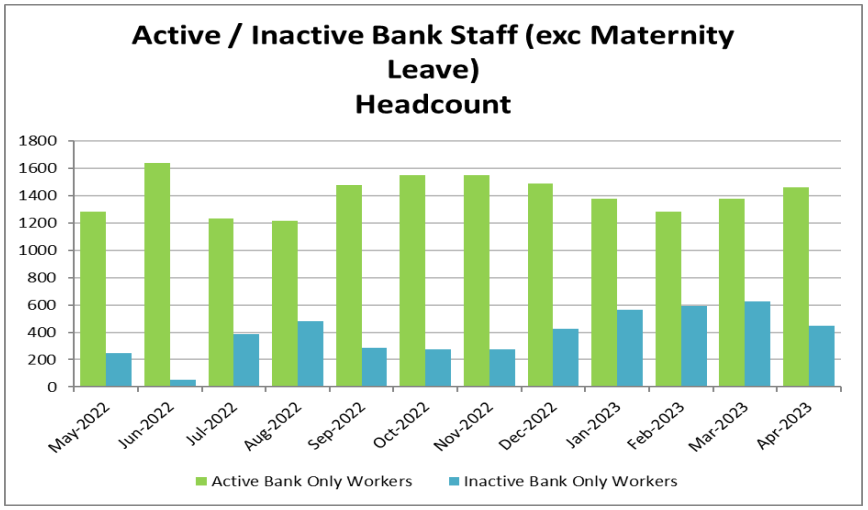


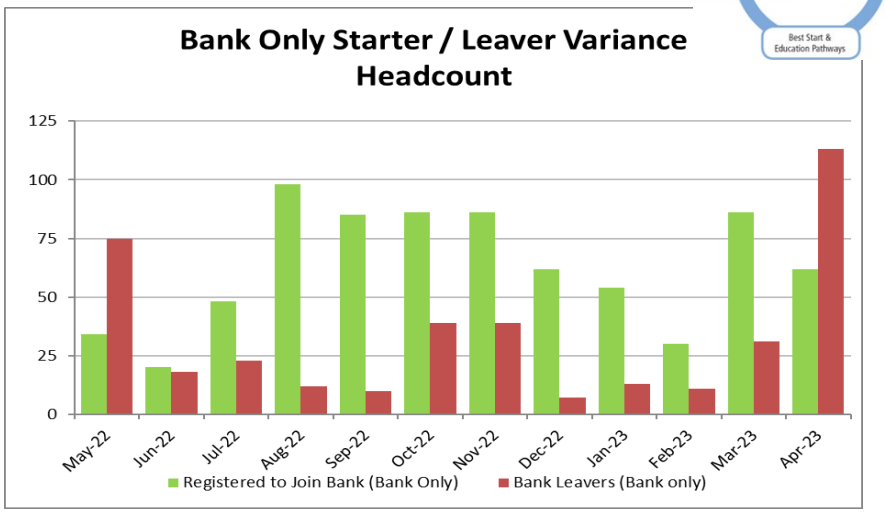
Key Issues & Challenges

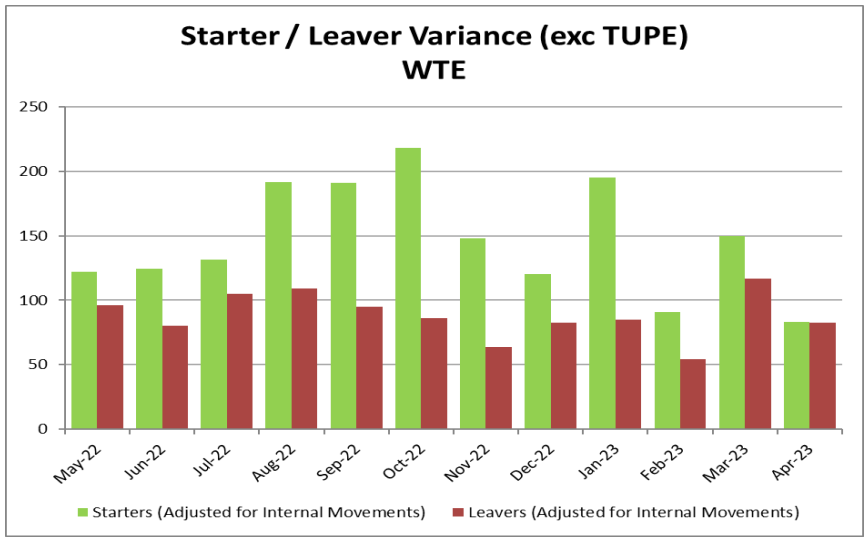
- Metrics for AHPs cover Podiatry, Dietetics, Occupational Therapy, Physiotherapy, Orthoptics, Radiography (diagnostic and therapeutic), Orthotics, Speech and Language Therapy (SaLT), and Operating Department Practitioners (ODPs).
- There are hotspots in particular staff groups, specifically, Chiropody/ Podiatry (2.6WTE, 19.91%), Dietetics (4.46WTE, 17.04%), Occupational Therapy (11.42WTE, 13.83%) and Operating Department Practitioners (8.41WTE, 9.51%).
- Turnover for AHPs is elevated.

Key Actions & Progress

- AHP vacancy levels overall are now meeting the Trust target over the last 10 months, the first time since April 2020.
- Radiology has seen significant improvements in vacancy rates which have shifted from over target to an over-established position as part of a management of change. International recruitment continues to be a success in radiology.
- Two offers have been made for internationally recruited Podiatrists through the NHSE programme for which RWT is the lead recruiter.
- Temporary staffing arrangements are in place for vacancies where necessary to ensure services are appropriately staffed.







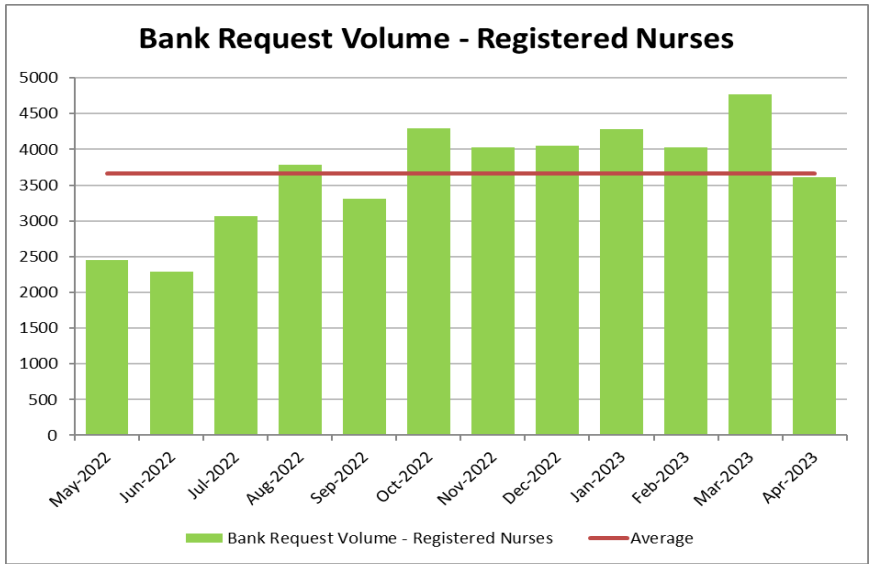
Key Issues & Challenges

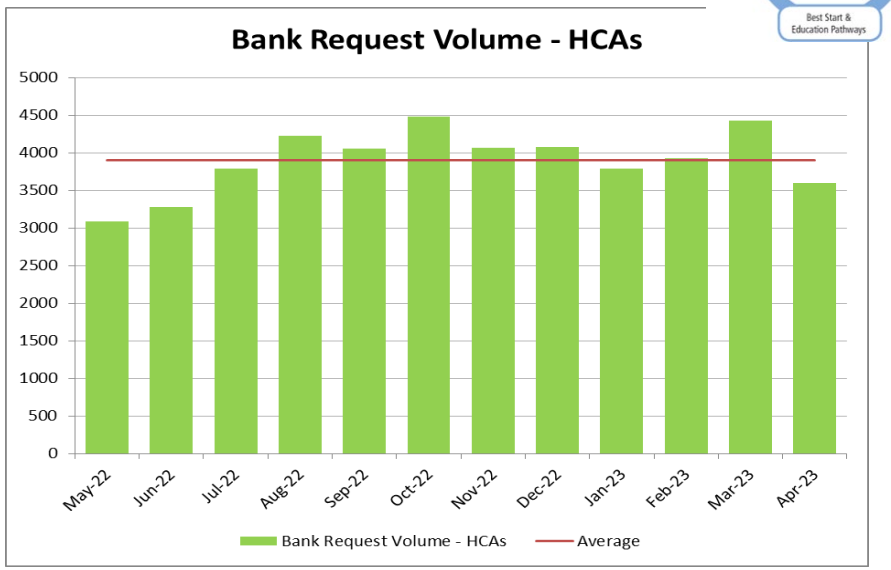
- There continues to be an issue with late requesting of shifts through the bank.
- 479 Late requested shifts (within and over 24 hours of the start time of the shift). A reduction on 731 late requests in the prior month. 315 of these shifts have been identified that prior notice may have been given, in addition 127 requests were requested more than 24 hours after the start time of the shift, with no opportunity to fill the shift.

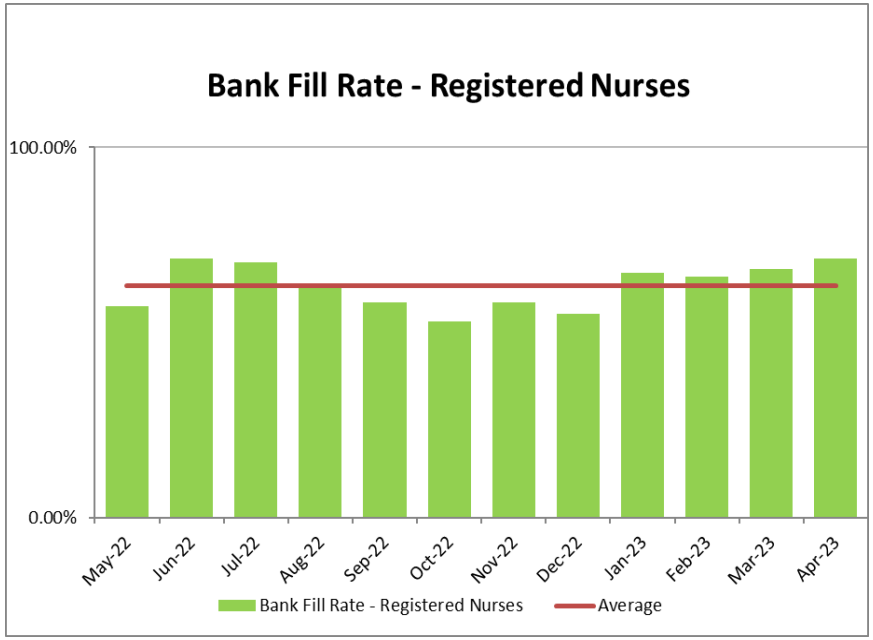
Key Actions & Progress

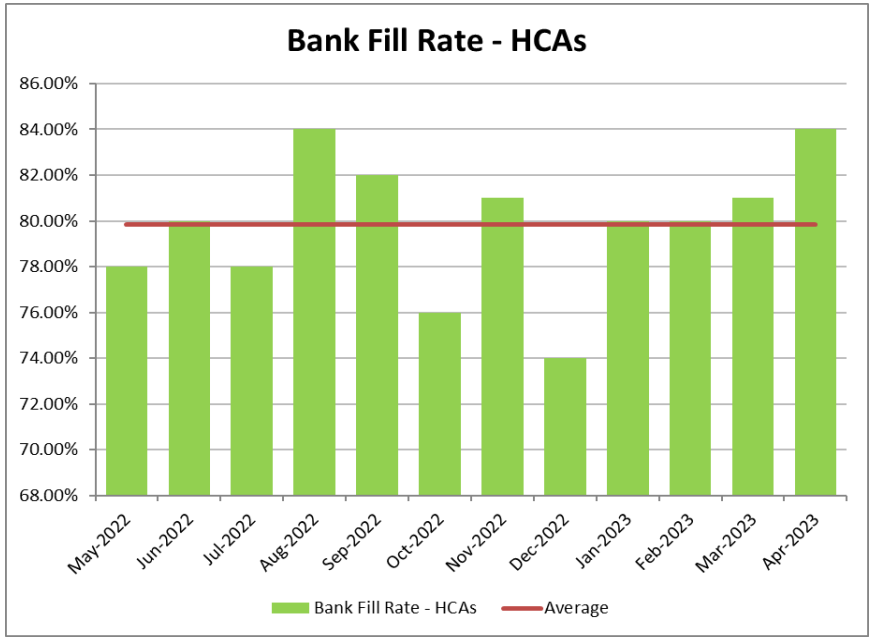
- The previously agreed additionally enhanced rate for bank work in the Emergency Department ceased on the 16th April and reverted to Enhanced Rate of £5 per hour from the 17th April. This same rate was applied to registered staff on A5, A6, A12 and chemotherapy trained Registered staff on the clinical haematology unit.
- Continued high levels of internal new starters to the bank with 47 registered nursing staff and 21 unregistered staff signing up to the bank in April 2023.
- 19 Students to join Bank as HCAs and are currently in offer stage.

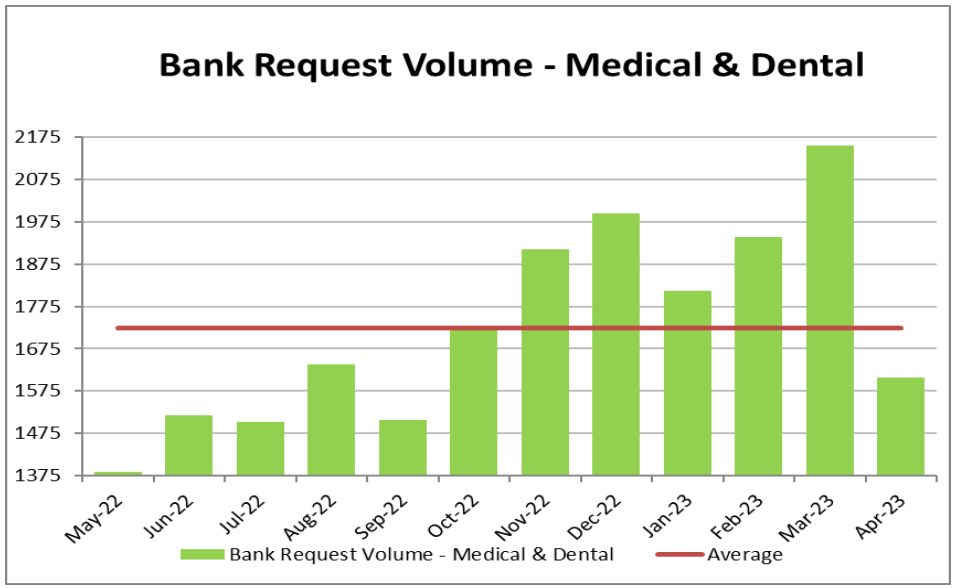

Employer Branding, Attraction, Recruitment & Retention
Career Pathways & Succession Planning
Best Start & Education Pathways
Apprentices & Graduates

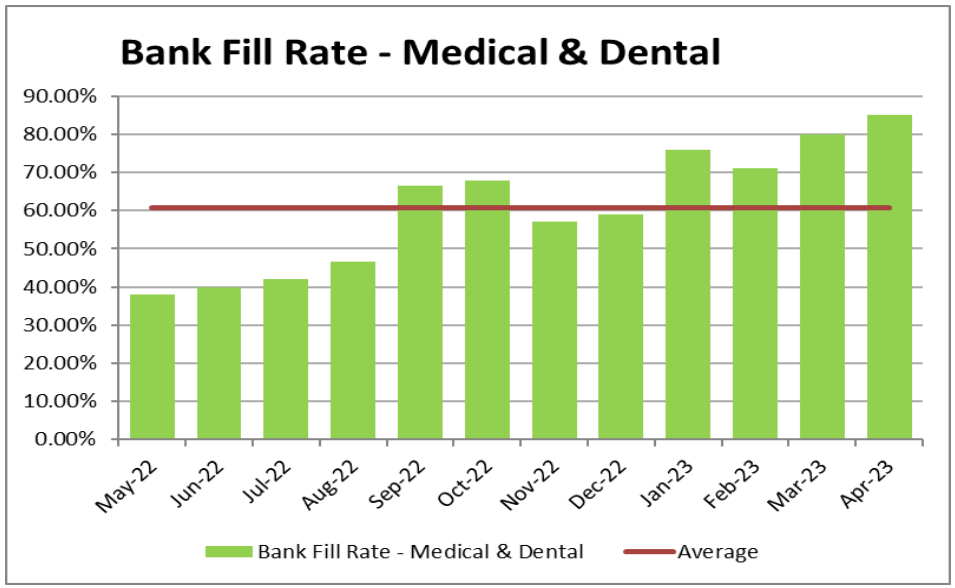

Bank Request Volume - Registered Nurses
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
May-2022
Jun-2022
Jul-2022
Aug-2022
Sep-2022
Oct-2022
Nov-2022
Dec-2022
Jan-2023
Feb-2023
Mar-2023
Apr-2023
Bank Request Volume - Registered Nurses
Average


Bank Request Volume - HCAs
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
Bank Request Volume - HCAs
Average


Bank Fill Rate - Registered Nurses
100.00%
0.00%
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
Bank Fill Rate - Registered Nurses
Average


Bank Fill Rate - HCAs
86.00%
84.00%
82.00%
80.00%
78.00%
76.00%
74.00%
72.00%
70.00%
68.00%
May-2022
Jun-2022
Jul-2022
Aug-2022
Sep-2022
Oct-2022
Nov-2022
Dec-2022
Jan-2023
Feb-2023
Mar-2023
Apr-2023
Bank Fill Rate - HCAs
Average





Key Issues & Challenges

Bank fill rates are as follows:
- 85% for medical staff in month
- 67% for registered nursing staff in month
- 81% fill rate for HCSW staff in month

- No further collaborative bank shifts booked by Walsall colleagues.
- Clinical system accesses for medical collab bank workers - further work to be done, review with IT required to make accessing systems much simpler for collab bank worker.
- Robot Utilisation – further work to continue. Successful use for ED as large amount of vacant shifts.
- Manual entry of shifts still in place for ad hoc shifts covering sickness etc.
- Bank request levels for HCSW and registered nurses both dropped slightly over the last month.
- Drivers for bank demand continues to be higher levels of absence, coupled with increased demand due to operational pressures.

Key Actions & Progress

- Bank demand reduced across all staff groups in month.
- Medical bank fill rate has sustained its increase from circa 40% to 85%. This improvement is due to medical staff continuing to join the medical locum bank internally and externally.
- Further promotion of collaborative bank across WHT and RWT.
- Continued work to increase supply of bank staff across all staff groups.
- Health Roster Accreditation training was successfully completed for two members of the team. Other team members have been booked onto the training in July 23.

Education / Organisational Development	BCPS	Corporate	Division 1	Division 2	Division 3	Division 4	Estates	Grand Total
Mandatory Training - Statutory Topics	90.90%	96.30%	94.90%	94.20%	96.10%	94.20%	97.50%	95.10%
Mandatory Training - Policy Required	95.10%	97.70%	93.10%	92.50%	96.10%	97.00%	98.00%	94.30%
Appraisal	89.20%	80.80%	80.90%	81.20%	81.20%	86.30%	90.90%	83.70%

Mandatory Training - Statutory Topics	Feb-23	Mar-23	Apr-23
225 Black Country Pathology Service	91.80%	91.90%	90.90%
225 Corporate Division	96.10%	96.30%	96.30%
225 Division 1	94.30%	94.70%	94.90%
225 Division 2	94.30%	94.20%	94.20%
225 Division 3	95.70%	96.10%	96.10%
225 Division 4	91.30%	94.10%	94.20%
225 Estates & Facilities Division	98.20%	97.80%	97.50%
Grand Total	94.90%	95.10%	95.10%

Mandatory Training - Policy Required	Feb-23	Mar-23	Apr-23
225 Black Country Pathology Service	95.20%	95.50%	95.10%
225 Corporate Division	97.50%	97.60%	97.70%
225 Division 1	92.50%	93.00%	93.10%
225 Division 2	92.40%	92.50%	92.50%
225 Division 3	95.80%	96.40%	96.10%
225 Division 4	96.10%	96.90%	97.00%
225 Estates & Facilities Division	98.60%	98.10%	98.00%
Grand Total	94.00%	94.30%	94.30%

Appraisals	Feb-23	Mar-23	Apr-23
225 Black Country Pathology Service	87.50%	88.40%	89.20%
225 Corporate Division	82.20%	81.00%	80.80%
225 Division 1	77.90%	79.80%	80.90%
225 Division 2	81.60%	83.90%	81.20%
225 Division 3	85.50%	88.10%	86.00%
225 Division 4	83.10%	84.50%	86.30%
225 Estates & Facilities Division	92.80%	92.00%	90.90%
Grand Total	83.00%	84.40%	83.70%

Key Issues & Challenges

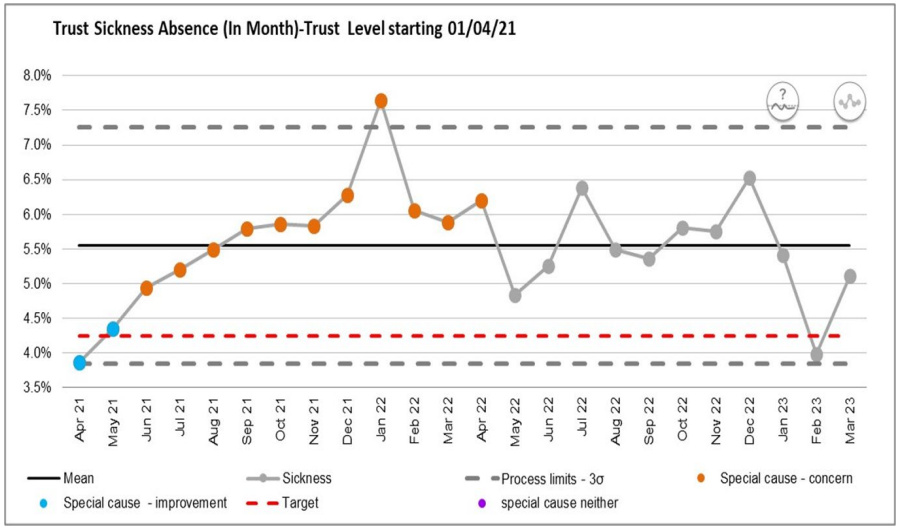
- Appraisal compliance is not meeting the target across the board and the last time this target was met was in December 2019.
- Particular focus is needed in corporate and Divisions 1 and 2 where performance is most challenged.
- Service pressures have had and continue to have a profound effect on the ability to undertake timely appraisals

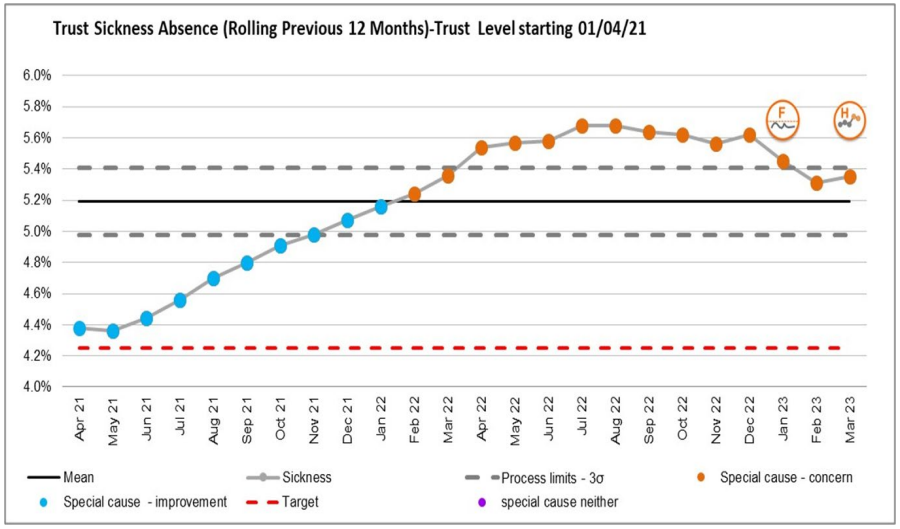
Key Actions & Progress

- This matter has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.
- Within Divisions, directorates and departments have been required to produce recovery plans for the delivery of appraisal activity and this will be managed through the Divisions.
- Mandatory training, both Tier 1 and Tier 2 continues to meet the Trust target.

Health & Wellbeing

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better





Key Issues & Challenges

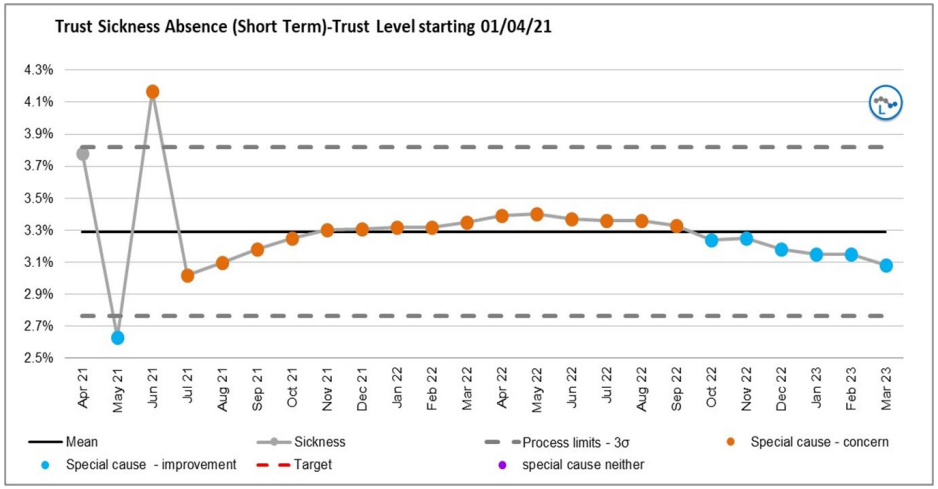
- The rolling 12 month absence rate remains above the Trust target at 5.31% despite an improvement in month..
- In month sickness absence has reduced to 3.99%, meeting the target, in February 2023.
- Occupational Health referrals reduced in April to 178 from 232 in March. There is generally a reduction in referrals around the bank holiday and April 2022 saw 146 referrals. The average for 2022/23 was 213 referrals per month.

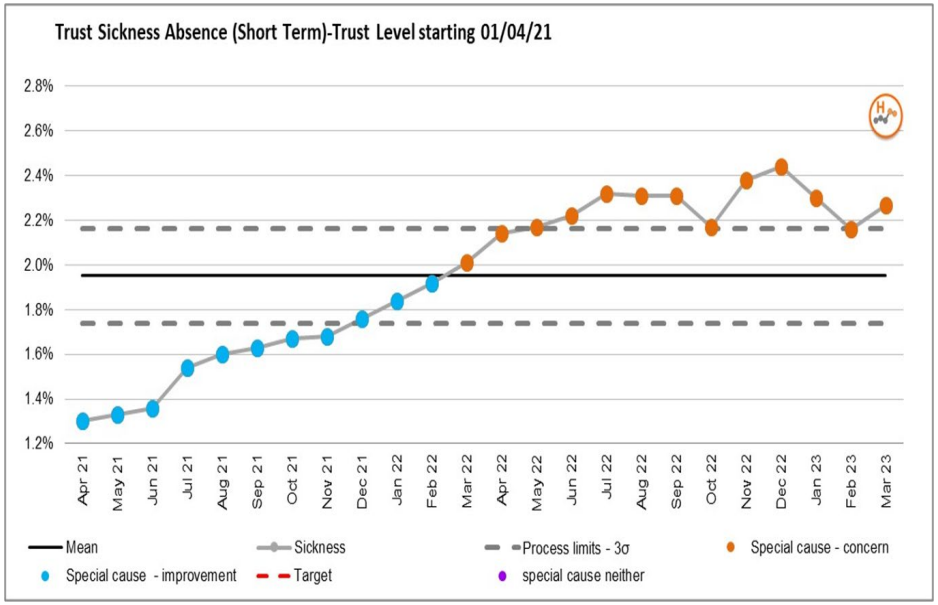
Key Actions & Progress

- 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 commence in September and future reports will include information on uptake.
- Occupational Health appointments with nurses have been made within the required timeline in 98% of cases despite the increase in activity as have 82% of referrals requiring a doctor were seen on the required timeline in April.

Health & Wellbeing

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better





Key Issues & Challenges

- Of the 5.00% target for sickness absence, it is typical for around 60% of the threshold (3.00%) to be attributable to long-term sickness absence and the remaining 40% (2.00%) to short term absence.
- Both absence types continues to be above this indicative 'targets' in March 2023. 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.

Workforce Metrics - Trust Board
M1: Data Effective 1st April 2023
Full Trust

The Royal Wolverhampton NHS Trust

B01	Workforce Profile	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Change Out-turn	Comments
B01.1	Substantive Staff WTE	9999.33		10002.13												2.80	Inc Permanent, Fixed Term, & Locums with WTE on Payroll
B01.2	Substantive Staff WTE (Exc Rotational Doctors)	9682.42		9687.54												5.12	Inc Permanent, Fixed Term, & Locums; Exc Rotational Drs
B01.3	Substantive Staff Headcount	11,371		11,379												8	Inc Permanent, Fixed Term, & Locums with WTE on Payroll
B01.4	Bank Staff Only Headcount	2,017		1,918												-99	
B01.5	Agency LMS Headcount	156		157												1	
B01.6	% Staff from a BME background	35.66%		36.41%												0.75%	
B01.7	TUPE In WTE	0.00		0.00												0.00	
B01.8	TUPE Out WTE	19.11		10.08												10.08	
	Data Owner: Workforce Planning & Business Intelligence																

B02	Changes to Workforce Profile	31st Mar 2023 Out-turn	Target	2023-2024 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)			-31.47												-31.47	
B02.2	Starters WTE (Exc Rotational Doctors)			114.67												114.67	Leavers current month target calculated as 1/12th of 10.5% of in-month Staff in Post
B02.3	Leavers WTE (Exc Rotational Doctors)			82.70												82.70	
	Data Owner: Workforce Planning & Business Intelligence																

B03	Workforce Profile by Staff Group	31st Mar 2023 Out-turn	Target	2023-2024 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	276.83		275.48												-1.35	
B03.2	Additional Clinical Services WTE	1,907.91		1,895.79												-12.12	
B03.3	*Add Clin Serv: Newly Qualified / Overseas Nurses Awaiting PIN*	*114.52*		*111.60*												-2.92	
B03.4	Administrative and Clerical WTE	2,162.10		2,170.84												8.74	
B03.5	Allied Health Professionals WTE	568.46		566.16												-2.30	
B03.6	Estates and Ancillary WTE	596.55		600.58												4.03	
B03.7	Healthcare Scientists WTE	499.42		499.13												-0.29	
B03.8	Medical and Dental WTE (Exc Rotational Doctors)	788.59		794.69												6.10	
B03.9	Medical and Dental WTE (Rotational Doctors)	316.91		314.59												-2.32	
B03.10	Nursing and Midwifery Registered WTE	2,863.55		2,865.87												2.32	
B03.11	Students WTE	19.00		19.00												0.00	
	Data Owner: Workforce Planning & Business Intelligence																

B04	Vacancy Rate by NHSI Staff Group	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B04.1	Total	2.87%	6.00%	3.40%												3.40%	
B04.2	Allied Health Professionals	4.66%	6.00%	0.93%												0.93%	Staff in Post WTE vs Budgeted WTE in ESR Refined calculation 2019/20: removal of recharges and reserves from
B04.3	Healthcare Scientists	15.00%	6.00%	1.29%												1.29%	Budgeted WTE therefore not directly comparable to previous figures
B04.4	Medical & Dental	4.75%	6.00%	7.63%												7.63%	Staff Group definitions determined by NHS Improvement
B04.5	NHS Infrastructure Support	5.98%	6.00%	3.65%												3.65%	Staff in Post ajusted for St Helen's employed Rotational Doctors and
B04.6	Other ST&T	-10.47%	6.00%	-0.26%												-0.26%	removal of Chair / NEDs
B04.7	Registered Nursing, Midwifery and Health Visiting Staff	1.96%	6.00%	4.03%												4.03%	
B04.8	Support to Clinical Staff	-0.04%	6.00%	2.18%												2.18%	RAG ratings updated effective May 21
	Data Owners: Finance & Workforce Planning & Business Intelligence																

B05	Vacancies by NHSI Staff Group	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B05.1	Total	296.27		352.02												352.02	
B05.2	Allied Health Professionals	27.98		5.36												5.36	Staff in Post WTE vs Budgeted WTE in ESR
B05.3	Healthcare Scientists	91.08		6.70												6.70	Refined calculation 2019/20: removal of recharges and reserves from
B05.4	Medical & Dental	56.40		93.90												93.90	Budgeted WTE
B05.5	NHS Infrastructure Support	86.86		52.08												52.08	Staff Group definitions determined by NHS Improvement
B05.6	Other ST&T	-22.04		-0.60												-0.60	Staff in Post ajusted for St Helen's employed Rotational Doctors and
B05.7	Registered Nursing, Midwifery and Health Visiting Staff	57.44		120.91												120.91	removal of Chair / NEDs
B05.8	Support to Clinical Staff	-1.45		73.67												73.67	
	Data Owners: Finance & Workforce Planning & Business Intelligence																

B06	Turnover	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B06.1	% Total Workforce Turnover (Rolling previous 12 months)	12.56%		12.50%												12.50%	Exc Rotational Drs (reflects NHS Digital Benchmarked data)
B06.2	% Normalised Workforce Turnover (Rolling previous 12 months)	11.03%	10.00%	10.95%												10.95%	
B06.3	% Normalised: Additional Professional, Scientific, and Technical	12.36%	10.00%	10.72%												10.72%	
B06.4	% Normalised: Additional Clinical Services	10.95%	10.00%	10.91%												10.91%	
B06.5	% Normalised: Administrative and Clerical	10.37%	10.00%	10.55%												10.55%	Exc Rotational Drs, Students, TUPE Transfers, End of Fixed Term
B06.6	% Normalised: Allied Health Professionals	13.12%	10.00%	13.29%												13.29%	
B06.7	% Normalised: Estates and Ancillary	11.39%	10.00%	10.88%												10.88%	RAG ratings updated effective May 21
B06.8	% Normalised: Healthcare Scientists	13.68%	10.00%	13.40%												13.40%	
B06.9	% Normalised: Medical and Dental (Exc Rotation Drs & Clinical Fellows)	7.75%	10.00%	6.86%												6.86%	
B06.10	% Normalised: Nursing and Midwifery Registered	11.14%	10.00%	11.21%												11.21%	
	Data Owner: Workforce Planning & Business Intelligence																

B07	Retention Rate	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B07.1	Retention Rate (12 months)	88.98%	88.00%	88.81%												88.81%	No. Employees with 1 or more years service now / No. Employees
B07.2	Retention Rate (18 months)	84.27%		84.01%												84.01%	employed one year ago x 100. Exc Rotational Drs, Students, TUPE
B07.3	Retention Rate (24 months)	80.41%		80.08%												80.08%	Transfers, Clinical Fellows, & Fixed Term
	Data Owner: Workforce Planning & Business Intelligence																

B08	Sickness Absence (1 month in arrears)	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B08.1	% Sickness Absence (In Month)	5.11%	5.00%	Available June													
B08.2	% Sickness Absence (Rolling previous 12 months)	5.35%	5.00%	Available June													
B08.3	WTE Days lost to Sickness	11,084.90		Available June													
B08.4	% Short Term Sickness	2.16%		Available June													
B08.5	% Long Term Sickness	3.15%		Available June													
B08.6	Estimated Cost of Sickness (£)	£1,091,089		Available June													
Data Owner: Workforce Planning & Business Intelligence																	

B09	Flu Campaign	2022-23 Season Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Cumulative	Comments
B09.1	Front Line Staff Vaccinated (Cumulative)	3828															Seasonal reporting only. Figures reported here those submitted to Public Health England for month-end periods. Figures can fluctuate due to leavers percentage.
B09.2	Non Front Line Staff Vaccinated (Cumulative)	1619															
B09.3	Total (Cumulative)	5051															
B09.4	% Front Line Staff Vaccinated (Cumulative)	61.73%	TBC														
Data Owner: Workforce Planning & Business Intelligence																	

B10	Open Employee Relations Cases - Number of Cases	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B10.1	Open Formal Grievances Cases + Open Bullying & Harassment Cases	41		32												32	
B10.2	Open Capability Cases	2		2												2	
B1103	Open Disciplinary Cases	36		36												36	
Data Owner: HR Employee Relations																	

B11	Freedom to Speak Up	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Cumulative	Comments
B11.1	New Genuine Whistleblowing Cases Raised	0														0	Cases reviewed and confirmed as Whistleblowing by FtSU Guardian. Discu
B11.2	Number of Concerns Raised through FTSU Guardian In Month	14		9												9	
Data Owner: Freedom to Speak Up Guardian																	

B12	Apprenticeships	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Cumulative	Comments
B12.1	Number of New Apprentices Started in Month	3		35												35	
B12.2	Number of Existing Staff Converted to Apprentices in Month	2		5												5	
Data Owner: Education & Training																	

B13	Education / Organisational Development	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B13.1	Trust Induction	90.00%	0.00%	89.80%												86.08%	
B13.2	Local Induction	94.30%	0.00%	94.50%												81.91%	
B13.3	Mandatory Training - Tier 1 - Statutory Topics (Formerly "Generic")	85.00%	85.00%	95.10%												95.13%	
B13.4	Mandatory Training - Tier 2 - Policy Required (Formerly "Specific")	94.30%	85.00%	94.30%												92.91%	
B13.5	Appraisal	90.00%	90.00%	83.70%												79.62%	
Data Owner: Education & Training																	

B14	Temporary Staffing Spend - Agency	2022-23 Total	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Cumulative	Comments
B14.1	Agency Spend - Total	£7,594,396		£721,813												£721,813	
B14.2	Agency Spend - Nursing & Midwifery	£0														£0	
B14.3	Agency Spend - Medical Staff	£6,298,177		£607,200												£607,200	
B14.4	Agency Spend - Other	£1,296,219		£65,325												£65,325	
Data Owner: Finance																	

B15	Temporary Staffing Spend - Bank	2022-23 Total	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Cumulative	Comments
B15.1	Bank Spend - Total	£37,183,785		£3,594,410												£3,594,410	
B15.2	Bank Spend - Nursing & Midwifery	£7,607,648		£751,216												£751,216	
B15.3	Bank Spend - Medical Staff	£13,584,214		£1,193,826												£1,193,826	
B15.4	Bank Spend - Other	£15,991,923		£1,649,368												£1,649,368	
Data Owner: Finance																	

B16	Bank Fill Rate	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B16.1	Registered Nursing Shifts Filled	67.00%	85.00%	70.00%												70.00%	Previously reported as number of shifts, now reporting fill rate
B16.2	Unregistered Nursing Shifts Filled	81.00%	90.00%	84.00%												84.00%	
B16.3	Medical Staff Shifts Filled	80.00%	60.00%	85.00%												85.00%	
Data Owner: Resourcing and LMS																	

The Royal Wolverhampton NHS Trust

TRUST BOARD	
Meeting Date:	6th June 2023
Title of Report	Patient Experience Annual Report – annual summary for 2022/23
Action Requested:	**Receive and note.**
For the attention of the Board	
Assure	a) Compliance with statutory regulations for complaint handling i.e. The NHS and Social Care complaint Regulations 2009 has remained. In addition, complaint handling approach has continued to be based on the principles of good complaints handling. **b)** Embed a culture of learning and continuous improvement. **c)** Positive FFT scores when compared to Black Country and Birmingham ICB average.
Advise	• 545 formal complaints received for 2022/23. The greatest volumes received are ED (29% increase) and Obstetrics and Gynaecology (15% increase). From 558 cases closed, 70% of cases were not upheld, 25% were partially upheld and 5% were upheld. • The outcomes of PHSO investigations: 3 cases, all were partly upheld with a financial redress total of £1350 (£300, £300, £750). Themes emerging from those cases were related to communication, information, and complex complaint handling. • The Friends and Family Test overall average recommendation score for 2022/23 was 83%. When looking at the different touchpoints, there is a fluctuation of 8% with scores ranging between 77% and 85%. The Trust's scores are higher for all of the touchpoints when compared to the Black Country and West Birmingham STP with the exception of Community. Comparisons with national scores indicate that Outpatients and Birth are above national scores however all of the other touchpoints are below. • 174 new clinical volunteers have been recruited throughout the year. The service has also seen an expansion of medical and surgical wards receiving volunteer support with the development of admin roles in the Emergency Department, Discharge Lounge, Maternity, and Cardiology. • The core values of the Youth Volunteer programme continue to be embedded and this supportive approach is used to recruit and support a large number of young volunteers. The Trust continues to work with St Johns Ambulance on the 'NHS Cadets' programme (Advanced Level) and have been able to offer 4 volunteer opportunities to cadets in September 2022, and 10 in March 2023. • The Chaplaincy - Spiritual, Pastoral and Religious Care (SPaRC) Department has continued to provide its core business of providing spiritual, pastoral, and religious care and support across all parts of our hospital and healthcare communities; Average encounters per month 375, or approximately 15 encounters per working day.
Alert	• N/A

Author and Responsible Director Contact Details:	Tel 01902 695363 alison.dowling1@nhs.net Debra Hickman, Director of Nursing 01902 307999 ext 85961	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	d) Embed a culture of learning and continuous improvement
	Support our Colleagues	
	Improve the Healthcare of our Communities	
	Effective Collaboration	a) Implement technological solutions that improve patient experience b) Progress joint working across Wolverhampton and Walsall
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	N/A	
Risks: BAF/ TRR	N/A	
Risk: Appetite	N/A	
Public or Private:	Public	
Other formal bodies involved:	Quality Safety Assurance Group TMC Trust Board	
References	Data on Written Complaints in the NHS, 2021-22 - NDRS (digital.nhs.uk) accessed on 17/4/2023	
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:	To provide summary data on recent patient experience metrics relating to statutory and non-statutory function including Compliments, Friends and Family Test (FFT). The report also provides detail on learning taken and a summary of activity to support an enhanced positive Patient Experience including updates on National Surveys, Volunteering, and Spiritual, pastoral, and religious care.

Item/paragraph 1.0

Background

A report on patient and carer experiences is presented to the Trust Management Committee and the Board of Directors on a bi-monthly basis as part of the series of quality reports.

This report focuses on patient and carer experiences and how people are involved with and engaged in shaping service developments. This provides an opportunity for trends to be identified and for improvement and learning arising from outcomes.

Details

Feedback Data

The Trust received a total of **62,361** feedback contacts between April 2022 and March 2023. This includes all Patient Relations related contacts, along with Friends and Family Test and Feedback Friend responses.

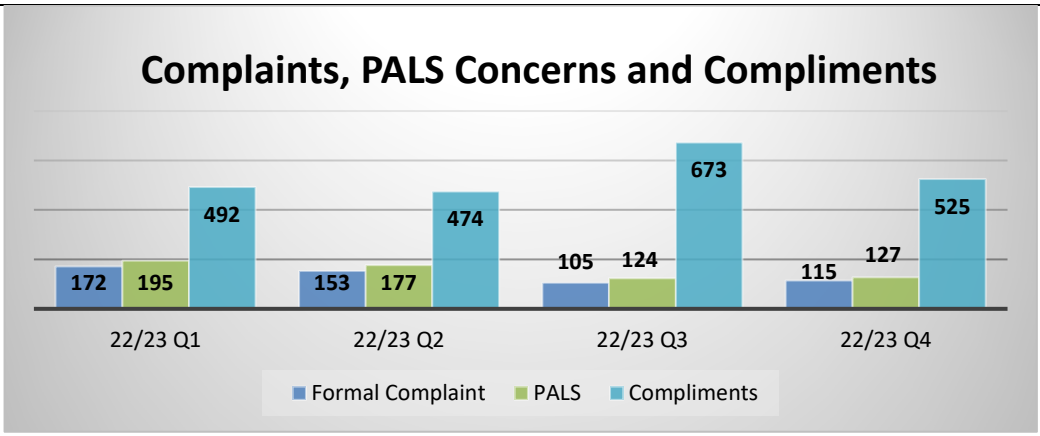
Complaints (including MP letters)	545
PALS Concerns	623
Local Resolution (October to March)	173
Compliments	2164
Friends and Family Test	58840
Feedback Friend (QR code)	16

Table 1. Patient Feedback by contact type

Formal Complaints, Patient Advice Liaison Service (PALS) Concerns and Compliments

There were 545 formal complaints received for the year 2022/23 compared to 562 the previous year. This represents a decrease of 3%. Areas of concern where the greatest volumes have been received when compared to the previous years are Emergency Department (ED) (29% increase) and Obstetrics and Gynaecology (15% increase).

Safeguarding concerns which are progressed through the formal complaints procedure as they do not meet the criteria for a Section 42 investigation are included in the total formal complaints received however this has seen a marginal increase from 50 in 2021/22 to 51 in 2022/23.



During the year 2022/23, from 558 cases which were closed, the Trust determined that 70% of cases were not upheld, 25% were partially upheld and 5% were upheld. As with the previous year, the Trust's performance measure for complaint outcomes were significantly lower than the national average of 33% (as recorded by NHS Digital for 2021/22[1]) for cases upheld.

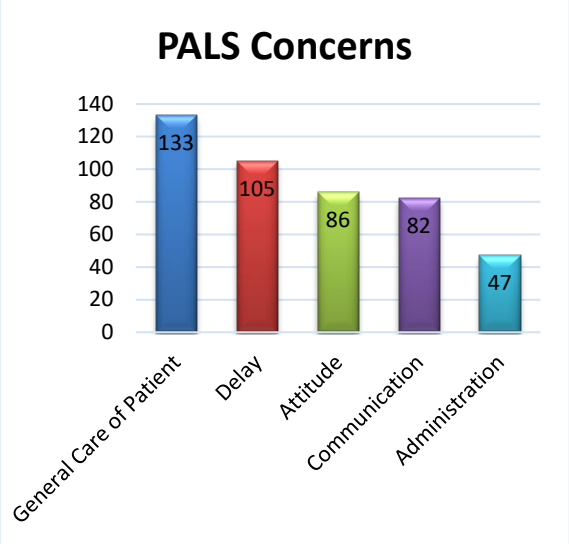
The volume of compliments received (2164) represents an increase of 36% on last year's total of 1592.

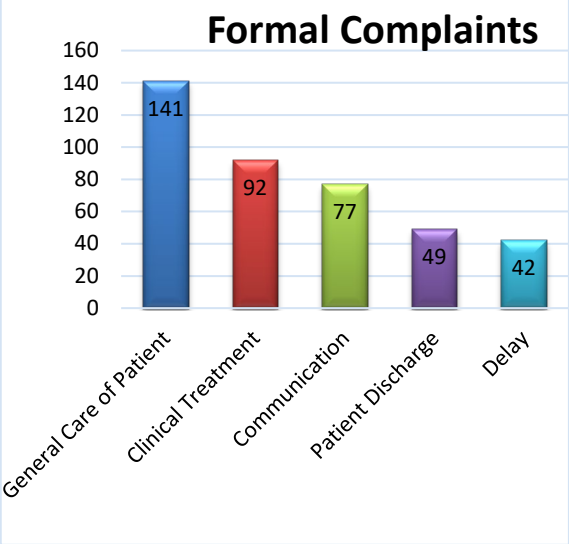
Quarter on quarter, there has been some fluctuation in the number of compliments received throughout the year although this is an increase when compared to the volume recorded in 2021/22 and far exceeds the volume of formal complaints and PALS concerns recorded.

Themes of Formal Complaints and PALS Concerns

During 2022/2023, there were 545 complaints raised. There is little variation between the key themes of complaints year on year, with the highest subjects being, general care of patient, attitude and communication, which is consistent with the previous year. The table below illustrates the top 5 categories for both formal complaints and PALS Concerns which shows some variance.

[1] Data on Written Complaints in the NHS, 2021-22 - NDRS (digital.nhs.uk) accessed on 17/4/2023



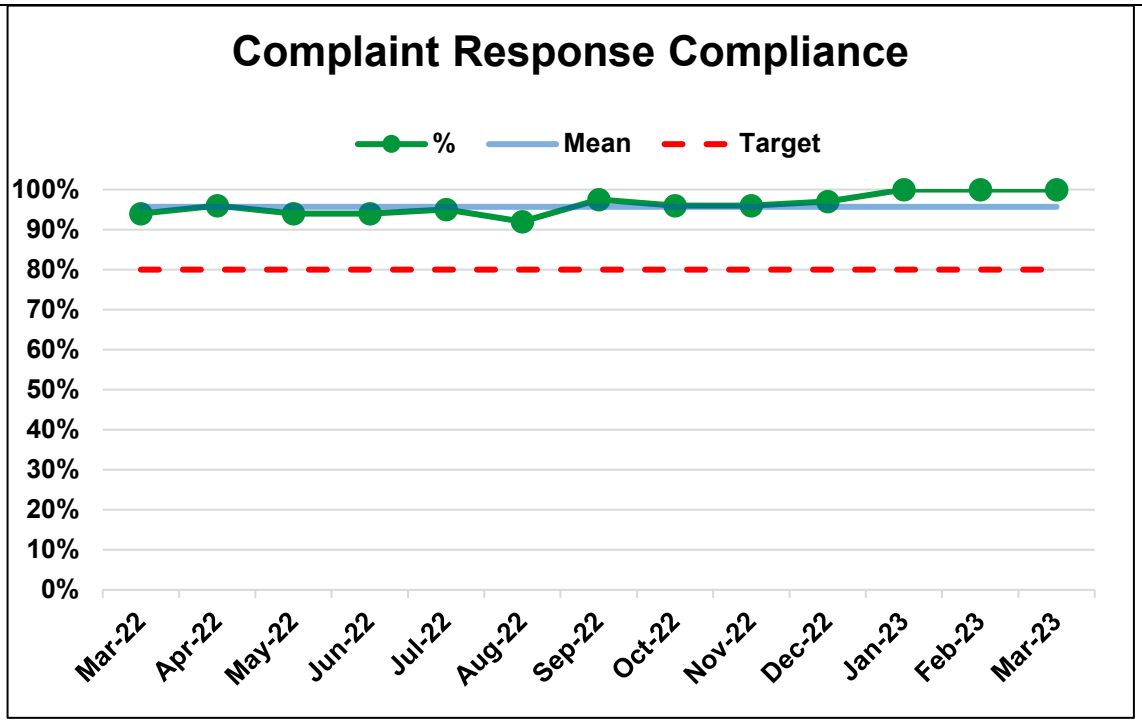


Responding to complaints and complaint outcomes

The Trust is required under the relevant complaints legislation to assess and record whether or not the issues were considered to be substantiated following investigation. The Trust will return the required annual KO41a collections to NHS Digital. The return records the number of written complaints received about hospital and community services made by, or on behalf of, patients received between 1st April 2022 and 31st March 2023.

The data includes the outcome of all complaints which are upheld, not upheld or partially upheld and is broken down by service area (which the complaint relates to) and by subject area (what the complaint was about) and is available on the public website. The outcome of a complaint is determined by the investigating officer and is substantiated by information gained as part of the investigation process and categorised using the methodology used by NHS Digital.

Complaint compliance is measured on the adherence to policy (30 working days) and gaining consent for an extension for completion. The Trusts compliance is shown below.



When compared to the previous year's overall performance the Trust overall has seen a positive 2% increase.

A more proactive approach and the implementation of more supportive measures by the Patient Experience Team has resulted in an increase in compliancy in the last six months of the year.

The Complaints Management Policy OP08 was subject to review and ratification this year with the Trust becoming an early adopter of the new Parliamentary and Health Service Ombudsman (PHSO) NHS Complaint Standards Framework, developed with the Care Quality Commission, General Medical Council, the Department of Health and Social Care, NHS England and NHS Resolution. Whilst the Trust continues to measure performance against the local 30 working day timescales, the Trust will also measure its compliance to timescales against the PHSO standards for responding to patient complaints during the standards implementation stage.

The table below shows the PHSO's definitions:

Complexity rating	Timescale for completion (from date of receipt to issue of our final response)	
Straightforward/single issue	95 % within 3 months	100% within 6 months
Complex/multiple issue or multiple organisations	50% within 3 months	80% within 6 months

For the new financial year, the Trust will also measure itself on meeting the PHSO timescales of 3 and 6 months for completion. This will require a further assessment of the complexity rating of the complaint.

Where a complaint has been partly or fully upheld, the Trust is requested to provide an action plan which sets out how it will improve services in the areas where the failings have been identified. Any identified learning is shared Trust wide via 'Risky Business' and is also shared via the Patient Experience newsletter which is released quarterly.

Each quarter a summary of all actions is provided to the divisional management teams in order to assist in promoting an ethos of reflection and learning Trust wide and to ensure that accountability at divisional level is customary. In conjunction with the information provided on the divisional dashboards, the Patient Experience Team liaise with relevant directorates to monitor and ensure compliance to identified actions.

Please note that the cases closed during the period may not necessarily correlate with the cases received due to the receipt date or completion dates falling outside of the respective reporting periods.

Learning from Complaints

A deep-dive approach was undertaken with regards to actions taken and learning from those complaints where the outcome was fully or partially upheld. The identified learning mostly correlated to the need for supplementary training and the provision of information, as opposed to facilitating service or policy procedure change.

A few examples include:

Information on the Dementia Specialist referral pathway to be included in the Induction Pack for Locums
Review and trial of dialysis service shift times to ensure continuity of service delivery and out of hours patient care.
Implementation of strategies for ensuring that all medication information is collated for patients admitted within the Elderly Medicine Directorate.
Creation of a combined toe walking pathway and accompanying patient information provide cohesive service delivery between Physiotherapy and Orthotics
Co-ordinated approach regarding communication to be embedded between nursing, patient flow and therapy staff prior to patient discharge.

The learning log for each quarter is extracted from Datix with resultant actions monitored by the Patient Experience Advisors to ensure compliance, provide assurance and where relevant, share good practice and learning with the wider Trust.

Parliamentary Health Service Ombudsman (PHSO)

In terms of the outcomes of PHSO investigations which were closed during 2022/23, (3 cases), it is noted that all three were partly upheld with a financial redress total of £1350 (£300, £300, £750). No other financial redress was awarded during the year.

Themes emerging from those cases were related to communication, information, and complex complaint handling.

Patient recommendation to Friends and Family

The Friends and Family Test (FFT) is a nationwide initiative which is a simple, single question survey which asks patients to what extent they would recommend the service they have received at a hospital department to family or friends who need similar treatment. The tool is used for providing a simple, headline metric, which when combined with a follow up question and triangulated with other forms of feedback, is used across services to drive a culture of change and of recognising and sharing good practice.

Results of these surveys are received monthly and shared at Directorate, Divisional and Trust Board level in the form of divisional dashboards.

The Trust believe that patient recommendation to their friends and family is a key indicator of the quality of care provided, and that our performance reflects that:

The Friends and Family Test recommendation scores are illustrated in the tables below. These include percentage changes on 2021/22 and the 2022/23 response rates. The Trusts overall average recommendation score for 2022/23 was 83%. When looking at the different touchpoints, there is a fluctuation of 8% with scores ranging between 77% and 85%. The Trust's overall response rate has varied between 15% and 20%.

In terms of the overall touchpoints for national reporting, the Trust's average quarterly reports are shown below with the comparison of the score against the 2021/22 year.

FFT	Inpatients and Day case (consolidated)				Outpatients				ED				Community			
	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*	Q1	Q2	Q3	Q4*
2022/23	92 %	92 %	91 %	92 %	93 %	93 %	94 %	94 %	71 %	71 %	65 %	72 %	90 %	87 %	90 %	91 %
2022/23 Comparison against 2021/22	-1	=	-1	+1	+12	+17	+12	+24 %	-4%	+3 %	-3%	=	-3%	-3%	-2%	=

FFT	Antenatal				Birth				Postnatal Ward				Postnatal Community			
	Q1	Q2	Q3	Q4 *	Q1	Q2	Q3	Q4 *	Q1	Q2	Q3	Q4 *	Q1	Q2	Q3	Q4 *
2022/23	77 %	89 %	78 %	86 %	91 %	95 %	90 %	93 %	80 %	82 %	84 %	87 %	86 %	82 %	83 %	82 %
2022/23 Comparison against 2021/22	-19 %	+22 %	-3%	+5%	-5%	+1 %	-3%	=	-6%	=	-1%	+4%	+3 %	-3%	-3%	-2%

* Q4 data subject to change inline with March 2023 data submissions for FFT being after reporting date.

The below table illustrates the percentage difference between the Trusts recommendation score for each touchpoint and the local STP and National results. The Trust scores higher for all of the touchpoints for the Black Country and West Birmingham STP with the exception of Community. Comparisons with national scores indicate that Outpatients and Birth are above national scores however all of the other touchpoints are below.

	Inpatients	Outpatients	ED	Comm	Antenatal	Birth	Postnatal Ward	Postnatal Comm
Trust overall	94%	69%	73%	92%	88%	95%	88%	77%
Compared to STP*	+3%	+4%	+2	-2%	+1%	+6%	+4%	+5%
Compared to National*	-4%	+3%	-5	-3%	-7%	+3%	-1%	-6%

* The Black Country and West Birmingham STP and National scores as at 28 February 2022.

Results of these surveys are received monthly and shared at directorate, divisional and Trust Board level in the form of divisional dashboards.

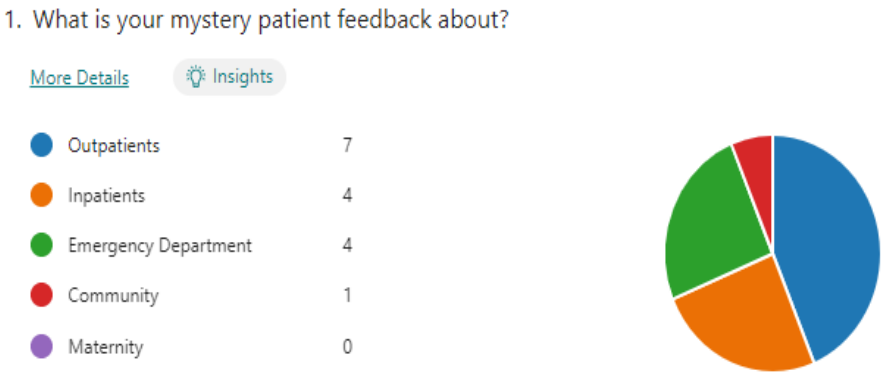
Throughout the year, the Trust had considered where their gaps were in surveying patients and worked with the FFT provider to improve the feedback for those areas.

The Trust have agreed improvement metrics as part of its recent enabling strategy and touchpoints will be monitored and reported on as part of the series of quality and patient experience reports.

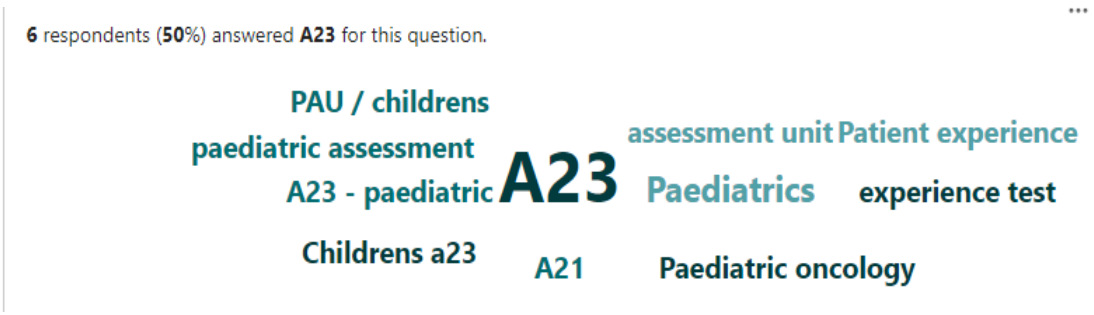
Learning from a successfully implemented programme at Walsall Healthcare Trust, the Patient Experience Team trialled a 'Mystery Patient' initiative in our Paediatric areas, from 1st January 2023.

The programme involves posters being displayed in patient areas with a QR code to scan, in which anonymous real time patient feedback can be provided, which is collated by the Patient Experience team and then shared with the clinical teams for their information and learning in real time.

Between 1st January 2023 and 31st March 2023 in the pilot phase, 16 pieces of patient feedback were provided using the initiative for which the results are as follows:
On the area the feedback is about:

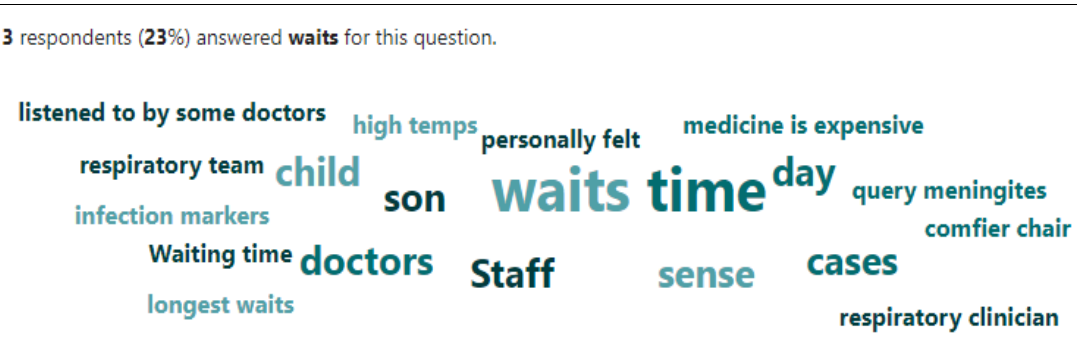


On a breakdown of the sub speciality within the area, 50 % of all feedback was about Children's Outpatients.



In what patients found good about the service received, 33% mentioned staff:

And in what can be improved, 23% mentioned waiting times as the biggest factor:



All feedback gained from this iniiative is shared with Matrons from the respective areas for action.

Following a discussion session with the Trusts Patient Involvement Partners (PIP's) on co-designing the project, they chose the name 'Feedback Friend' for the wider roll out following the pilot phase. A plan for wider implementation has been compiled and future results will feature in future reports.

CQC National Adult Inpatient Survey 2022

The 2022 Inpatient Survey was part of a National Survey Programme run by Care Quality Commission (CQC) to collect feedback on the experiences of inpatients using the NHS services across the country. The results contribute to the CQC's assessment of NHS performance as well as ongoing monitoring and inspections. The programme also provides valuable feedback for NHS trusts, which they can then use to improve patient experience.

Provisional results are due to be received by the Trust in June 2023. However, the official CQC results will not be released until September 2023 (date to be confirmed) and will feature in future reports.

Spiritual, Pastoral and Religious Care (SPaRC)

The Chaplaincy - Spiritual, Pastoral and Religious Care (SPaRC) Department has continued to provide its core business of providing spiritual, pastoral, and religious care and support across all parts of our hospital and healthcare communities; whether this has been an inpatient encounter at the bedside, supporting worried relatives, conducting a funeral service for grieving parents, or supporting staff as they face challenging work situations.

In 8 months of collecting data (Aug- March) they made 3004 significant pastoral encounters. Scaling that up to 12 months that is 4506 encounters over the year. That's equivalent to 375 encounters per month, or approximately 15 encounters per working day.

The most common duration of an encounter is 15-30 minutes. So, in 2022/23 they provided at least 1125-2250 hours of SPARC care – that's equivalent to 30 -60 weeks of non-stop spiritual, pastoral, and religious care.

It is noted that whilst 78% of support went to patients, 14% of their support went to staff. This is a significant area for Chaplaincy and for the Trust. Staff need care and support too, and Chaplaincy ought to be well placed organisationally and in terms of skills set to meet, support and care for the staff who provide the care to the patients. Support has been varied – from a quick chat on the corridor, to gently checking in over a period of weeks, to supporting individuals and departments following traumatic events or the sad and sudden deaths of staff members. Over the past year Chaplaincy have led 3 memorial services for staff members.

The team have supported the following this year as well as the standard ward visits-

- Supported Viewings
- Adult Funerals
- Pregnancy Loss
- Baby Funerals

And the following religious festivals during this time:

- Easter 2023
- Ramadan 2022/23
- Vaisakhi 2022/23
- Diwali 2022
- Bandi Choir 2022
- Annual Babies Memorial Service 2022
- Babies Christmas Act of Remembrance 2022
- Christmas Service 2022

With the increase in Chaplaincy visibility in and around the hospital, the response has been encouraging, with growing numbers of ward referrals and a flow of positive feedback from patients and staff. With a growing team Chaplaincy aim to greater serve the SPaRC needs of those who are under the care of the Trust, but also build partnerships with the surrounding community.

Engagement, Involvement and Experience

15 Steps Initiative – This is an NHS England and Improvement and collaborative initiative whose purpose is to help staff, service users and others to work together to identify improvements that can be made to enhance the service user experience.

This initiative, arranged by the Wolverhampton Maternity Voices Partnership (MVP) was undertaken within Maternity Services in February 2023. The Patient Experience team supported the facilitation of which 6 areas were visited - Neo natal, Maternity Ward, MLU, Triage, Delivery Suite, and Transitional Care. An action plan has been compiled by the MVP which has been shared with the Senior Maternity staff and progress will be discussed within the Matron's meetings and actions fed back to the MVP.

Renal and Diabetes wards were attended in October 2022 with a team of directorate management staff, nursing staff, and Patient Involvement Partners (PIP's). Feedback was shared with the Directorate team who discussed within their Governance meetings.

In March 2023 15 steps visits were made to Wards C22 and C25 with the same groups of staff and patient representatives. Following these visits, feedback was provided to the Senior Matron.

NHSEI Funding - The Patient Experience Team commenced work on the Anti-Aggression/Conflict Customer Skills training sessions for ED in January 2022.

In order to ensure that the training was relevant, a scoping exercise was undertaken within the ED department in order to establish what knowledge was needed about the situations that staff faced and had to deal with. Also, what their skills and knowledge were at that time around identifying and managing conflict and identifying how their own skills could alleviate or contribute to conflict situations. This included a survey which was sent out to ED staff for completion and return alongside a few observation sessions within the department at various times of the day, and analysis of complaints data to identify any relevant trends and themes.

Following completion of the training, between January 22 and February 23 ED it was established that prior to the training between January and December 2021, there were 20 complaints aligned to ED under the category of attitude of which 2 had a sub subject of aggression. On completion of the training a review of complaints received showed that they had 13 complaints aligned under the category of attitude of which none were recorded under the sub subject of aggression. This shows a positive 35% reduction in the number of complaints for which the main subject of dissatisfaction was attitude and a 100% reduction for those attributed to aggression.

Following the successful engagement and delivery of these training sessions the Patient Experience Team have been asked to deliver this training to a wider range of Trust staff as the knowledge and skills are transferrable. This includes Maternity Services, Junior Doctors, Preceptorship and GP Surgeries aligned to the Trust.

Co Production – The Ward Notice Boards/ Adult Boards were co-produced in collaboration with the Trusts Patient Involvement Partners (PIP's) in January 2023. Children from St Anthony's Primary School worked collaboratively with the Patient Experience Team to produce the Paediatric Ward Welcome Board in March 2023.

Dudley Voices for Choice Self Advocacy group were visited by the Patient Experience Team in February 2023 to gather service user general feedback on 'what makes a hospital stay better for a person who has learning disabilities'.

EDI - Sickle Cell and Thalassaemia**.** The Patient Experience Team have implemented a short life working group meets on a regular basis to address issues for patients with sickle cell and thalassemia conditions. The group, which includes patients, community representation and RWT staff, looks at existing

services, identify gaps, and considering the findings of a report following a national inquiry into avoidable deaths and failures of care for sickle cell patients. So far, the focus of the working group has been to raise awareness of the sickle cell and thalassemia conditions, promote understanding of Trust complaints procedures for patients and address specific issues raises in ED. A newly developed training course is being rolled out to staff in ED. Work is currently underway to produce an awareness video involving group patient members.

Following on from the previous successful British Sign Language (BSL) Deaf awareness sessions for staff a further two sessions were delivered in June and September 2022.

Two training sessions at RWT and Walsall hospitals for the International Nurses in LGBTQ+ awareness was jointly delivered in September and June 2022.

Bereavement Hub - Our monthly Bereavement Hub, delivered in partnership with Compton Care, was re-launched in March 2023 following pausing since 2020, due to Covid-19. This hub is a safe space for anyone to attend who is bereaved, to access support and information, and also gain companionship from other people experiencing the same issues. The sessions are staffed by volunteers trained by Compton Care. Our relaunch session had four individuals attend.

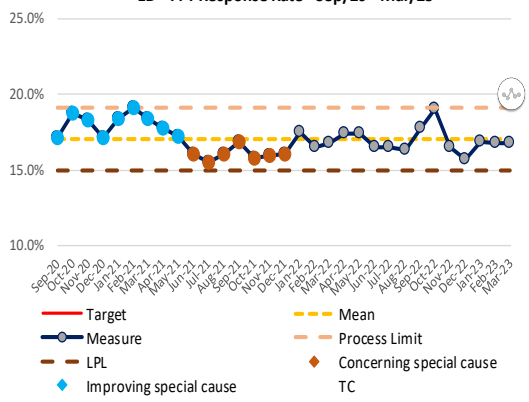
Patient Experience Enabling Strategy – This is a joint strategy with Walsall Hospital which sets out the priorities for improving patient experience in the next 3 years. The three pillars of improvement which have been identified are Involvement, Engagement and Experience and have been guided and informed by the patient voice. Each of the Trust's divisions will refer to the pillars in order to embed the ethos of engagement as customary practice when considering service improvements, with updates being reported through the Trusts newly formed Patient Experience Group (PEG).

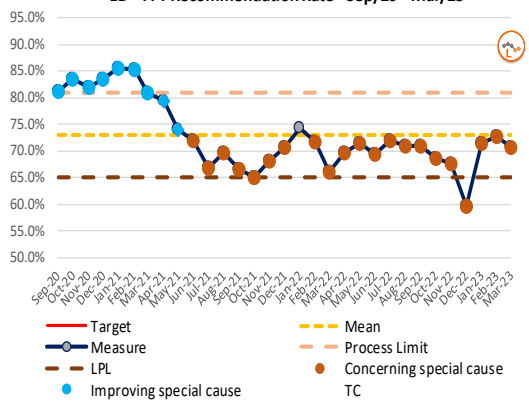
	Voluntary Services Within the last 12 months Volunteer Services have successfully recruited 126 new volunteers who are supporting services at Cannock, New Cross and West Park Hospitals. The attributed volunteer hours equate to 5648. The Trust have continued with recruitment into the clinical volunteer role; in total 174 new clinical volunteers have been recruited throughout the year. The service has also seen an expansion of medical and surgical wards receiving volunteer support with the development of admin roles in the Emergency Department, Discharge Lounge, Maternity, and Cardiology. The core values of the Youth Volunteer programme continue to be embedded and this supportive approach is used to recruit and support a large number of young volunteers. The Trust continues to work with St Johns Ambulance on the 'NHS Cadets' programme (Advanced Level) and have been able to offer 4 volunteer opportunities to cadets in September 2022, and 10 in March 2023. The 'Volunteer of the Month' initiative on social media was launched and during Volunteers Week 2022, an innovative 'live volunteer shift takeover' on the Trust Instagram account. To support the developmental aspect of volunteering access to the Health Education England National Volunteer Certificate is offered as an optional training opportunity; so far, 3 volunteers have completed and passed the certificate. Volunteer Services are continuing to seek pathways and opportunities for volunteers to access employment development opportunities as for many this is their aim, and during this year successfully supported 5 volunteers with gaining Bank positions in the Trust. Funding was applied for and received via NHS Charities Together, for a 2-year community social isolation volunteer project called Holistic Opportunities Preventing Exclusion (H.O.P.E). Delivering this project is one of our key priorities going forward, in 2023- 2025. Within this last year, external charities and specialist services are beginning to bring back their own voluntary services, and we are pleased to see this commencing with Infant feeding, League of Friends at Cannock Hospital, Neo Natal Unit, West Park Hospital Therapy Services, and the Drug and Alcohol Liaison service.

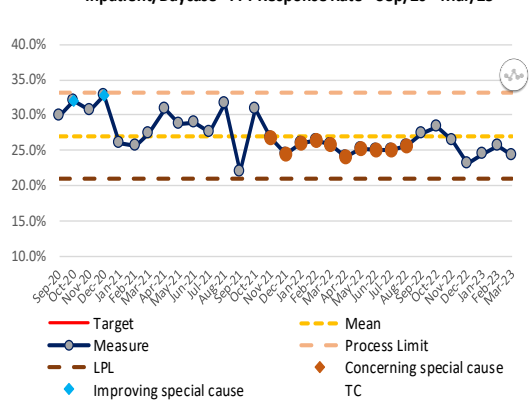
Appendices	
1	FFT yearly metrics

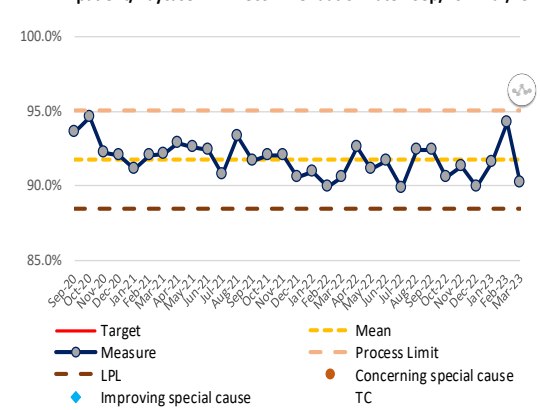
Friends and Family Test

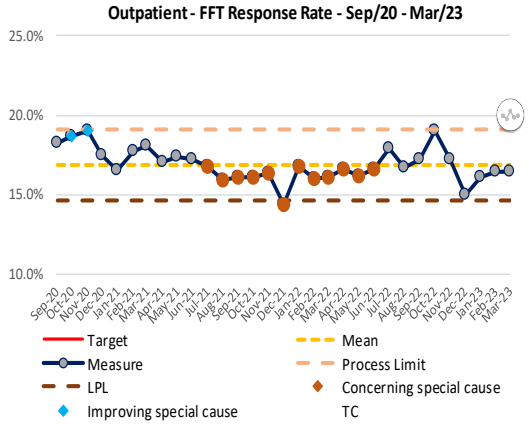
Home | Summary page | Save | Print | Export to power point

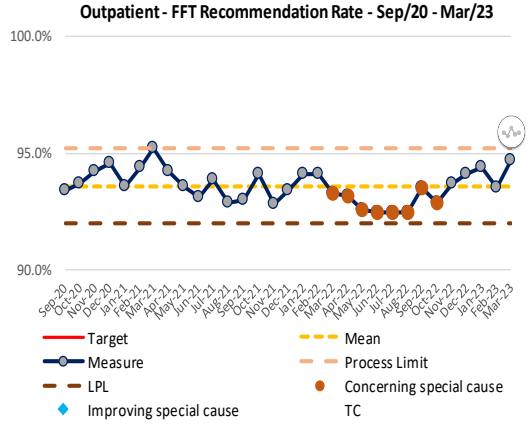


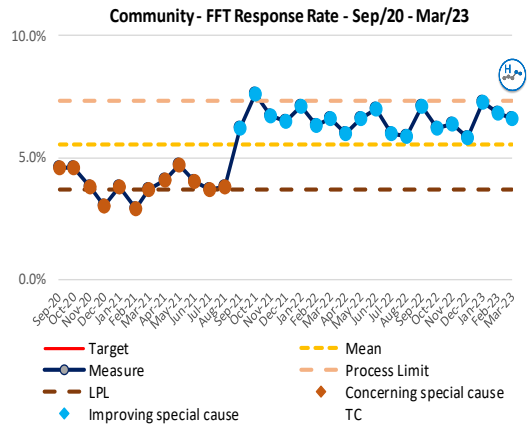


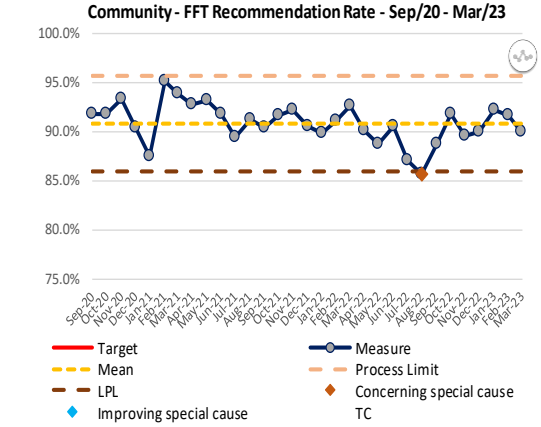


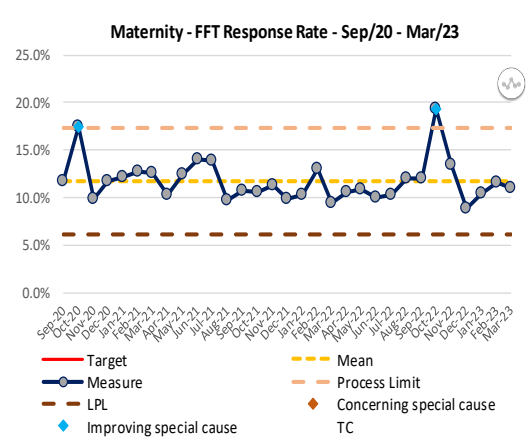


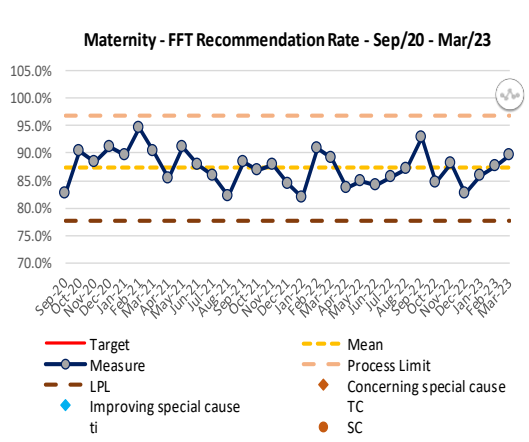


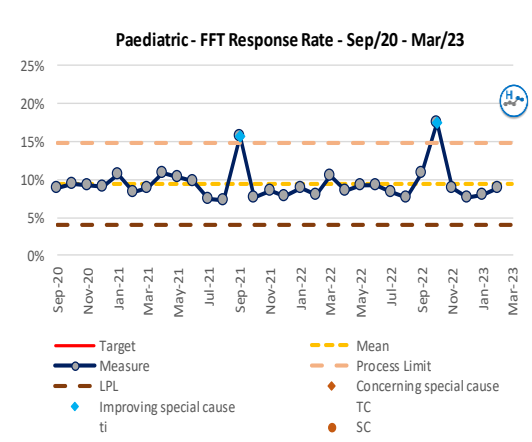


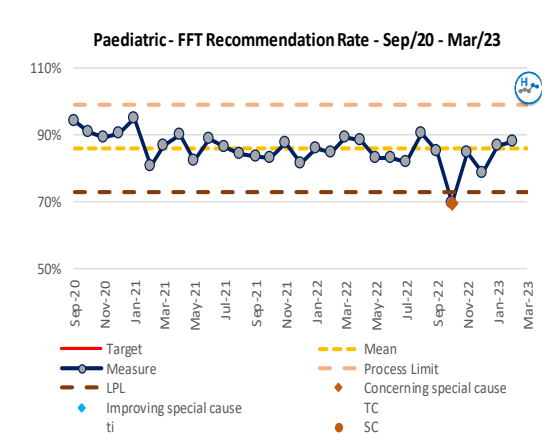












The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	6th June 2023
Title:	Integrated Quality and Performance Report – April 2023
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

New Cross Hospital
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

Integrated Quality and Performance Report
April 2023

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: further improvement seen during April 23. Progress and additional interventions are discussed at the Deteriorating Patient Group and other relevant forums. Quality improvement work continues with wards and this includes focus on the use of NEWS2 Scale 2.
C.diff: 6 cases in month against a target of 4. The new target for 2022/23 is 53 cases in the year. An action plan is in place for Clostridioides difficile which includes, increased education for staff.
MRSA: no cases during April 23.
CHPPD (total nursing): The second return scheduled rostering confirm and challenge meetings are underway to ensure best rostering practice and these are scheduled for every clinical area across the year.
Smoking at delivery: although we have seen some improvement this month, this remains above target. Additional funding has been agreed to increase support for stopping smoking and healthy living in pregnancy.

RTT incomplete pathway: slight increase in month but in line with the trajectory expected for a continued rise throughout 2023/24 as demand from the pandemic restores.

RTT 78+ week wait: the trend of increasing breaches has been reversed with a fall of two breaches in month. Additional weekend activity is planned to reduce the number of 78 week waits further ahead of the end of June target. This indicator has been impacted by the Junior Doctor Industrial Action in March/April 23 and subsequent cancellations. A total of 2,988 patients were affected (373 admitted & 2,615 outpatients) were cancelled or rescheduled.

Diagnostics: performance has remained relatively static during April 23 with the biggest waits in endoscopy, echocardiography and ultrasound - all driven by staffing challenges. Remedial action plans are in place with an expectation that performance improves throughout 2023/24.
ED 4 hour: Performance improved in month, exceeding the new national standard of 76%. The Streaming/Navigation pilot has been extended with an evaluation of its effectiveness planned. We continue to benchmark well both locally and nationally.
Cancer 2ww: we continue to see high volumes of 2ww referrals and is driving our underperformance. Mutual aid is being sought where available and likewise, RWT is continuing to offer mutual aid support to Walsall within the Skin specialty.
Cancer 62 day: the referral numbers above, combined with delays within histopathology and some specialty specific constraints continue to impact on our 62 day performance. Additional capacity has been procured outside of the system to support with the transfer of some urology patients.

RIT referrals/patients accepted and seen: there has been a marked reduction in the number of referrals over the last 3 month period, this is currently being investigated to understand the reasons why.
Virtual ward: is currently performing and managing its referrals within the current pathways.

Care Coordination: this centre streamlines all referrals into Adult Community Nursing Services. They are there to help patients, relatives and other professionals ensure they access the right services they need. Once the referral has been accepted the patients are streamed to alternative/appropriate pathways more suitable for the patient, thereby reducing ambulance conveyancing, ED attendance and aiding admission avoidance.

Executive Summary (continued)

Trust vacancy rate: very slight deterioration seen during April 23, however, this indicator remains above target.
Turnover (normalised): this target has shown some slight improvement when compared with the previous month, this continues to exceed the target.
Retention (24 months): this remains below target. This has been very consistent over the past 7 months.
Appraisals: this is seeing an overall improving trajectory, however, this remains below target. This performance has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.
Sickness (monthly): deterioration seen in month, taking this indicator back above target. Considerable work has been undertaken to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

Corporate Scorecard Summary

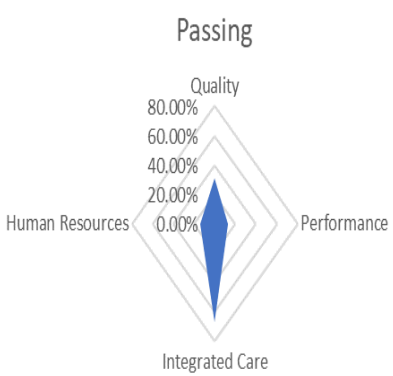
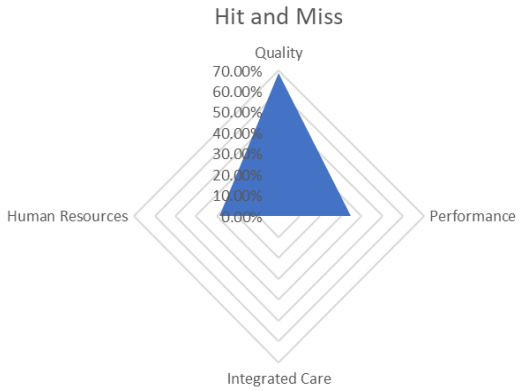
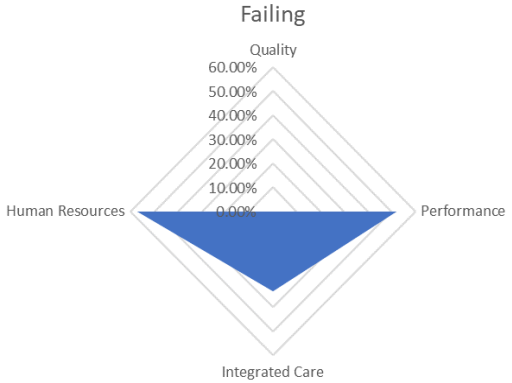
Quality				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Observations on time	>90%	85.30%		
Clostridioides difficile	4	6		
MRSA Bacteraemia	0	0		
CHPPD (total)	>/= 7.6	8.6%		
Smoking at delivery	<7%	10.8%		

Performance				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RTT - Incomplete Pathway	92%	56.92%		
RTT - 78+ Weeks	0	83		
Diagnostic 6 week wait	<1%	51.71%		
ED - 4 hour wait	76%	79.23%		
Cancer 2 week wait	93%	78.64%		
Cancer 62 day traditional	85%	29.82%		

Integrated Care				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RIT referrals received		941		
Patients accepted and seen		932		
Virtual Ward		119		
Care Coordination referrals accepted		2,547		

Human Resources				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Trust Vacancy Rate	6%	3.40%		
Turnover (normalised)	9%	10.95%		
Retention (24 months)	85%	80.08%		
Appraisals	90%	83.70%		
Sickness (monthly)	4.25%	5.11%		

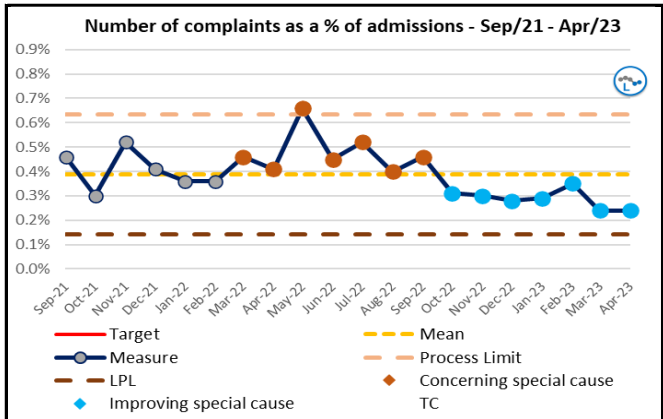
Indicator Summary

Consistently Passing	Hit and Miss	Consistently Failing
		
Quality - Duty of candour elements 1&2, patient falls rate, serious incidents reported within 48 hours & Midwife to birth ratio. **Performance** - Cancelled ops as % of electives, urgent cancelled ops for 2nd time & E-discharge summary **Integrated Care** - Patients offered HIV test & Crisis response **Human Resources:** mandatory training (generic)	**Quality** - Complaints against policy, obs on time, C.diff, MRSA, medication incidents causing harm, never events, Care hours per patient day total & registered nurses, sepsis ED/inpatient & smoking at time of delivery. **Performance** - Cancelled ops not rebooked within 28 days, patient stay on Stroke Unit, stroke patients within 24 hours, cancer 2ww, cancer 2ww breast, anti cancer drug, radiotherapy & 28 day FDS. **Human Resources:** vacancy rate & sickness rate monthly	**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, retention, appraisals & sickness rate (rolling 12 months)

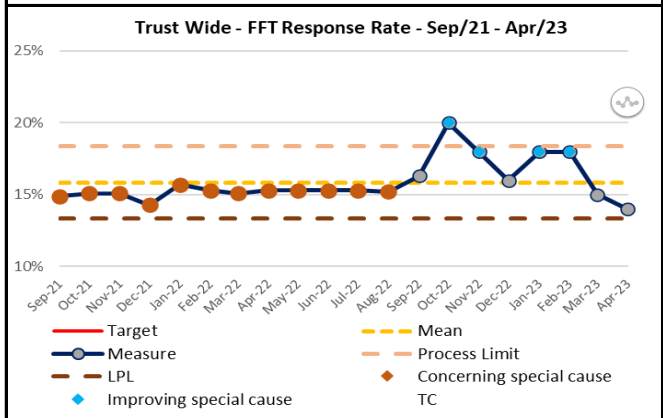
Quality

Metric - Patient Experience	Target	Variation	Assurance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Number of complaints as a % of admissions	Surveillance			0.30%	0.28%	0.29%	0.35%	0.24%	0.24%
Complaints response rate against policy	90%			96.0%	97.0%	95.0%	100.0%	100.0%	90.0%
FFT response rates - Trust wide	Surveillance			18.0%	16.0%	18.0%	18.0%	15.0%	14.0%
FFT recommendation rates - Trust wide				82.0%	77.0%	85.0%	86.0%	84.0%	86.0%
Observations on time (Trust wide)	>90%			74.71%	72.20%	75.60%	79.10%	81.30%	85.30%
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			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			0	0	0	0	0	0
Metric - Patient Outcomes	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Pressure ulcers - STEIS reportable cases	Surveillance			0	0	0	1	0	0
Pressure ulcers per 1,000 occupied bed days				1.06	1.59	2.17	1.25	1.41	1.34
Falls rate with harm per 1,000 occupied bed days				0.00	0.04	0.11	0.00	0.04	0.00
Patient falls - rate per 1,000 occupied bed days	<5.6			3.89	4.29	3.80	3.64	3.69	2.61
Crude mortality rate	Surveillance			1.71%	2.00%	2.16%	2.07%	1.84%	1.97%
RWT SHMI				0.9249	0.9249				

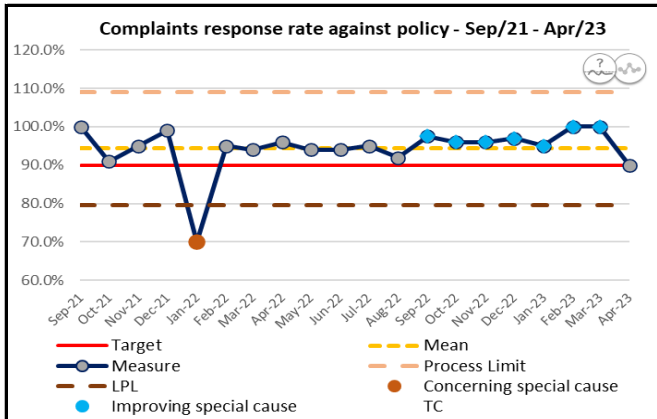
Metric - Patient Safety	Target	Variation	Assurance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Clostridioides difficile	5			3	8	9	5	11	6
MRSA Bacteraemia	0			0	0	0	1	0	0
E.Coli	Surveillance			21	18	19	17	18	14
Covid outbreaks				9	3	9	7	7	5
Medication error - incidents causing harm	0	L		0	0	0	0	0	0
Serious 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**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Care hours per patient - total nursing & midwifery staff actual	>/= 7.6	H		7.6	7.7	7.9	7.6	8.1	8.6
Care hours per patient - registered nursing & midwifery staff actual	>/= 4.5	H		4.5	4.6	4.7	4.8	4.8	5.1
Midwife to birth ratio	</=30		P	30.0	30.0	29.0	29.0	28.0	29.0
Sepsis screening - ED	>/= 90%			88.0%	98.0%	86.0%	84.0%	88.0%	100.0%
Sepsis screening - Inpatients (reported quarterly)	>/= 90%	H		90.00%		93.33%			
Thrombus - Hospital acquired (VTE numbers) per 1,000 occupied bed days (reported quarterly 1 month in arrears)	Surveillance	H		0.65		0.64			
Metric - Maternity	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Smoking at delivery	<7%			11.9%	13.3%	9.5%	10.8%	11.7%	10.8%
Babies being cooled (born here)	Surveillance			1	1	0	2	1	1



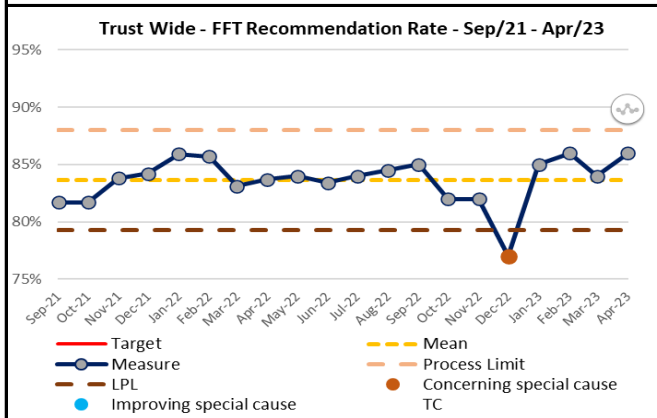
Apr-23
0.24%
Variance Type
Metric is showing lower cause (improving)



Apr-23
14.0%
Variance Type
Metric is showing common cause variation

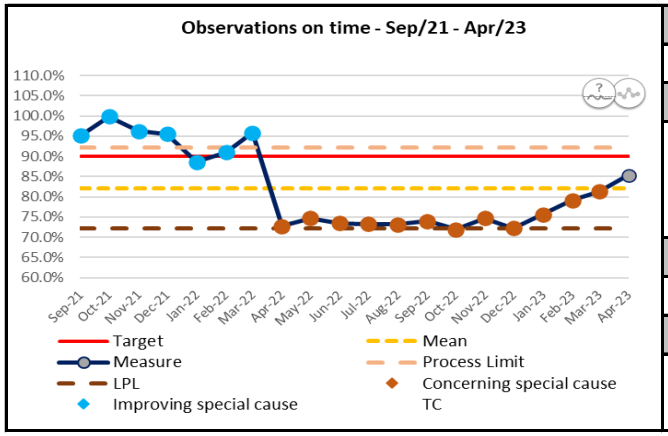


Apr-23
90.0%
Variance Type
Metric is showing common cause variation
Target
90.0%
Achievement
Metric is currently passing the target

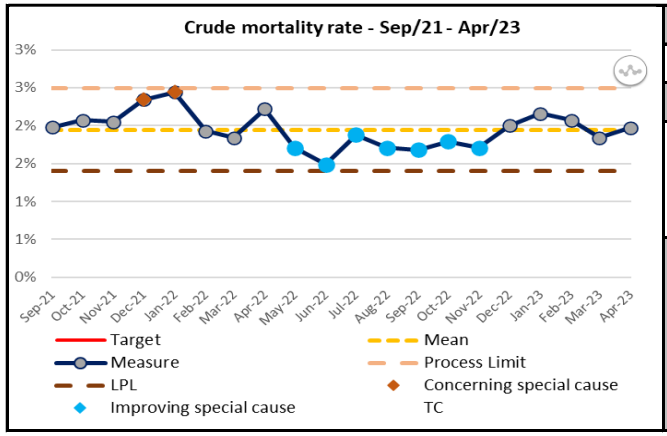


Apr-23
86.0%
Variance Type
Metric is showing common cause variation

Summary	Actions	Assurance
Complaints: There were 27 formal complaints received. This represents a 7% decrease when compared to the previous month. **Complaints Response:** There were 4 complaints which took longer than 30 days to complete, that did not gain consent to breach from the complainant.	The reduction in compliance performance specifically relates to 4 cases. Whilst draft letters were received on the date they were due to be sent to the complainant, divisional oversight did not allow for sufficient time for executive approval. This will be addressed with the relevant directorates and monitored in the future for improvement.	Attendance at Divisional Governance meetings by the Patient Experience Team to discuss complaints and FFT performance, undertake trend analysis and agree actions is custom and practice.
FFT: The overall Trust wide response rate for April 2023 was 14% with 86% recommending the Trust and 9% not recommending the Trust. The response rate has seen a 1% decrease when compared with the previous month. Pleasingly the recommendation rate has seen a 2% increase when compared with the previous month, with the non-recommendation rate noting a 1% decrease.	The Trust is currently undertaking a full review of the hierarchy for reporting touchpoints in addition to ensuring all senior nursing staff have access to the real time reporting system Envoy. This work should be complete by mid June 23.	

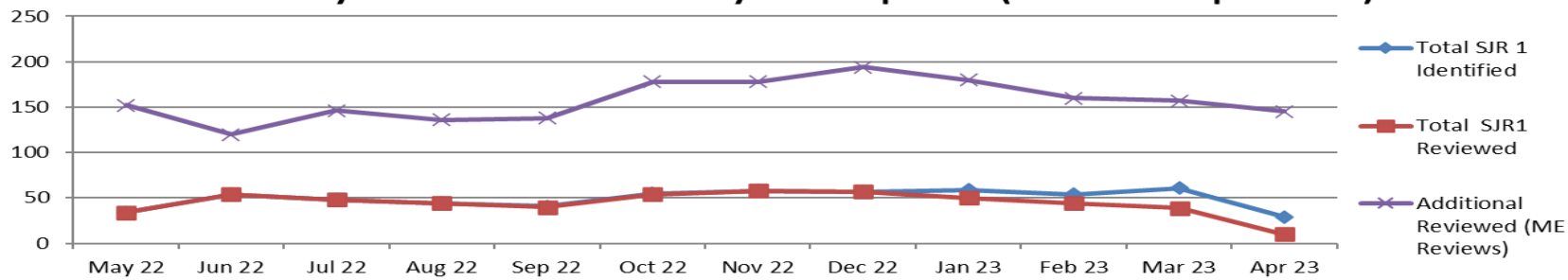


Apr-23
85.30%
Variance Type
Metric is showing common cause variation
Target
90%
Achievement
Metric is currently failing the target

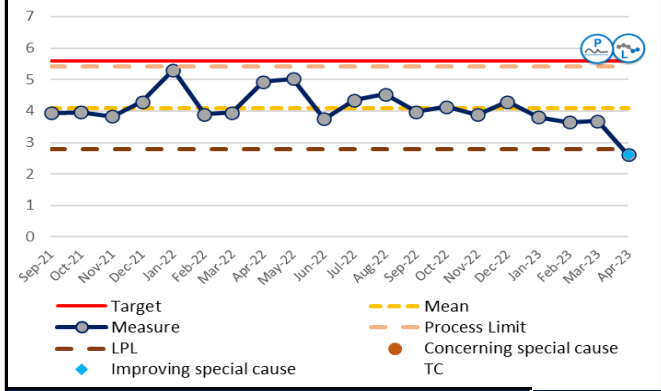


Apr-23
1.97%
Metric is showing common cause variation

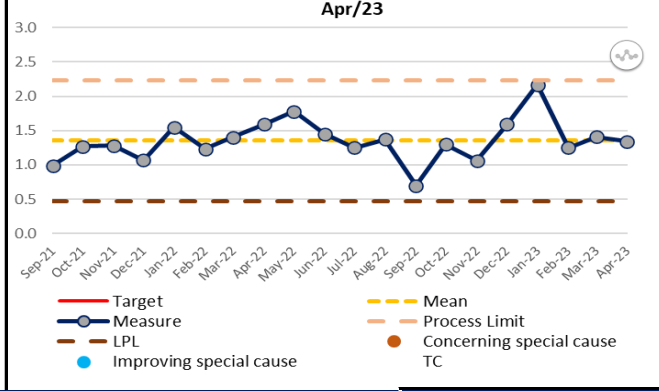
Scrutiny of Deaths - Period May 22 to April 23 (as at 28th April 2023)



Summary	Actions	Assurance
Observations on time: Performance was 85.3% in April 2023 and this represents an increase of 4% on the previous month.	Our quality improvement work continues with wards and this includes focus on the use of NEWS2 Scale 2. The Quality team is continuing to work with wards individually regarding tips to improve observations on time such as 'bay watch' were the time of the next observations is noted outside the bay, some wards have an observations champion for the day.	Monitoring and progress continues to be discussed at the Deteriorating Patient Group and other relevant forums.
Mortality: The SHMI is 0.9249 and is within the expected range. At last reported position to MRG Chair as at 29th April 23, there were 62 outstanding SJRs awaiting review. 41 of these are deaths from March and April 2023.	Of the SJRs completed during quarter 1 reported to MRG Chair on 4th May 2023, 1 case was assessed where an element of poor care has been identified at the overall phase of care.	SHMI remains within expected range.

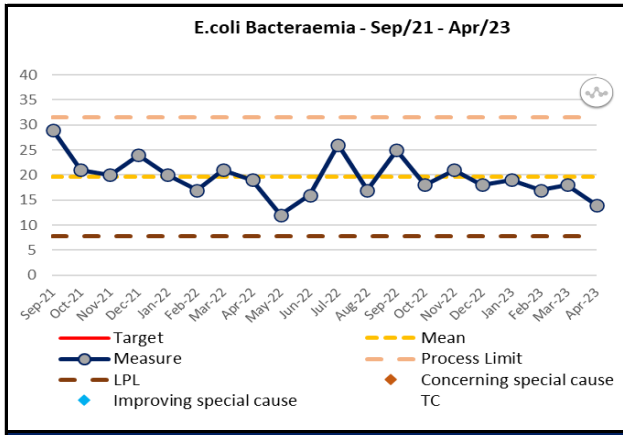


Apr-23
2.61
Variance Type
Metric is showing lower cause (improving)
Target
<5.6
Achievement
Metric is currently passing the target

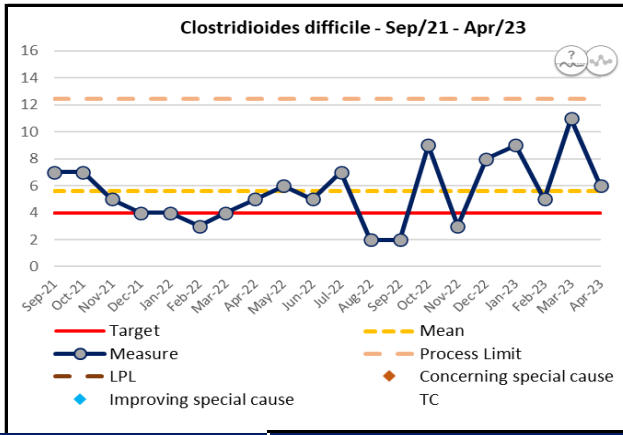


Apr-23
1.34
Variance Type
Metric is showing common cause variation

Summary	Actions	Assurance
Falls: In total, there were 77 falls reported in April 2023 compared to 116 in March 2023 which represents a reduction of 33.63% and the return to normal visiting may have contributed to this reduction. **Pressure Ulcers:** In total, 35 pressure ulcer incidents were reported in April 2023, in comparison to 39 reported in March 2023. From a moisture associated skin damage (MASD) perspective, 62 MASDs were reported in April 2023, in comparison to 60 reported in March 23.	**Falls:** A variety of actions are being progressed via the overarching Falls Prevention Improvement Plan which is overseen by the joint Falls Steering Group. **Pressure Ulcers:** A variety of actions are being progressed via the overarching Wound Prevention and Healing Ambition Plan which is overseen by the joint Tissue Viability Steering Group.	In line with the agreed improvement plans. .

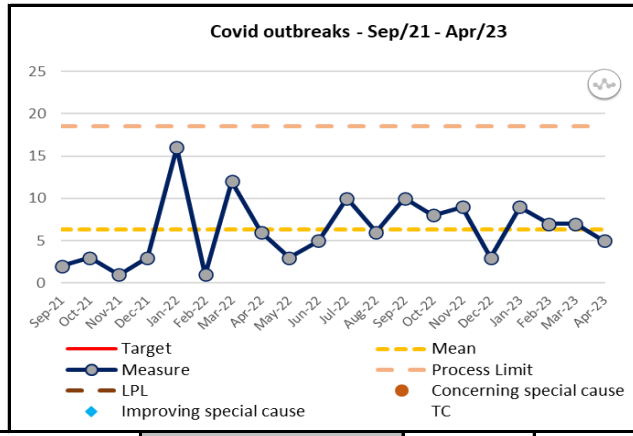


Apr-23
14
Variance Type
Metric is showing common cause variation

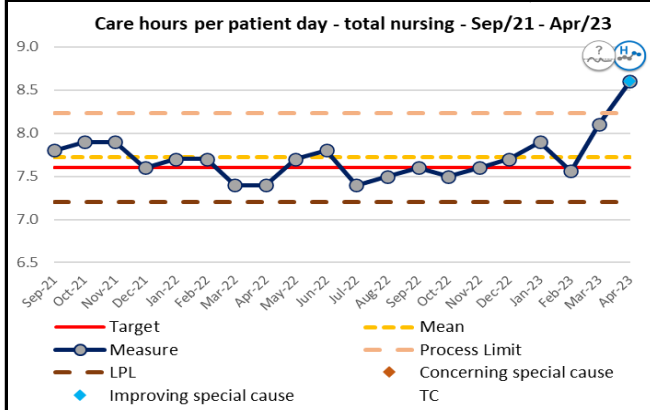


Apr-23
6
Variance Type
Metric is showing common cause variation
Target
4
Achievement
Metric is currently failing the target

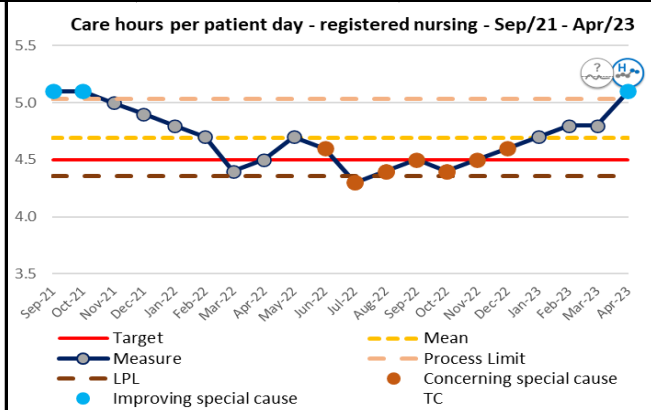
Summary	Actions	Assurance
HCAI: C.difficile saw 6 cases in month against the target of 4 during April 2023. The new target for 2023/24 is 53 cases. There were no cases of MRSA Bacteraemia cases during April 2023.	IP team continue to be involved in collaborative working groups with NHSE for Gram negative bacteraemia, C. difficile and surgical site infection. Internal C. difficile task and finish group continues to meet to review the Trust C. difficile action plan and identify any further actions required. NHSEI conducted a site visit in January 2023 with feedback received. Please see the separate Infection Prevention report being presented to the Trust Management Committee (TMC) in May 2023 and subsequently to Trust Board in June 2023 for more details. Decant plan under review	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.



Apr-23
5
Variance Type
Metric is showing common cause variation

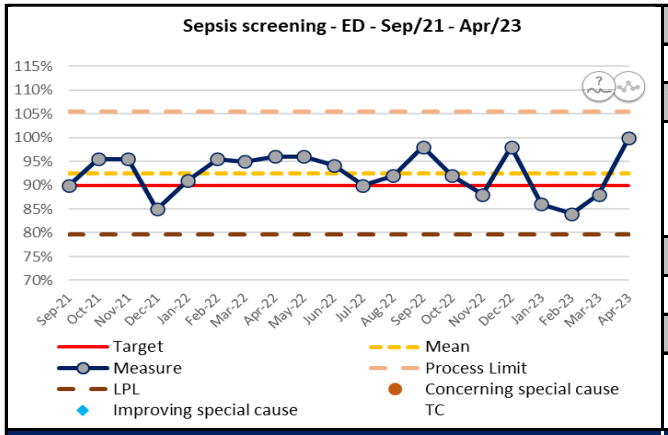


Apr-23
8.6
Variance Type
Metric is showing higher cause (improving)
Target
>7.6
Achievement
Metric is currently passing the target

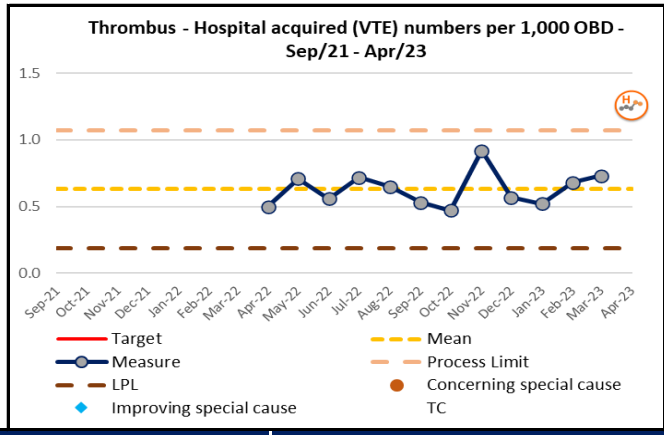


Apr-23
5.1
Variance Type
Metric is showing higher cause (improving)
Target
>4.5
Achievement
Metric is currently passing the target

Summary	Actions	Assurance
Covid Outbreaks: There were 5 COVID outbreaks in April 2023. 226 HCAIs were linked to outbreaks, with 23 not being linked to an outbreak.		Outbreak management processes are in place as per Trust policy.
Care Hours per Patient Day (CHPPD): The Trust's average for April 2023 was 8.6. The model hospital dashboard shows a national median to be 8.1 (January 2023). Adult inpatient range was between 5.3 - 10.8 (Mean 7.1) Critical care/Neonatal range was between 30.01 - 33.3 (Mean 31.7) Emergency portal range was between 7.7 - 9.9 (Mean 8.8)	The second return scheduled rostering confirm and challenge meetings are underway to ensure best rostering practice and these are scheduled for every clinical area across the year. These aim to improve efficiency by driving improvements in Rostering to ensure maximum availability of staff.	Continued local, international recruitment and new to care staff with the Prince's Trust The local recruitment pipeline is currently, 131.16 for Registered Nurses/Midwives and 29.62 for Unregistered staff.

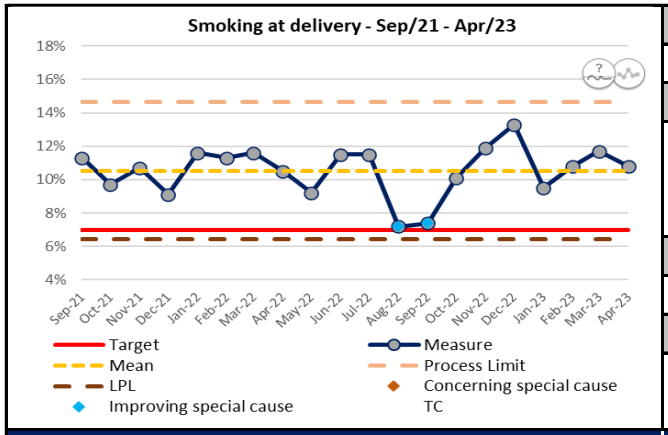


Apr-23
100.0%
Variance Type
Metric is currently showing common cause variation
Target
90%
Achievement
Metric is currently passing the target

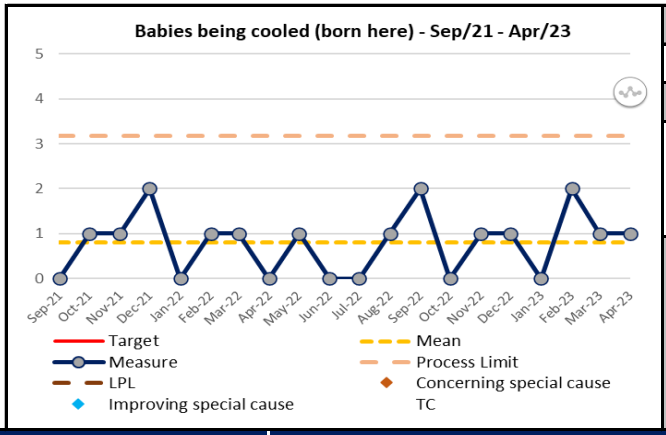


Apr-23
0.64
Variance Type
Metric is showing higher special cause variation (concern)

Summary	Actions	Assurance
Sepsis screening in ED: Reported as 100% in April 2023.	Sepsis training is ongoing as part of the departmental new starters' study days. The department is also focusing on ensuring that staff are attending the generic sepsis study day offered by the Trust, in addition to completing my focus sepsis training.	The Deteriorating Patient Group maintains oversight of sepsis performance and required improvement actions.
VTE: 52 hospital associated VTE were reported during quarter 4 (0.64 per 1,000 occupied bed days). New VTE cases are identified through radiology reports, discharge coding and the bereavement office. The summary is taken from a review of patient notes, vitals, EPMA and badgernet systems and a VTE level 1 RCA report compiled.	VTE incident and RCA process are being reviewed with Divisional Governance managers taking into consideration the new Patient Safety Incident Response Framework (PSIRF). A system error in Badgernet was identified in Q3 whereby it is possible that a postnatal VTE risk assessment could be completed before the patient had delivered their baby. This was escalated to digital midwife who has reported error to clever med on the 14/12/22. A fix was due to be deployed in March 23, however, this has now been delayed and a new release is expected during May 23. The Obstetric directorate are managing the risk.	No hospital associated VTE cases causing serious harm have been identified. The percentage of hospital associated cases compared to non-hospital associated new VTE cases has remained within 20-30% range. A clinician is providing additional support to VTE group with level 1 RCA reviews.



Apr-23
10.8%
Variance Type
Metric is currently showing common cause variation
Target
<7%
Achievement
Metric is currently failing the target



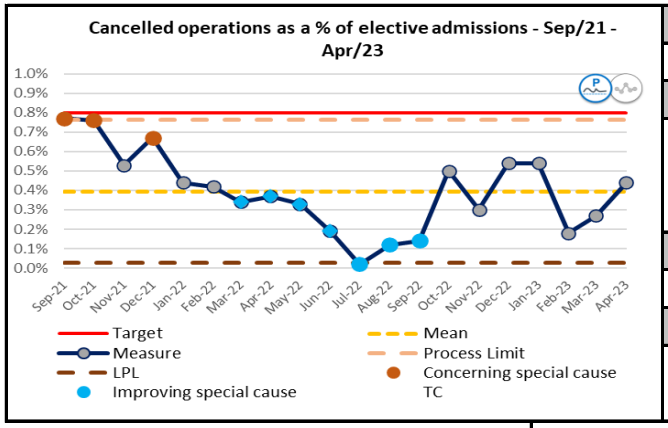
Apr-23
1
Variance Type
Metric is currently showing common cause variation

Summary	Actions	Assurance
Maternity: **Smoking times at delivery (SATOD)** - although there has been some improvement in month this remains above target. **Bookings** – the service continues to see high numbers of bookings, however, birth trajectories remain on plan. The directorate continues to monitor closely to ensure midwife to birth ratios are maintained.	Additional funding has been agreed to increase support for stopping smoking and healthy living in pregnancy.	Midwifery recruitment is looking positive, and steps are in place to support newly qualified midwives expected to join the service in September 2023 as well as longer term plans to nurture future leaders and secure future clinical staff.

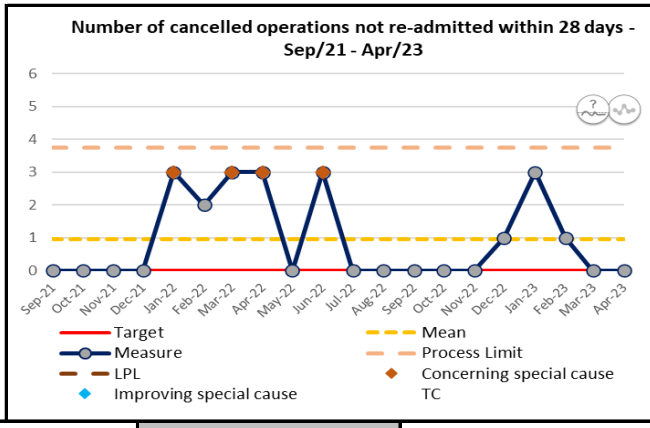
Performance

Metric - Patient Experience	Target	Variation	Assurance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Number of cancelled operations on the day of surgery for non-medical reasons				17	24	28	9	14	19
Cancelled operations as a % of elective admissions	<0.8%		P	0.30%	0.54%	0.54%	0.18%	0.27%	0.44%
Number of cancelled operations not re-admitted within 28 days	0		?	0	1	3	1	0	0
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				70	86	61	65	76	54
Metric - Waiting Times	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
RTT - % of patients on an incomplete pathway	92%	L	F	58.73%	55.03%	57.05%	56.65%	56.98%	56.92%
RTT - number of patients waiting 78+ weeks		L		284	310	258	164	85	83
Total Incomplete Number		H		73,071	73,634	73,135	73,213	75,958	76,722
Diagnostic Test - % of patients waiting 6 weeks or more	<1%	H	F	42.95%	52.18%	51.57%	47.12%	47.94%	51.71%
Metric - Urgent Care	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Total time spent in ED (4 hours) - New Cross Hospital	76% (from Apr 23)		F	66.39%	58.29%	66.96%	66.63%	63.68%	69.86%
Total time spent in ED (4 hours) - Combined				73.29%	64.03%	75.79%	75.92%	75.18%	79.23%
% of ED attendances >12 hours	0		F	10.38%	12.76%	7.23%	7.24%	9.83%	4.35%
Ambulance handover within 15 minutes	65%		F	32.20%	24.96%	46.88%	61.25%	49.61%	68.04%
Ambulance handover within 30 minutes	95%		F	69.60%	58.98%	83.39%	91.51%	82.37%	95.72%
Ambulance handover >60 minutes	0%		F	14.47%	22.81%	6.71%	2.07%	4.95%	0.14%
% of emergency admissions via Emergency Department				38.89%	36.96%	42.39%	42.09%	41.11%	42.63%

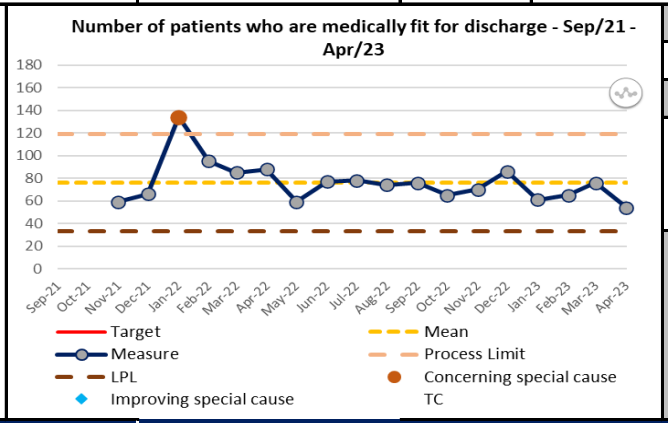
Metric - Stroke	Target	Variation	Assurance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Patients admitted with primary diagnosis of stroke should spend greater than 90% of their hospital stay on a dedicated stroke unit	80%			97.59%	85.53%	95.12%	100.00%	100.00%	100.00%
Stroke patients will be assessed and treated within 24 hours	60%			85.14%	84.93%	75.74%	74.23%	72.58%	61.73%
Metric - Organisational Efficiency	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Electronic discharge summary within 24 hours of patient discharge	>/= 90%			92.74%	94.54%	95.60%	94.29%	94.97%	94.13%
Metric - Cancer Waiting Times	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
2 Week Wait - Cancer Referrals	93%			82.01%	83.59%	83.87%	86.85%	86.70%	78.64%
2 Week Wait - Breast Symptomatic Referrals	93%			90.00%	96.04%	96.34%	97.65%	90.16%	98.86%
31 Day to First Treatment	96%			77.33%	73.89%	76.37%	80.10%	78.60%	78.33%
31 Day Sub Treatment - Anti Cancer Drug	98%			90.16%	93.06%	75.78%	82.29%	88.46%	87.78%
31 Day Sub Treatment - Surgery	94%			44.44%	66.67%	47.27%	58.54%	43.90%	50.00%
31 Day Sub Treatment - Radiotherapy	94%			81.17%	93.70%	88.89%	87.68%	83.33%	91.04%
62 Day Wait for First Treatment	85%			32.48%	29.44%	27.92%	40.23%	39.32%	29.82%
62 Day Wait - Screening	90%			47.37%	35.29%	45.16%	37.84%	47.46%	37.84%
62 Day Wait - Consultant Upgrade (local target)	88%			51.70%	51.59%	50.93%	54.76%	51.80%	39.36%
28 Day Faster Diagnosis Standard	75%			68.52%	68.10%	65.92%	72.16%	72.43%	68.87%



Apr-23
0.44%
Variance Type
Metric is showing common cause variation
Target
<0.8%
Achievement
Metric is currently passing the target

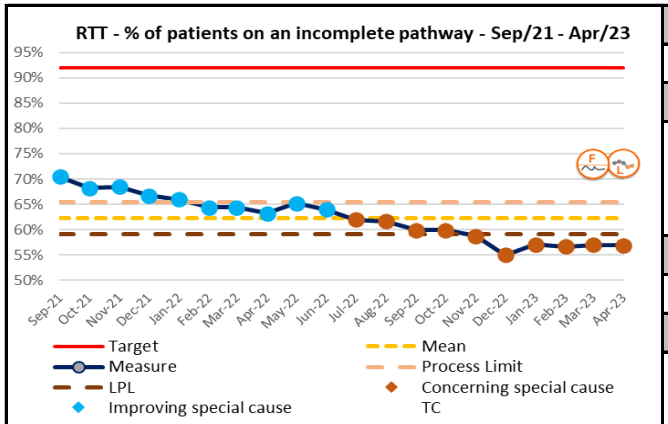


Apr-23
0
Variance Type
Metric is showing common cause variation
Target
0
Achievement
Metric is currently passing the target

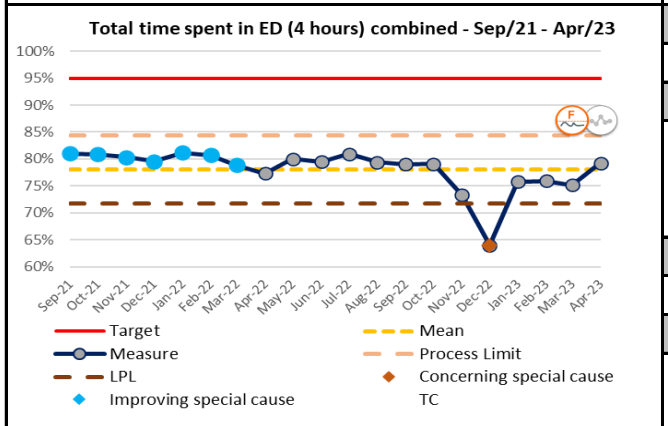


Apr-23
54
Variance Type
Metric is showing common cause variation

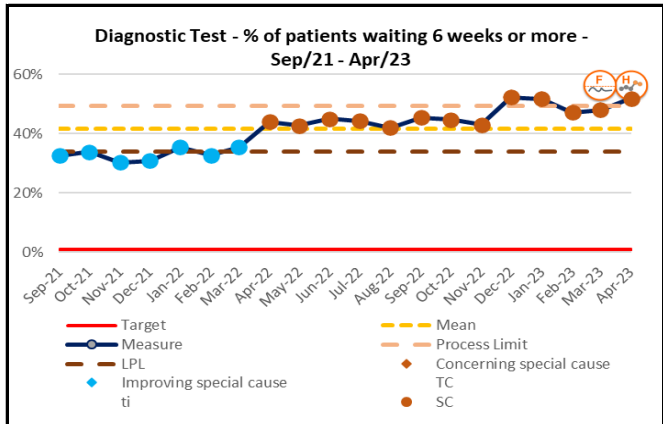
Summary	Actions	Assurance
Cancelled Operations: April 23 position saw slight deterioration when compared with the previous month, however, we remain below target. There were no patients who had been cancelled on the day that was not rebooked within 28 days.	All cancelled operations on the day of surgery 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 April 23 we had 54 patients in a hospital bed that were medically fit for discharge, this is a significant improvement of 22 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.



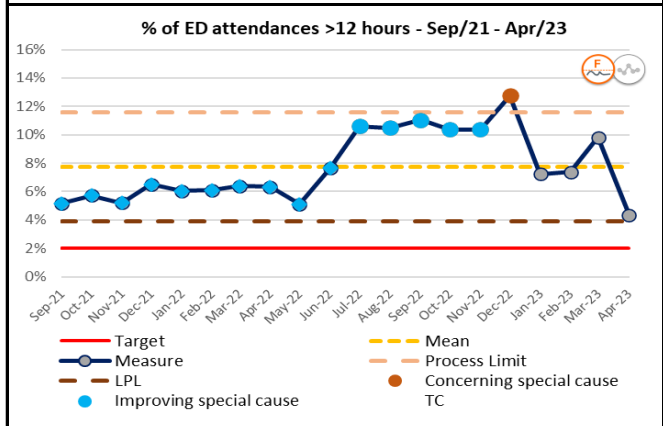
Apr-23
56.92%
Variance Type
Metric is showing lower special cause variation (concern)
Target
92%
Achievement
Metric is currently failing the target



Apr-23
79.23%
Variance Type
Metric is showing common cause variation
Target
76%
Achievement
Metric is currently passing the target

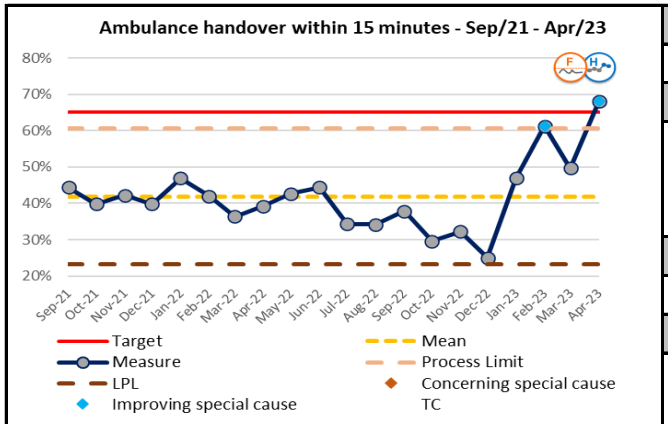


Apr-23
51.71%
Variance Type
Metric is showing higher special cause variation (concern)
Target
<1%
Achievement
Metric is currently failing the target

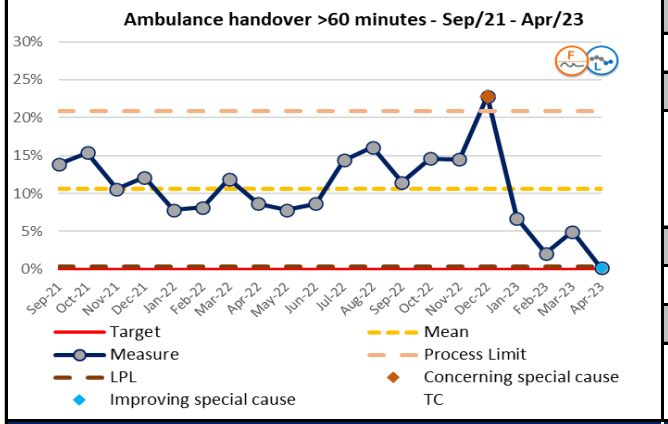


Apr-23
4.35%
Variance Type
Metric is showing common cause variation
Target
<2%
Achievement
Metric is currently failing the target

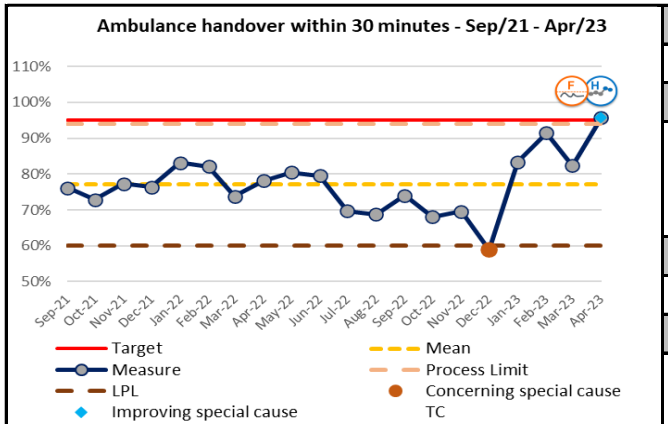
Summary	Actions	Assurance
RTT: 83 patients were reported as waiting 78+ weeks at month end. This has been impacted by the Junior Doctor Industrial Action in March/April 23 and subsequent cancellations. A total of 2,988 patients were affected (373 admitted & 2,615 outpatients)	Daily reporting and monitoring of long waiting patients. Weekly PTL meetings with specialty managers. Use of mutual aid where available.	These patients continue to be monitored at the weekly waiting list meeting where they are reviewed on an individual basis, with the aim to be at zero by end June 23.
Diagnostics: April 23 performance has declined slightly as a result of reduced capacity over the Bank Holiday period.	U/S scans remain the biggest issue due to large backlog (overall performance excluding U/S is 42.2%). Endoscopy continue to have high numbers due to the addition of the overdue planned patients.	All modalities have individual trajectories and action plans to work towards. This is monitored at the weekly performance meeting.
ED: Nationally RWT ranked 13th out of 110 Trusts for the month (compared with 17th in the previous month). Locally RWT we ranked 3rd out of 14 Trusts (compared with 2nd in the previous month).	Streaming/Navigation pilot commenced on 22nd March – was initially for two weeks but is to be extended and further pathways for streaming to be established.	The 4 hour target changed from 1st April 23 and is now 76%. Trust has maintained a strong position regionally and nationally.



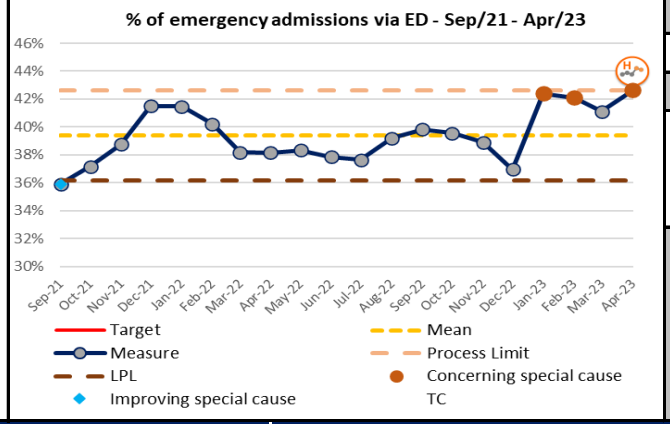
Apr-23
68.04%
Variance Type
Metric is showing higher variation (improving)
Target
65%
Achievement
Metric is currently passing the target



Apr-23
0.14%
Variance Type
Metric is showing lower variation (improving)
Target
0%
Achievement
Metric is currently failing the target

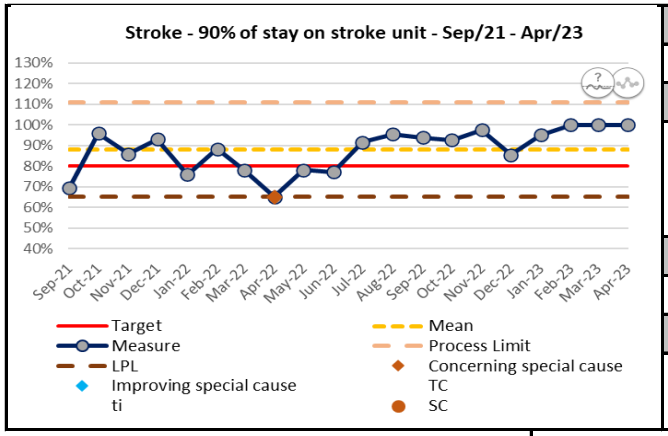


Apr-23
95.72%
Variance Type
Metric is showing higher variation (improving)
Target
95%
Achievement
Metric is currently passing the target

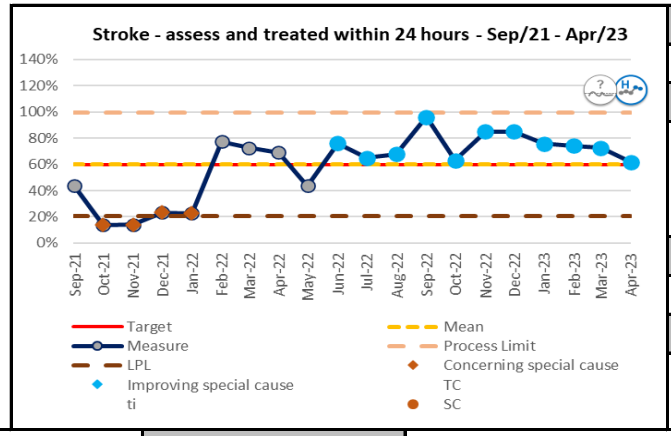


Apr-23
42.63%
Variance Type
Metric is showing higher variation (concern)

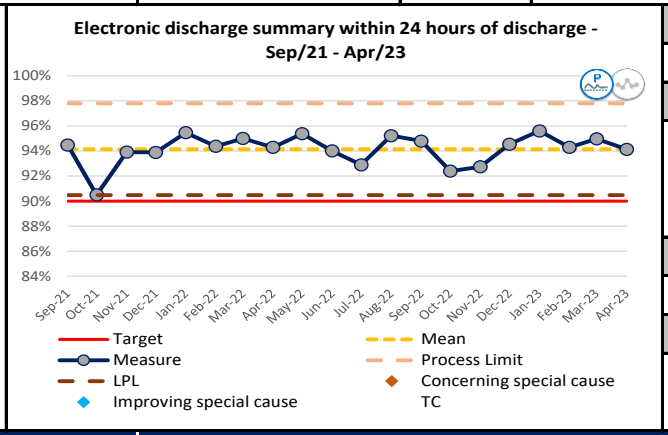
Summary	Actions	Assurance
Ambulance Handover: Significant improvement seen in all of the handover performance during April 23. The overall improved position has been seen since the 5th January and has been maintained to date.	Criteria Led Handover continues in Divisions 1 & 2 to expedite timely transfers. Streaming/Navigation pilot commenced on 22nd March – this was initially for two weeks but is to be extended and further pathways for streaming to be established. Workstream has been set up specifically focusing on improving the 4 hour target	Ongoing recruitment and retention of Nursing and Medical workforce to ensure timely review of patients
Emergency Admissions via ED: We saw an increase in the emergency admission rate during April 23. Admission numbers were lower than the previous month, however, due to the bank holiday ED attendances were considerably lower than normal, this has impacted on the admission rate. The increase was been seen in SDEC attendances.		Discussed in detail at the weekly performance meeting.



Apr-23
100.00%
Variance Type
Metric is currently showing common cause variation
Target
80%
Achievement
Metric is currently passing the target

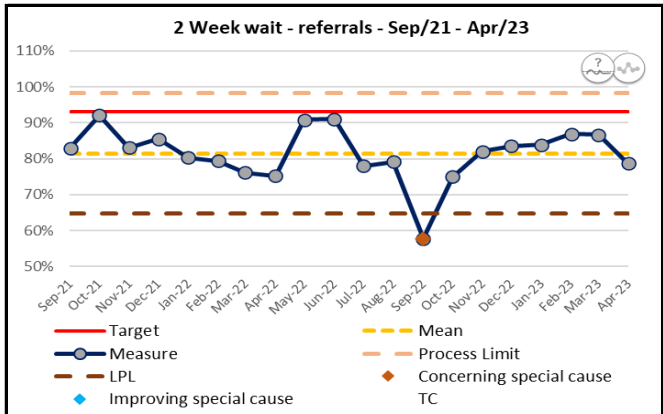


Apr-23
61.73%
Variance Type
Metric is showing higher special cause (improving)
Target
60%
Achievement
Metric is currently passing the target

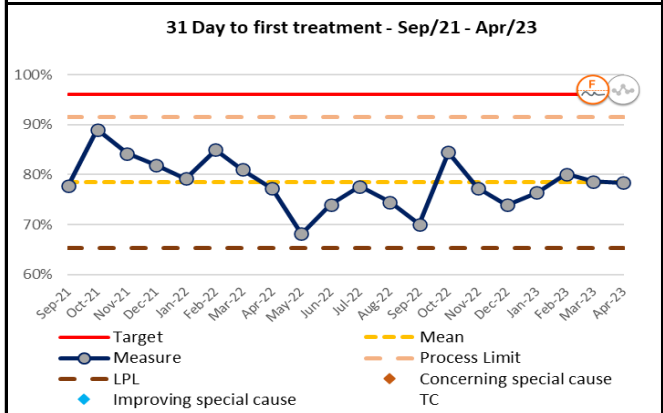


Apr-23
94.13%
Variance Type
Metric is currently showing common cause variation
Target
90%
Achievement
Metric is currently passing the target

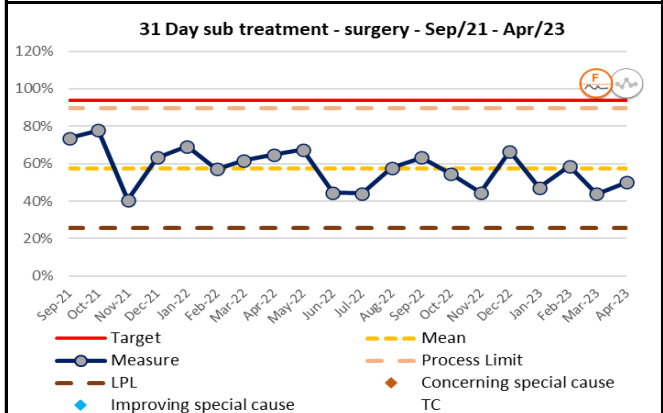
Summary	Actions	Assurance
Stroke: Patients spending 90% of time on a stroke ward remained static at 100% during April 23.		Continue to monitor outliers within the pathway, link discussion to pre-alert pathway and out flow model for stroke.
Stroke: Performance dipped slightly during April 23 for patients being assessed and treated within 24 hours largely due to the Bank holiday period, however, 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.



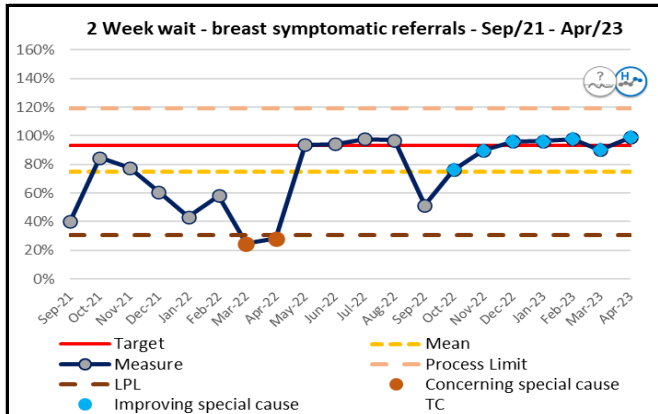
Apr-23
78.64%
Variance Type
Metric is showing common cause variation
Target
93%
Achievement
Metric is currently failing the target



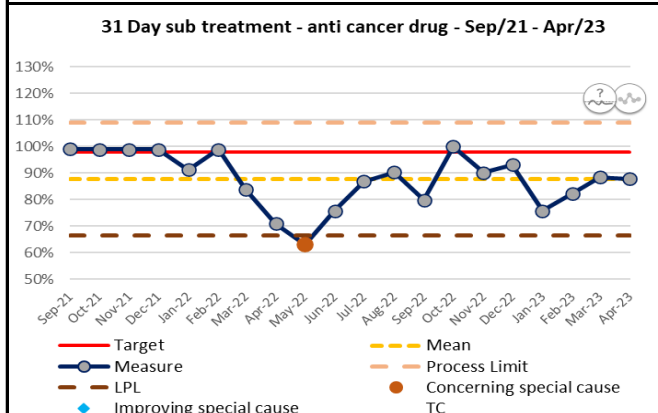
Apr-23
78.33%
Variance Type
Metric is showing common cause variation
Target
96%
Achievement
Metric is currently failing the target



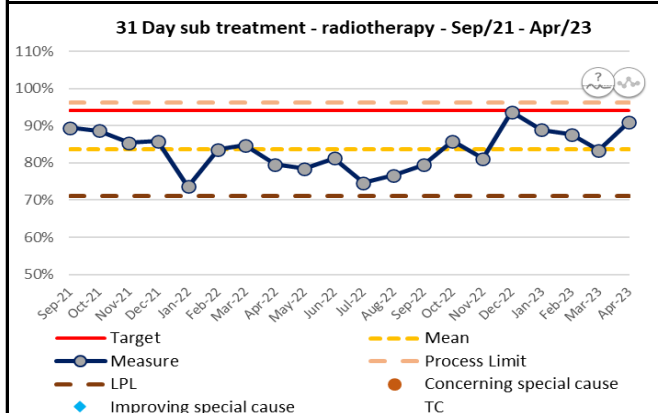
Apr-23
50.00%
Variance Type
Metric is showing common cause variation
Target
94%
Achievement
Metric is currently failing the target



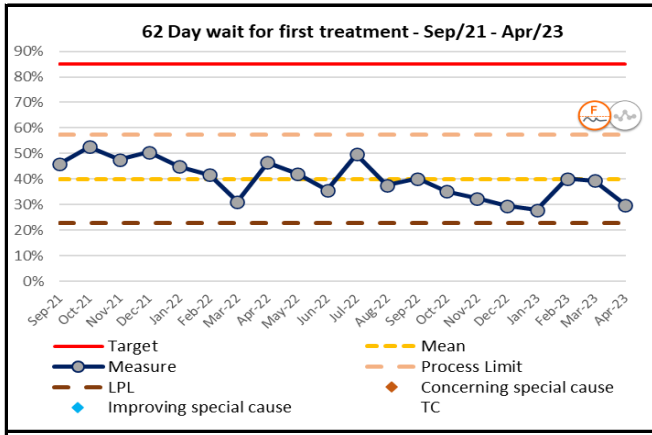
Apr-23
98.86%
Variance Type
Metric is showing higher special cause (improving)
Target
93.00%
Achievement
Metric is currently passing the target



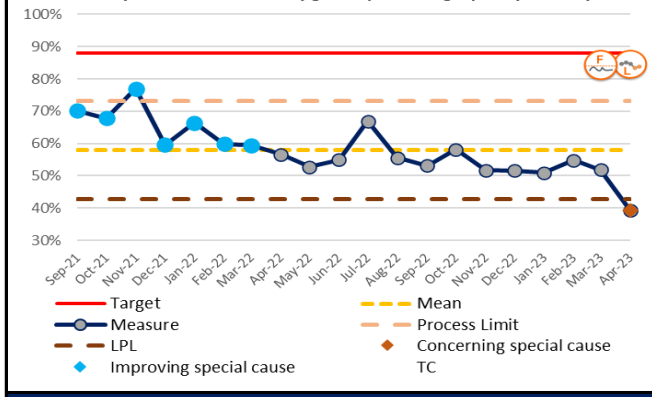
Apr-23
87.78%
Variance Type
Metric is showing common cause variation
Target
98%
Achievement
Metric is currently failing the target



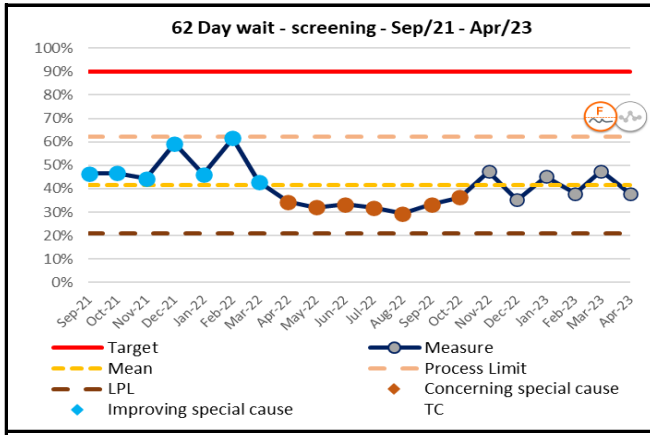
Apr-23
91.04%
Variance Type
Metric is showing common cause variation
Target
94%
Achievement
Metric is currently failing the target



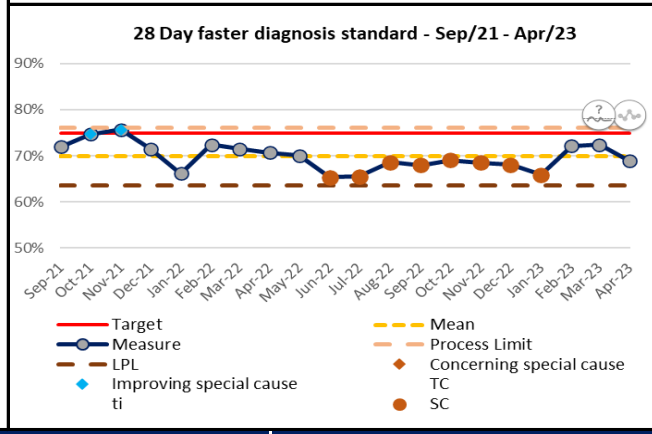
Apr-23
29.82%
Variance Type
Metric is showing common cause variation
Target
85%
Achievement
Metric is currently failing the target



Apr-23
39.36%
Variance Type
Metric is showing lower cause variation (concern)
Target
88%
Achievement
Metric is currently failing the target



Apr-23
37.84%
Variance Type
Metric is showing common cause variation
Target
90%
Achievement
Metric is currently failing the target



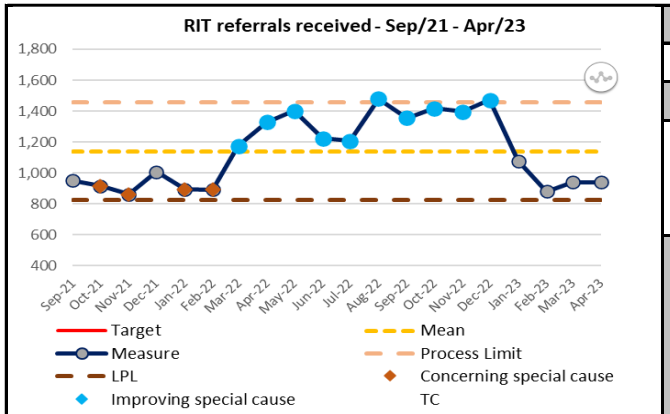
Apr-23
68.87%
Variance Type
Metric is showing common cause variation
Target
75%
Achievement
Metric is currently failing the target

Summary	Actions	Assurance
Cancer: We continue to see high volumes of 2ww referrals particularly in Breast, Gynaecology and Skin. Referrals for April 23 were around the same number that we saw in the same period last year. 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. RWT are continuing to offer around 20 skin slots per week to Walsall. Increase to Subsequent radiotherapy performance and escalation meetings are now in place. Improvements have been seen in numbers awaiting marking up. Process under review by CD and individual meetings to be held.	All cancer indicators are monitored at the weekly Trust performance meeting along with a separate weekly PTL meeting focussing on individual pathways and patients.

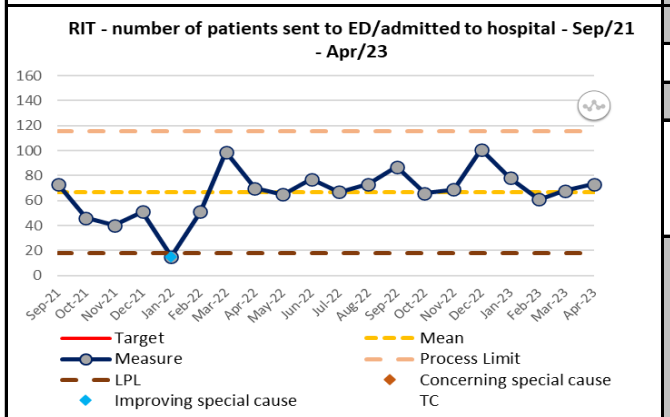
Integrated Care

Metric - Sexual Health (a month in arrears)	Target	Variation	Assurance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Total number of appointments against block contract	>/=4,500	H	F	3,455		3,455			
% appropriate patients offered HIV test	>/=95%	H	P	99.9%		99.1%			
Metric - Community Nursing (Rapid Intervention Team)	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Referrals received				1,397	1,471	1,079	882	941	941
Patients accepted and seen (actuals)				1,340	1,367	1,057	864	932	932
Number of patients sent to ED/admitted to hospital by RIT's				69	101	78	61	68	73
% of referred patients who are sent to ED/admitted				5.14%	6.86%	7.37%	7.06%	7.29%	7.83%
Number of referrals from West Midlands Ambulance Service				48	70	59	47	57	65
Night visiting service (initial)				243	271	236	217	201	206
Rapid response (initial)				928	1,017	854	703	768	748
Crisis response (within 2 hours)	>/=35%	H	P	69.7%	68.5%	75.6%	79.2%	79.7%	80.6%
Metric - Virtual Ward	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Virtual ward (initial)		H		132	153	119	94	120	119
Metric - Rapid Access Care	**Target**	**Variation**	**Assurance**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
Rapid access social care (initial)				49	62	49	43	54	55

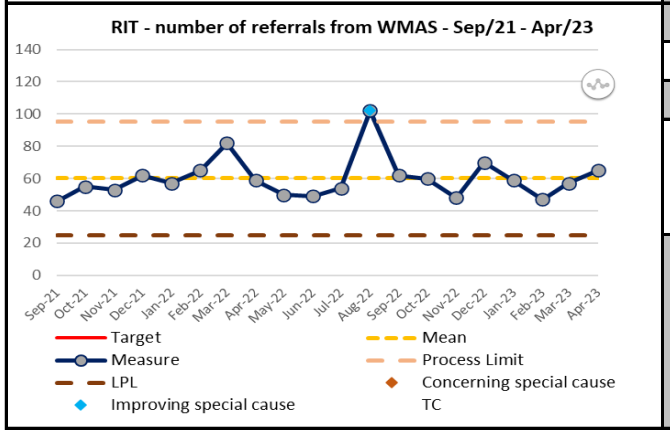
Metric - Care Co-ordination	Target	Variation	Assurance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Total number of referrals accepted				2,243	2,958	3,088	2,531	2,690	2,547
Number of referrals closed				570	898	724	668	564	867
Number signposted to ED				55	108	86	72	88	49
Number referred onto SDEC				65	51	84	58	64	47
Number referred on to community				1,539	1,884	2,171	1,728	1,952	1,557
Number of referrals sustained (admission avoidance)				13	12	15	3	11	13
Number of referrals admitted to hospital				1	5	8	2	11	14



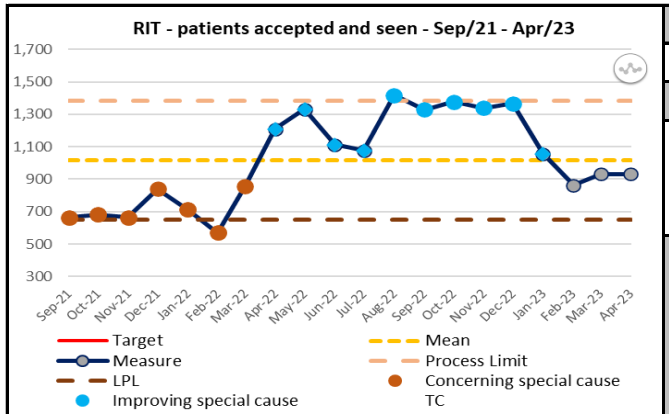
Apr-23
941
Variance Type
Metric is showing common cause variation



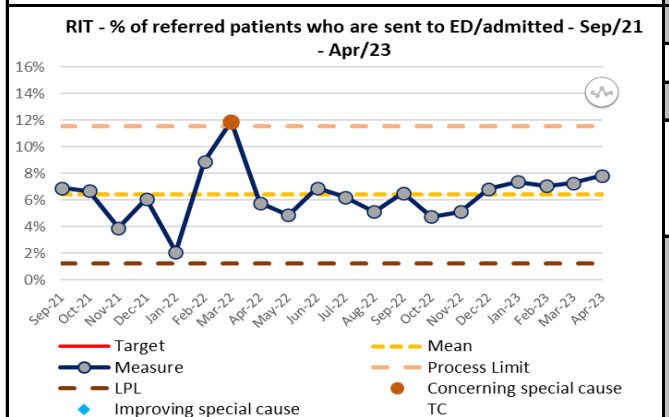
Apr-23
73
Variance Type
Metric is showing common cause variation



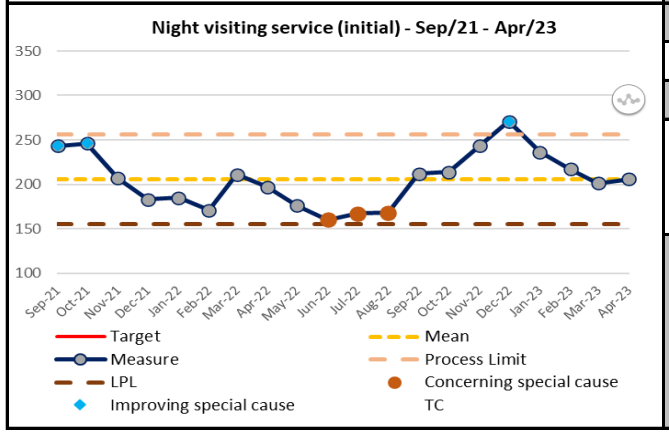
Apr-23
65
Variance Type
Metric is showing common cause variation



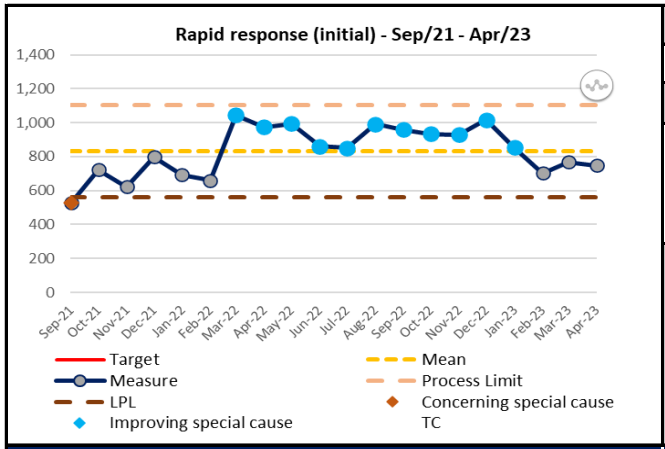
Apr-23
932
Variance Type
Metric is showing common cause variation



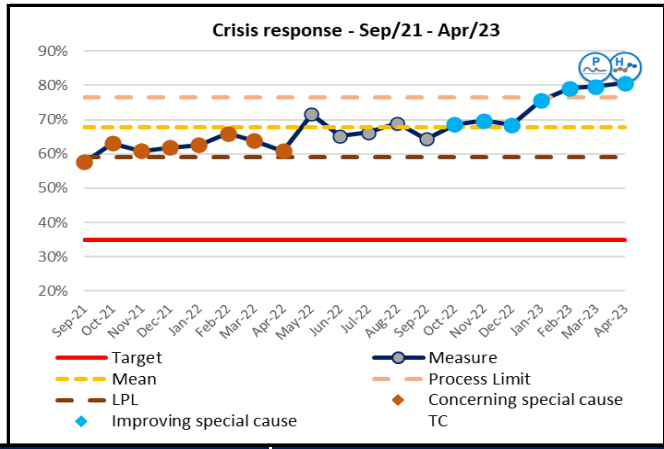
Apr-23
7.83%
Variance Type
Metric is showing common cause variation



Apr-23
206
Variance Type
Metric is showing common cause variation

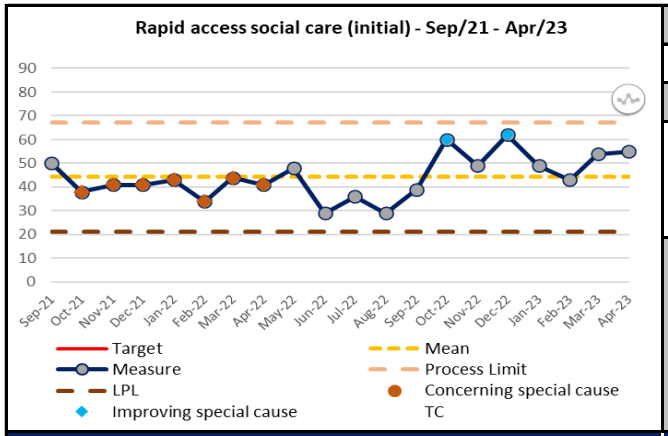


Apr-23
748
Variance Type
Metric is showing common cause variation

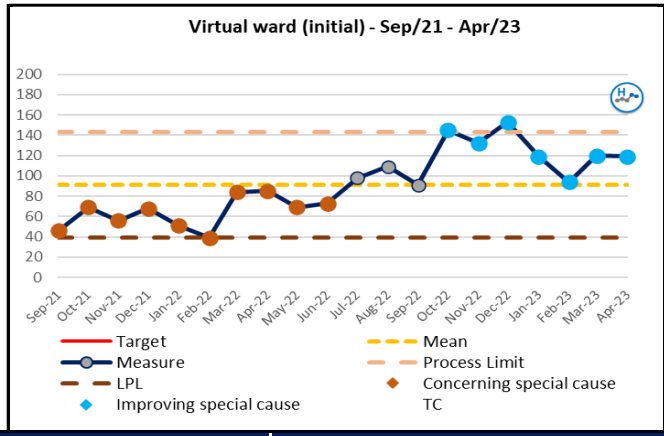


Apr-23
80.6%
Variance Type
Metric is showing higher special cause (improving)
Target
35.0%
Achievement
Metric is currently passing the target

Summary	Actions	Assurance
Community Nursing (Rapid Intervention Team): Referral numbers have remained static when compared with the previous month, however, we have seen a marked reduction over the past 3 month period. Within these referrals we are continuing to see high acuity of patients. 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. Deep dive currently been undertaken to understand the reduction in referral numbers.	WMAS DOS lead aware and continues to promote service and alternate pathways to crews.
Night Visiting Service: During April 2023 the numbers have risen very slightly in terms of referrals into the night visiting services, however, the admission numbers are remaining low.	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.

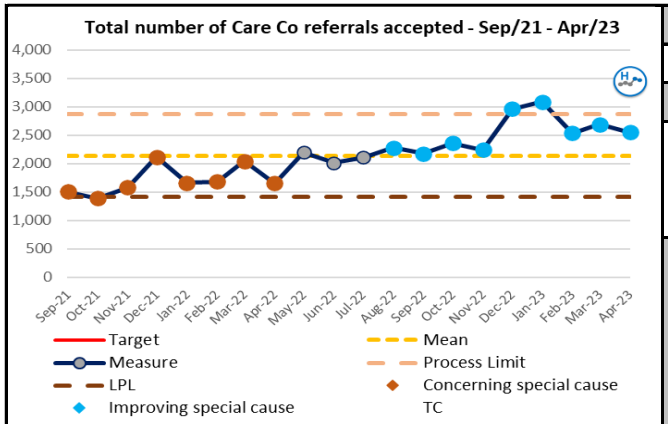


Apr-23
55
Variance Type
Metric is showing common cause variation

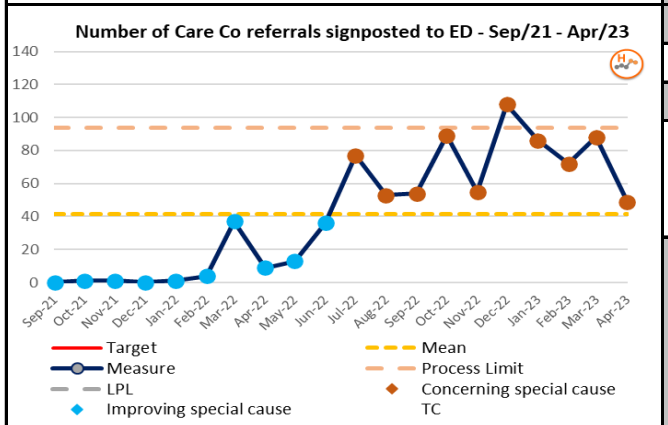


Apr-23
119
Variance Type
Metric is showing higher special cause (improving)

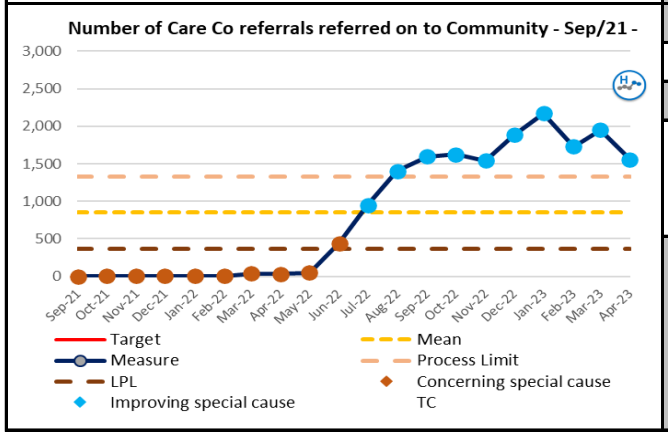
Summary	Actions	Assurance
Virtual Ward: is currently performing and managing its referrals within the current pathways. Overall the performance is demonstrating an improving trend.	Continual service developments and virtual bed expansion. Expansion of pathways in line with nationally submitted plan.	A dashboard is used to monitor use against national submission, and evaluation of the impact.
Rapid access to social care: Increased End Of Life patients on the caseload. Handoff to Social Care continues to be an on-going cause for concern. Numbers remains above the mean.	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.



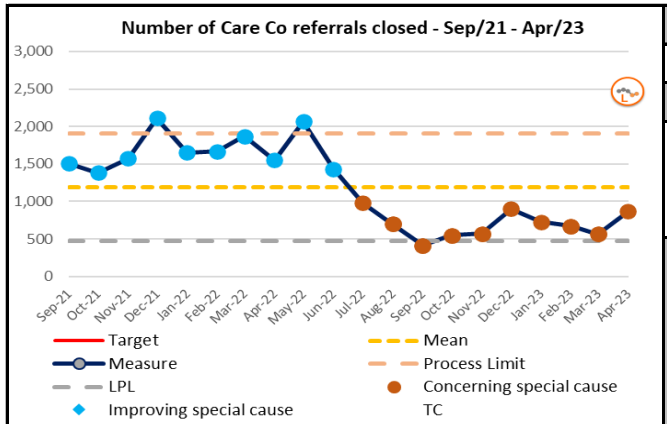
Apr-23
2,547
Variance Type
Metric is showing higher special cause (improving)



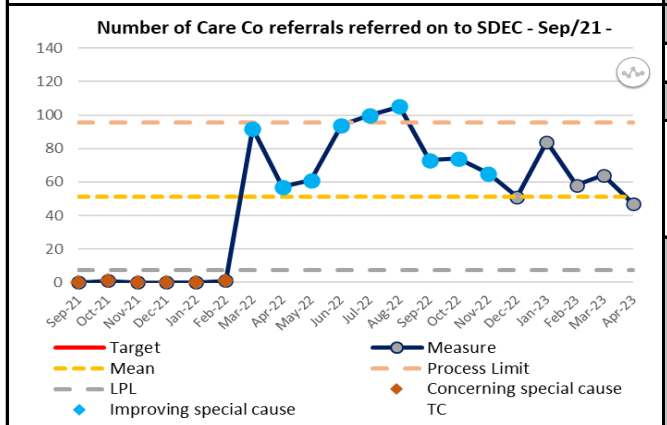
Apr-23
49
Variance Type
Metric is showing higher special cause (concern)



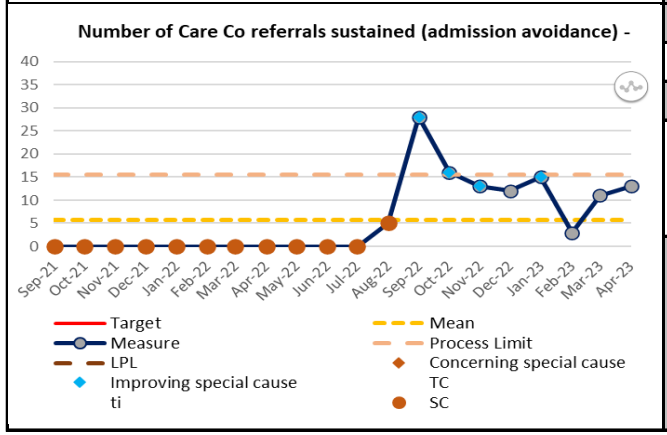
Apr-23
1,557
Variance Type
Metric is showing higher special cause (improving)



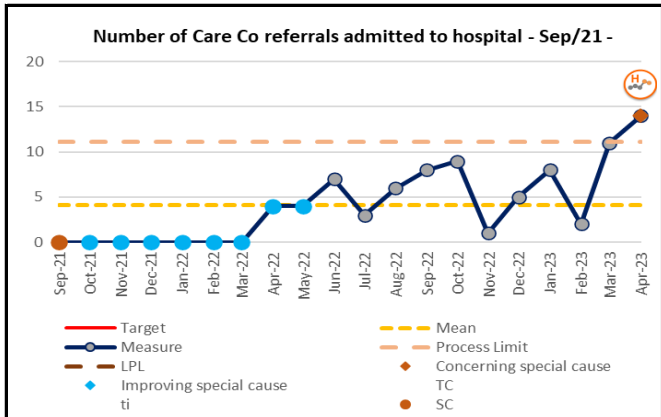
Apr-23
867
Variance Type
Metric is showing lower special cause (concern)



Apr-23
47
Variance Type
Metric is showing common cause variation



Apr-23
13
Variance Type
Metric is showing common cause variation

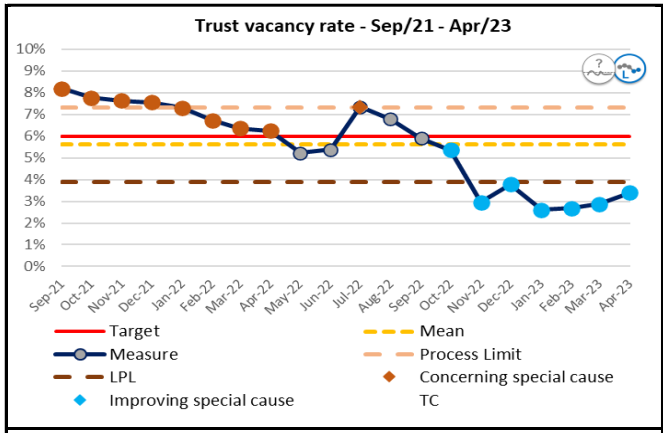


Apr-23
14
Variance Type
Metric is showing higher special cause (concern)

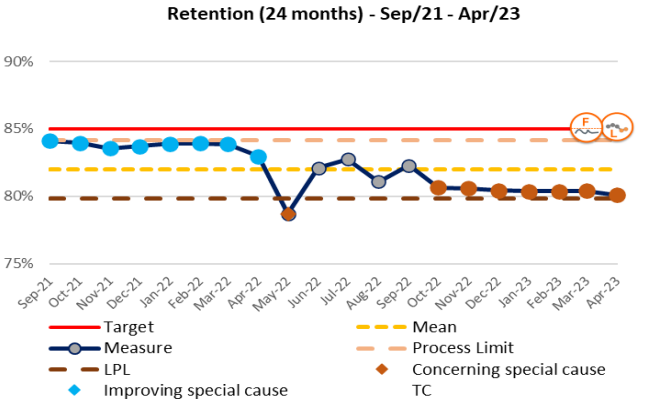
Summary	Actions	Assurance
The Care Coordination Centre streamline all referrals into Adult Community Nursing Services. They are there to help patients, relatives and other professionals ensure they access the right services they need. They triage all contacts made to the service, ensuring onward referrals are made as needed but also give health advice and education. The above graphs show the total number of referrals received into the service and the amount of referrals rejected as not appropriate.	Monitor referrals to ensure they are appropriate and not out of the area.	The Care Coordination team works 24 hours a day, 7 days a week.
Once the referral has been accepted by the service the further graphs show what numbers are streamed to alternative/appropriate pathways for the patient, thereby reducing ambulance conveyancing and ED attendance.	To support admission avoidance where possible. Support planned discharge for patients who are admitted to hospital to ensure seamless, safe and timely discharge back home is achieved.	To achieve this the Care Coordination Inreach Team visit ward areas, working collaboratively with their colleagues in the acute setting.

Human Resources

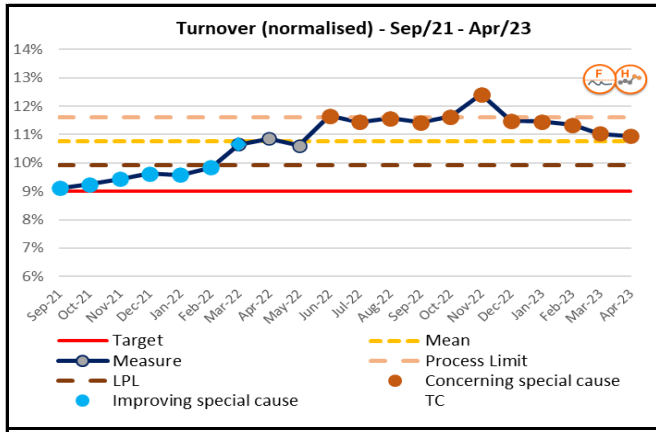
Metric	Target	Variation	Assurance	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Trust Vacancy Rate	6%	L	?	2.95%	3.79%	2.61%	2.68%	2.87%	3.40%
Turnover (normalised)	9%	H	F	12.41%	11.49%	11.46%	11.34%	11.03%	10.95%
Retention (24 months)	85%	L	F	80.60%	80.45%	80.37%	80.36%	80.41%	80.08%
Appraisals	90%	H	F	80.10%	79.70%	81.30%	83.00%	84.40%	83.70%
Mandatory Training (generic)	85%		P	94.70%	94.50%	94.70%	94.90%	95.10%	95.10%
Sickness (in month)	4.25%	H	?	5.75%	6.54%	5.41%	3.99%	5.11%	
Sickness (rolling 12 months)	4.25%	H	F	5.56%	5.62%	5.45%	5.31%	5.35%	



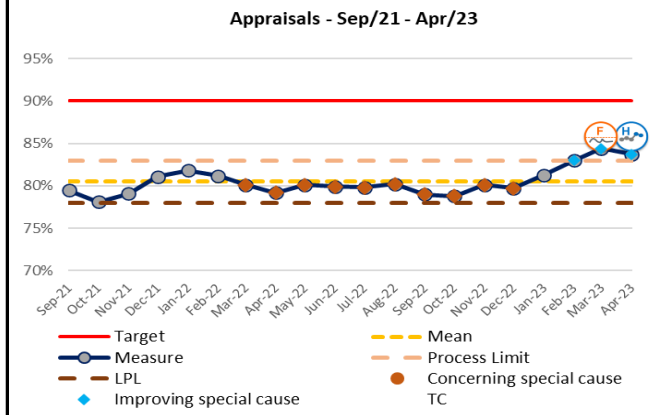
Apr-23
3.40%
Variance Type
Metric is showing lower special cause (improving)
Target
<6%
Achievement
Metric is currently passing the target



Apr-23
80.08%
Variance Type
Metric is showing lower special cause (concern)
Target
>85%
Achievement
Metric is currently failing the target

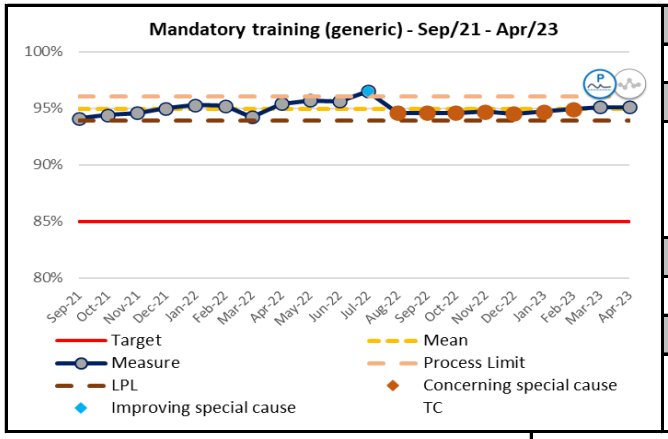


Apr-23
10.95%
Variance Type
Metric is showing higher special cause (concern)
Target
<9%
Achievement
Metric is currently failing the target

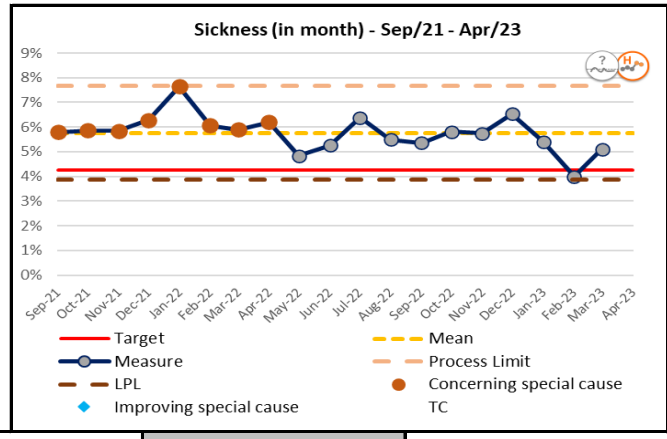


Apr-23
83.70%
Variance Type
Metric is showing higher special cause (improving)
Target
>90%
Achievement
Metric is currently failing the target

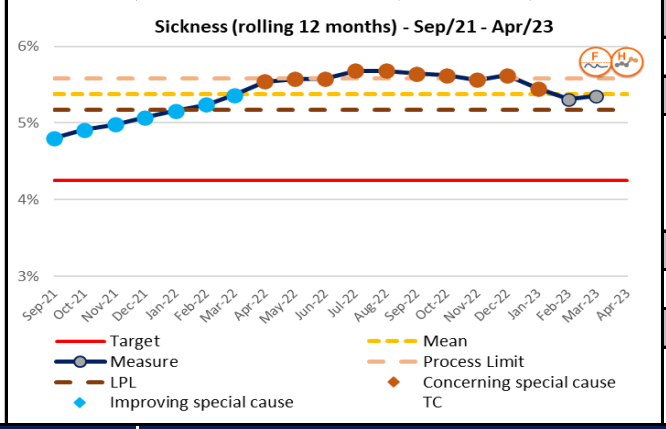
Summary	Actions	Assurance
Trust Vacancy Rate: very slight deterioration since last month, however, this indicator remains within target.	Whilst the vacancy levels are improving, there is a lead time, particularly in relation to international and newly qualified nurses where the recruitment will have 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.	The vacancy rate is now meeting the target and is improving for nursing staff.
Retention/Turnover: Turnover has shown slight improvement in April 23, whilst retention has shown slight deterioration. Both indicators remain above target.		
Appraisals: appraisal performance is seeing an improving trajectory, although compliance remains below target. Service pressures have had and continue to have a profound effect on the ability to undertake timely appraisals.	Within the Divisions - directorates and departments have been required to produce recovery plans for the delivery of appraisal activity This will be managed through the Divisions.	This matter has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.



Apr-23
95.10%
Variance Type
Metric is showing common cause variation
Target
>85%
Achievement
Metric is currently passing the target



Mar-23
5.11%
Variance Type
Metric is showing higher special cause (concern)
Target
<4.25%
Achievement
Metric is currently passing the target



Mar-23
5.35%
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, and remain above target.		
Sickness: Both indicators have seen deterioration in month and monthly sickness rate is back above target. The rolling 12 month sickness rate also remains above target. Levels of absence as a result of COVID-19 will continue to impact performance in relation to the 12 month rolling absence rate for some time.	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 undertaken to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

The Royal Wolverhampton NHS Trust

Trust Board	
Meeting Date:	6th June 2023
Title of Report:	Quality Improvement Team update
Action Requested:	Note
For the attention of the Board	
Assure	• The QI team continues to work collaboratively across both organisation, training and supporting colleagues to deliver improvements (Appendix 1) • The QI team continue to respond to the CQC requirements for organisations to develop a mature QI and Quality Management System approach via the QI Board Action plan.
Advise	• The number of staff trained is steadily increasing with a wide range of areas represented. We are below trajectory compared to ambitious training targets for QSIR P and there remains underutilised training capacity. The team continue to provide bespoke training when requested, facilitated away days, team events and QI support to all Divisions to raise awareness of QI and advertise the QSIR P offering. • The QI team are working more widely with partners across the Black Country and beyond with an established network of QI leads meeting regularly to share good practice, ideas and reviewing opportunities for closer working. A clear steer and role modelling from executives and divisions about training expectations may help engage those key directorate triumvirate teams and other change leaders working on the trusts improvement priorities. • The first joint QI awards will take place on Wednesday 5th July showcasing improvement work from teams across both Trusts
Alert	• NHSE have recently published the NHS delivery and continuous improvement review and recommendations (Appendix 2) following a request by Amanda Pritchard, NHS Chief Executive (April 2022). The Review considered how the NHS, working in partnership, can both deliver effectively on its current priorities and continuously improve quality and productivity in the short, medium and long term. The leadership team are collaborating across the BCPC and wider to review the findings and recommendations, produce a gap analysis and formulate an action plan which will be submitted in a separate report. The report recommends the following: a) Establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work b) Launch a single, shared 'NHS improvement approach' c) Co-design and establish a Leadership for Improvement programme A maturity matrix will be sent to all NHS trusts in the next few weeks requiring them to self-assess against 5 criteria: a) Building a shared purpose and vision

	b) Building improvement capability c) Developing leadership behaviours for improvement d) Investing in culture and people e) Embedding a quality management system
Author and Responsible Director Contact Details:	Dr Lee Dowson, Associate Medical Director for Quality Improvement Simon Evans, Group Chief Strategy Officer Tel 01922 695944 simon.evans8@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Safe and responsive urgent and emergency care c) Deliver the priorities within the National Elective Care Strategy
Support our Colleagues	a) Improve overall staff engagement
Improve the Healthcare of our Communities	a) Reduction in the carbon footprint of clinical services by 1 April 2025
Effective Collaboration	a) Improve clinical service sustainability b) Implement technological solutions that improve patient experience c) Progress joint working across Wolverhampton and Walsall
Resource Implications:	None
Report Data Caveats	This is a standard report using the previous quarter's data.
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:
Equality and Diversity Impact	None.
Public or Private:	Public
Other formal bodies involved:	N/a
References	B2137 - NHS delivery and continuous improvement review and recommendations - https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf
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:	Quality Improvement Team update
1.0	The purpose of the report is to inform the Board of the progress with increasing the capacity and capability of colleagues in the QI Approach, namely the Quality Service Improvement and Redesign (QSIR) programmes across the organisation, it also provides an overview of the final position for quarter 4 of financial year 2022/23.

	The paper also informs the Committee of the specific projects that are being supported by the QI team Programme Partners and Divisional Clinical leads, ensuring the QI approach is adopted in making improvements across the Trust. The QI subject matter experts have been able to support the organisation more broadly in a variety of ways, according to the requirements of the service and/or specific project.
2.0	Working closely with our WHT colleagues we have developed a bespoke Estates & Facilities QI Training package with specific plans for Bands 3-4 (half day sessions) and Bands 5-6 supervisors (full day sessions), to be rolled out during Q1 2023-24. This training will include portering, catering, medical physics, domestics, waste managers, fire officers etc with the ambitious plan for up to 90 staff to have received this training across all sites. This coincides with the roll-out of the QI huddle board, trialled with the Portering team at RWT. An improvement huddle board has also been installed at Alfred Squire GP Practice, led by our QI Clinical Divisional lead, Dr Raj Pitchika.
3.0	The QI team across both organisations are working collaboratively together, sharing resources and developing and adopting the various QI 'offerings' each provide. The team continue to provide bespoke training when requested, facilitated away days, team events and QI support to all Divisions, the detailed report provides more detail on the progress and outcomes of specific projects.
4.0	The priority areas of work for the next quarter include: • A review of the recommendations from the published guidance on the NHS Delivery of Continuous Improvement (DCI review) is being undertaken with colleagues across the BCPC to produce a gap analysis and action plan; to be submitted as a separate paper in early Summer. • Continuation of the projects identified within the Divisions to support, flow and patient safety
5.0	Detail of the QI performance pack can be found at Appendix one.
6.0	The Board is asked to **Note:** • the ongoing delivery of face-to-face and virtual training in the Trusts QI approach. • the ongoing support by the QI Team to service and trust-wide projects using a QI approach to make improvements. • the work plan for quarter 1, 2023/24.

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Quality Improvement Update

Quality Improvement Team

Kate Salmon - Deputy Director of Strategy & Improvement

Dr Lee Dowson - Associate Medical Director for Quality Improvement

May 2023

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Contents

Quality Improvement Team

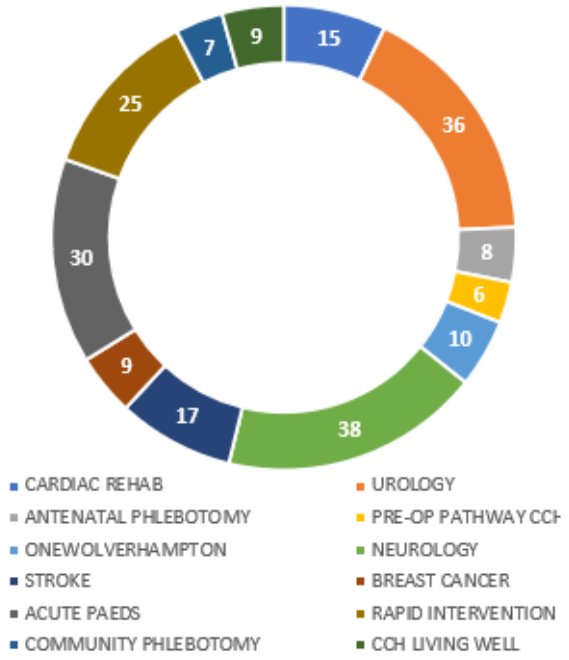
The Royal Wolverhampton NHS Trust

Capacity & Capability

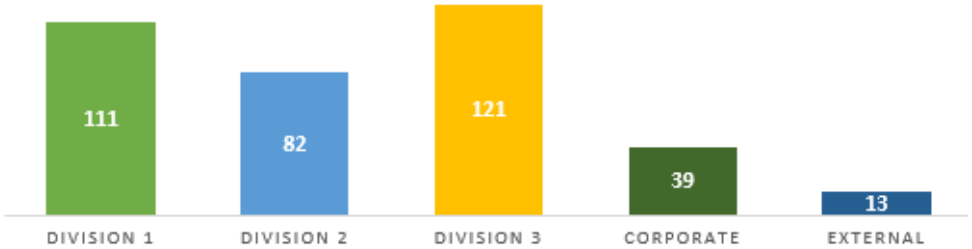
Total number of people completed or undertaking QSIR training

366

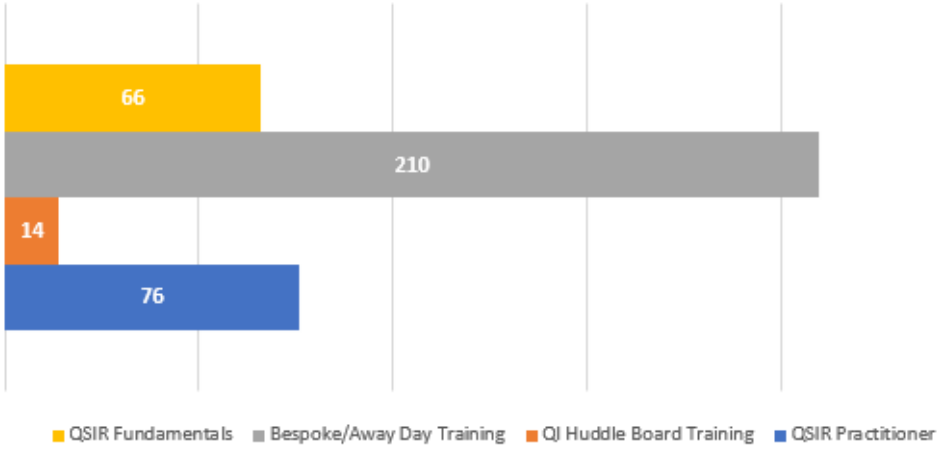
Away Days & Bespoke Training



Number of Trainees by Division



Trainees by Course Undertaken



Quality Improvement Team

The Royal Wolverhampton NHS Trust

Capacity & Capability

In addition to the QSIR training the team offer bespoke training programmes and are also leading on the QI Huddle Board Implementation Programme

QI Huddle Board Implementation Programme	The QI Team have adopted the approach which developed, tested and embedded in a few areas at WHT. The first Huddle Board has been installed in the Porters department based in the basement of A3 New Cross Hospital. Ten facilitators were identified and received QI Huddle Board training by the QI Team. QI Huddle Board meetings have been regularly held since the initial meeting held on 14th February 2023. Feedback tells us that the QI Huddle Board has been received positively by the Porters; so much so that they plan to submit an entry to the QI Awards showcasing their successes so far. A second QI Huddle Board has been installed at Alfred Squire GP practice with initial sessions identifying the need to focus appointment capacity , particularly on Monday mornings, the team is capturing data to look at the current baselines assessment of these volumes to enable them to discuss further.
Bespoke Estates & Facilities QI training Programme	Training sessions commence June 2023 across both Wolverhampton and Walsall. All sessions will open with a video message recoded by our CEO that underlines the value of our estates and facilities team and the valuable contribution they can make to QI across the organisation.

Quality Improvement Team

The Royal Wolverhampton NHS Trust

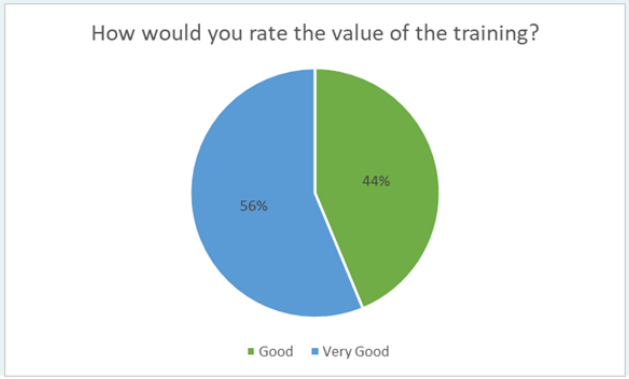
Capacity & Capability

Division One bespoke QSIR Fundamentals Training

A bespoke QSIR Fundamentals Training day was delivered to 24 colleagues from Division One's DMT and Directorate Triumvirates on 20th January to support the development of Quality Improvement capacity and capability throughout the division. The training was well received with 56% of attendees rating the value of the training as "very good" and valuing tools and methodologies such as measurement for improvement and PDSA cycles.

The day provided colleagues with the opportunity to:

- Develop QI knowledge and skills
- Explore QI methodology, tools and techniques
- Share experiences of leading improvements and learn from others
- Consider QI opportunities within their service



The day was well structured and applicable to my role

I am inspired to make sustained changes

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Team Events & Away Days

Team Away Day	Themes	Outcomes
HEE Clinical Endoscopist Course (11th January 2023 – 15 attendees)	• Quality Improvement & Leadership	The QI Team were asked to present on QI and Leadership at the national HEE Clinical Endoscopist Course to outline the role of QI and Leadership when implementing change. This is a national forum and the team have been invited back to present again June 2023.
Neurology Away Day (17th March 2023 – 38 attendees)	• Staffing & Workforce • Activity – Demand & Capacity • Communication & Infrastructure • Quick Wins for the Team	Away day outcomes shared with the team to develop further in respect of leads and aims for each theme. QI support available as required by the directorate.
OneWolverhampton Away Day (23rd March 2023 – 10 attendees)	• Communication • Stakeholder Engagement • Team processes	Away day outcomes shared with the team to take forward with the offer of QI support as required.
Stroke Follow-Up Away Day (31st March 2023 – 17 attendees)	• Front Door, TIA & Diagnostics • HASU Effectiveness & Safety • Ward Safety & Education • Discharge & Community Care	Workstream actions continue within the directorate building on previous work already underway.

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Team Events & Away Days

Team Away Day	Themes	Outcomes
Acute Paediatric Services Away Day (21st April 2023 – 30 attendees)	• Acuity and workforce pathways • Winter planning	• Workstreams being developed • Review 2022 Action Plan
Rapid Intervention Team (17th January / 9th March 2023 – 24 attendees)	• Presentation of QSIR Principles, tools and methodology • Triage, referrals and pathways • Case load management	• Development of service process map • Workstreams identified
Community Services Phlebotomy Team (30th March 2023 – 7 attendees)	• Referrals • Triage Process • Pathway Review • Work flow	• Process map developed • Workstreams identified and developed around bottle necks
Cardiac Rehabilitation Away Day (17th February 2023 – 15 attendees)	• Developing a vision for the service • SWOT analysis of current service • Workforce development	• agreed improvement priorities • A team charter that describes clear agreed upon behaviours to support service delivery and team expectations

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Theme 2 – Patient Journey

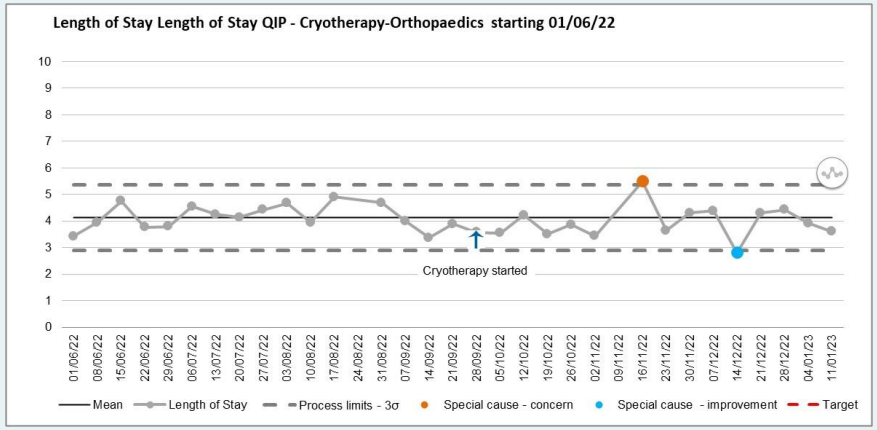
Division 1 Flow Workstreams

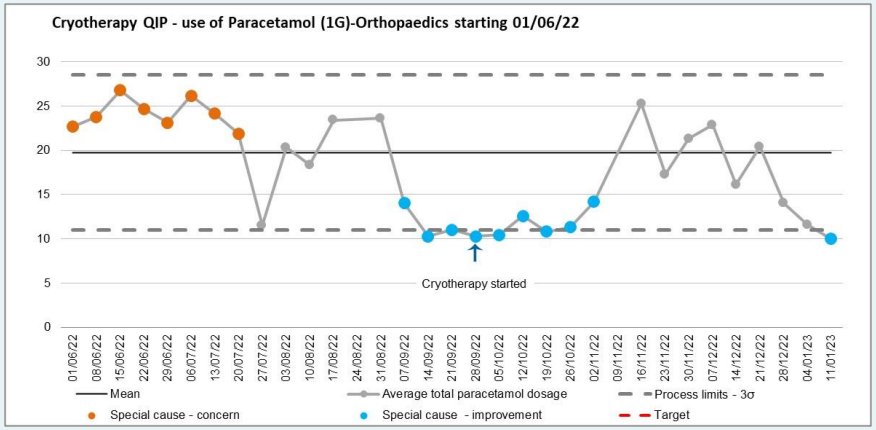
Reducing Length of Stay for Primary Hip and Knee replacements at Cannock Chase Hospital through the use of cryotherapy

The aim of the project was to use cryotherapy in 200 consecutive primary knee replacements to improve post-op management of primary Total Knee replacements and reduce length of stay over the period of the PDSA. Cryotherapy has now been used on 200 patients with primary knee replacements. The data shows no significant improvement in Length of Stay, although there has been a slight overall improvement in overall length of stay from 4.20 days compared to 3.85 days with the use of cryotherapy.
There have been improvements in the use of post operative analgesia, particularly for Paracetamol and Codeine.

Next Steps:

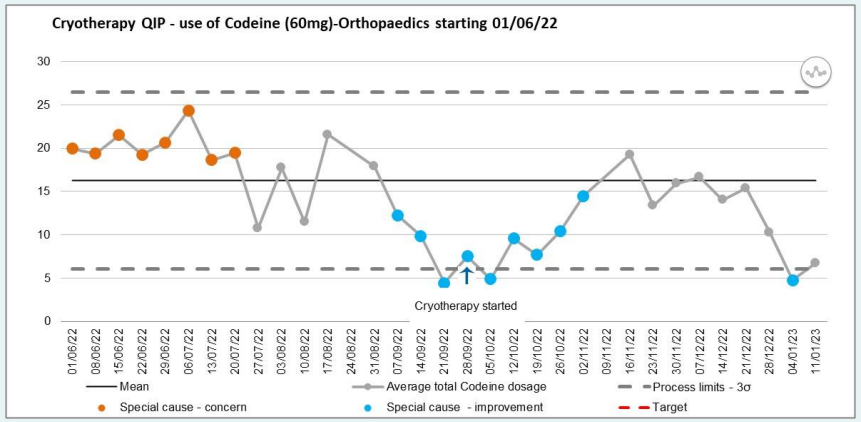
We are working with the team to capture key lessons and agree next steps. We are also facilitating a stakeholder session to define the root causes of a long length of stay for hip and knee replacements. We will
generate improvement ideas to test and ensure buy-in and ownership of QI projects – including: Cryotherapy, enhanced recovery and increasing day case surgery. The teams will continue to monitor length of stay data.

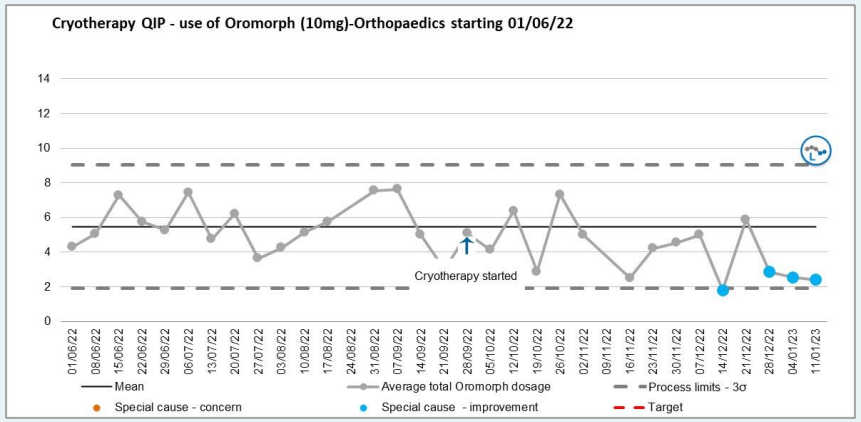




Division 1 Flow Workstreams

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





* Please note that there was no data for weeks commencing 24/8/22 and 9/11/22 due to cryocuffs being unavailable on the ward. Data was excluded for these weeks.

Division 1 Flow Workstreams
Improving trans-urethral resection of bladder tumour (TURBT) day case rates

There is a national drive to provide day case TURBT as the standard from GIRFT. Model hospital data reports that the highest performing trusts have day case rates of over 70%. Currently RWT are an outlier at 8.7% and a peer median of 32.8%. This QI project will aim to increase the percentage of TURBT rates to 30% by 1 October 2023.

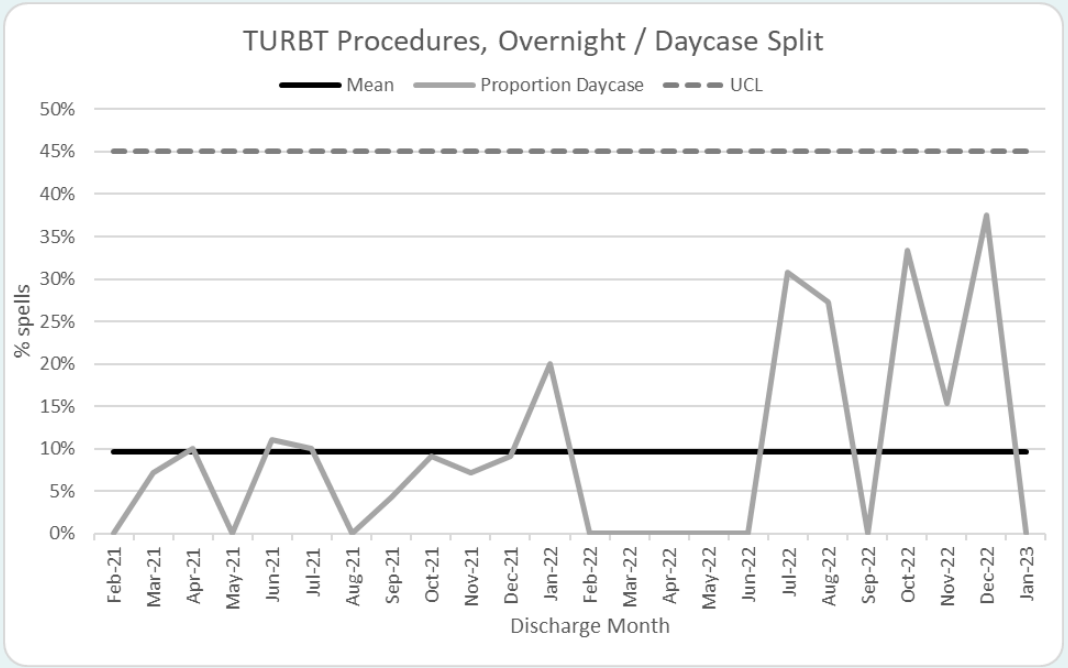
A TURBT improvement project group has been established to design and test improvements that will lead to increase day case TURBTs.

The key areas of focus as agreed by the project group are:

- Improving the criteria for day case when listing patients
- Improving time between resection and instillation of Mitomycin
- Dedicated day-case ward to increase likelihood of same day discharge

The first PDSA cycle is currently underway to improve the criteria for day case with data being gathered for:

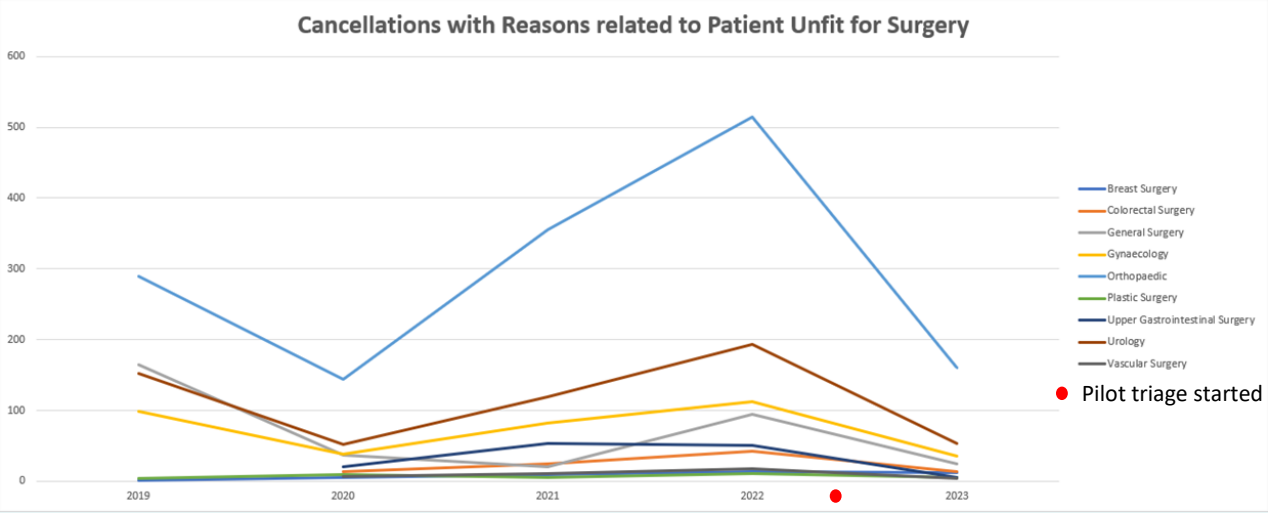
- Proportion of TURBT overnight/daycase
- Average length of stay
- Readmissions (balancing measure)



Division 1 Flow Workstreams
Reducing on the day cancellation of theatre slots by increasing time lapse between pre-op and TCI date

There are on average 8,000 patients who go through the pre-operative pathway per year. There is currently no triaging of the pathway, with all patients booked pre-operative appointments once their TCI date has been confirmed by waiting list clerks. This is often within 7 days or less of surgery once the Surgeon chooses their list. This QI project aims to reduce cancellations on the day of surgery that are associated with patients being unfit or due to the pre-op assessment itself.

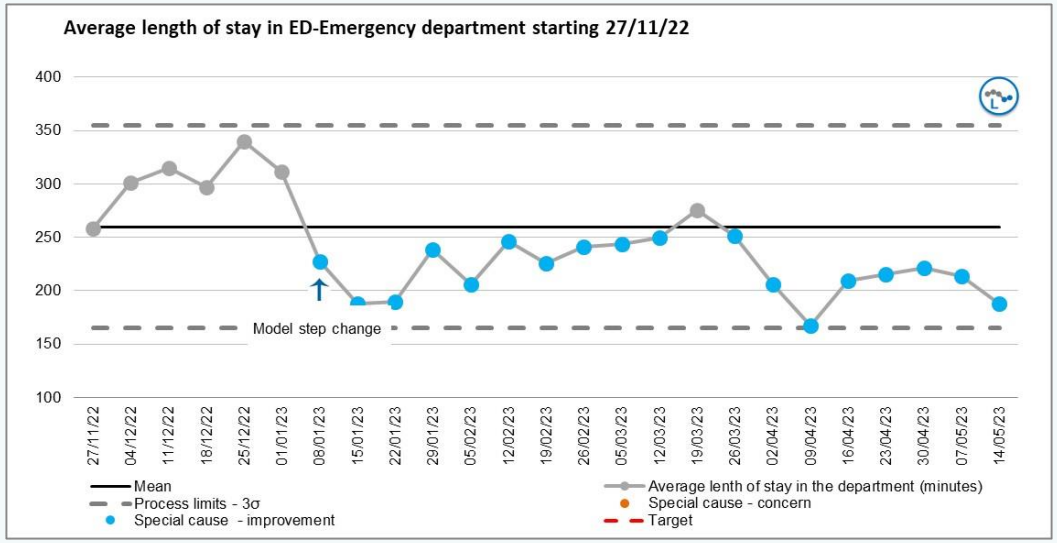
The first PDSA cycle introduced a triage pilot on 6 June 2022 in Orthopaedics, Urology and Gynaecology in 2022 which enabled patients to attend walk-in pre-op assessment on the day of consent. Data shows that cancellations related to patient unfit for surgery have decreased over the duration of the pilot phase. Data is being gathered to measure: increasing the time lapse between PreOp and TCI and reducing the time lapse between Consent and PreOp



s at Cannock Chase Hospital. The triage would take place before the patient is given a TCI date to create some slack in the process as well as developing a pool of fit for surgery patients to reduce wasted slots and ensure maximum theatre utilization.

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 re-grouped in April, post junior doctor strikes, to evaluate learning and re-review the focus for this programme of work. The programme priorities going forward will be; Earlier Specialty Review, Criteria Led Discharge and Improving Weekend Discharges. There continues to be wide representation from directorates across the Division to support the programme.
PUSH Model	The RWT version of the North Bristol Push Model was introduced in Division 2 on 27 September 2022 with a step change in the approach launched on 6 January 2023.

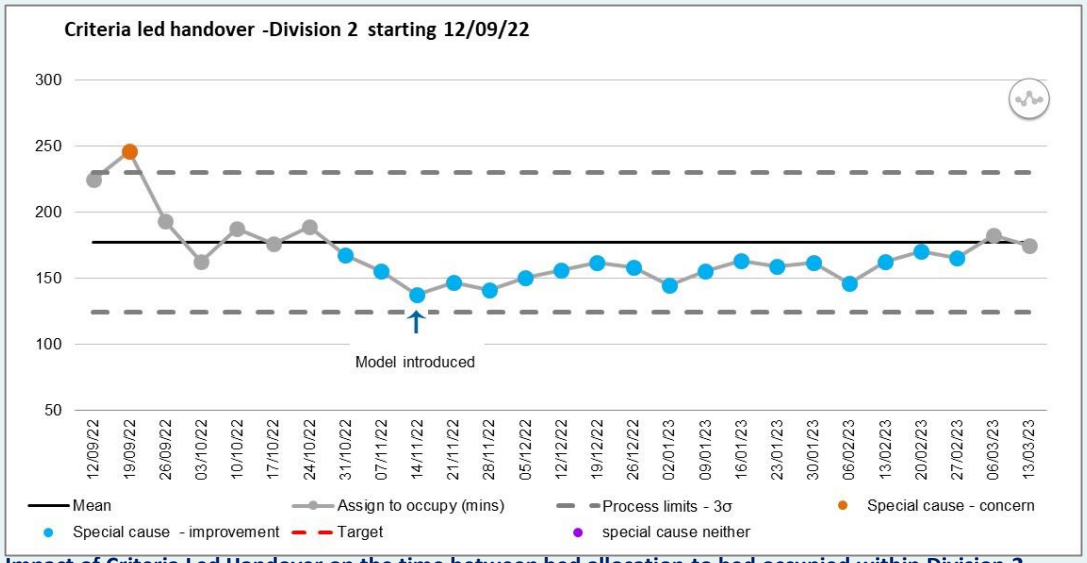


The model has developed over multiple PDSA cycles, starting with small scale tests of change so that progress can be reviewed and monitored. This has helped to ensure its sustainability; supported by lessons learnt and feedback gained from teams. It is now fully operational across Division 2 and includes patients and teams in the Emergency Department (ED), Acute Medicine Unit (AMU) and fifteen base wards.

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;

Criteria-Led Handover (CLH)

Implemented in November 2022, the aim of the project was to reduce handover delays and ensure the timely transfer of all patients between services (ED to AMU, ED to base ward, AMU to base ward, and base ward to base ward). The time between bed allocation and bed occupied across Division 2 has reduced.



Impact of Criteria Led Handover on the time between bed allocation to bed occupied within Division 2.

Following the sustained successful implementation of CLH, the initiative was amended to meet the needs of surgical patients and was implemented within the non-elective wards in Division 1 in February 2023.
From April, CLH has also been implemented for patients going to the Discharge Lounge whereby a more concise telephone handover is in place.

Division 3 Workstreams
Reducing DNA for Rheumatology Podiatry patients within outpatient settings

The aim of this project is to increase clinic efficiency by reducing the DNA rate. Patient forums will be held in May and June to gather feedback and understand the root causes for DNA's. The learning will be translated into a number of co-designed changes which will be tested using PDSA cycles in order to reduce the DNA rate, improve waiting list times and give patients a voice.

Division 3 - Living well with chronic pain self management

CCH therapy team have identified a need to increase the flow of patients though the service to most appropriate support team/service or self management system.
The QI team has supported the team with a number of QI exercises including stakeholder analysis, driver diagram and sustainability tool completion. Baseline data is being collected and change ideas are being generated for PDSA testing.

Division 3 - Community Phlebotomy – Improving time from referral to testing

This projects aims to reduce the time from referral to testing. Process mapping has been facilitated and change ideas generated including improving referral information, making the referral process more efficient. Baseline data is being collected.

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:

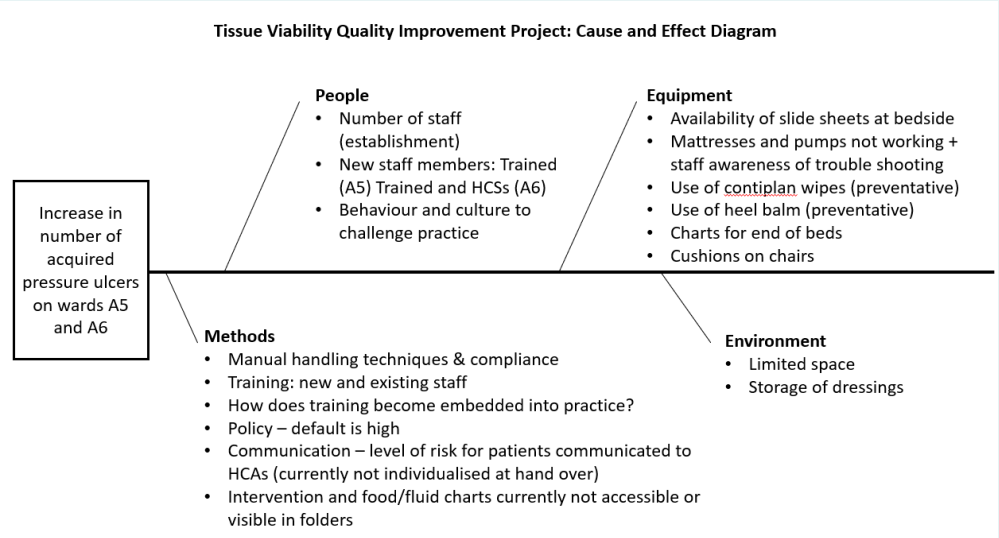
Reducing hospital acquired pressure injuries on A5 and A6

Project aim: To reduce the rate of hospital acquired pressure injuries by 50% (of 6 pressure ulcers per month to 3 pressure ulcers per month) on wards A5 and A6 by September 2023.

The QI Team facilitated a cause and effect discussion with staff on A5 and A6 to identify the causes of high hospital acquired pressure injuries.

PDSA cycles are currently underway to improve hospital acquired pressure injuries:

- TVN education facilitator providing education and training.
- Manual handling supporting the ward with better manual handling practices.
- Heel video created to increase awareness around heel friction.
- Increased use of heel balm and addition to ward stock
- Use of contiplan wipes and addition to ward stock
- The ward have also produced a TV information board



Quality Improvement Team

The Royal Wolverhampton NHS Trust

Theme 3 – Patient Safety

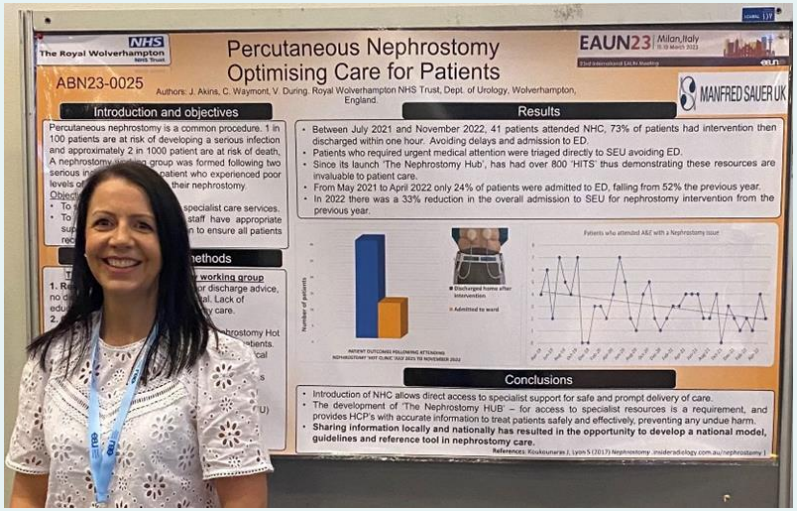
QI overview of Patient Safety Projects continued	
Improving Phlebotomy Pathway in Ante Natal Clinics	The QI team facilitated a process mapping session, following a blood sampling error RCA and several unreported near misses. The process map has provided an understanding of the current state and areas for improvement have been identified and will be taken forward by a newly formed antenatal improvement group.
E consent	Project scoping continues with input from IT and Governance teams to establish potential solutions and required infrastructure to support the project. QI support is ongoing.
Use of QR coded patient information leaflets	The introduction of QR coded leaflets reduces potential of out of date surgical informational and post operative care being used for both parental information and informed consent . Programme of work includes ENT, general surgical , dental orthopaedic and urology procedures .
Orthotic right device right place	Trauma and Orthopaedic fracture clinic and Paediatric therapy services have agreed to pilot this new of working commencing early June (subject to financial and budget discussions currently taking place\0 and data collection for current process timings.

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Good News Story

Nephrostomy Education

Nephrostomy Education Programme	The QI team supported an MDT working group to define current ways of working and the development of a new patient pathway to support improving Nephrostomy care. In December a new dedicated INTRANET page was launched containing downloadable resources, education videos and contacts for teams and supported with a communications launch to promote the materials and information available. The outcomes of this project were shortlisted for a Nursing Times National Award and Jenny Akins recently represented the Trust at the European Association of Urology Nurses (EAUN) conference in Milan. What a fantastic achievement! 

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Areas of Focus During Next Quarter

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

Capacity & Capability	• Delivery of Estates & Facilities QI Training Programme – June / July 3 one day sessions for supervisors and 6 half day sessions for team leaders will commence 5th June 2023. • Review the recommendations from the published guidance on the NHS Delivery of Continuous Improvement (DCI review) with colleagues across the BCPC to produce a gap analysis and action plan. • Further expansion of QI Huddle Boards Planning is in place to roll out the programme to Wards A5 & A6, Paediatric Assessment Unit and the Paediatric Pre Op Team
Division 1	• Signing off a portfolio of QI projects in Orthopaedics that will aim to reduce length of stay for hip and knee replacements • Antenatal improvement group: defining smart aims and measures. Working in partnership with the Patient Engagement Team to gather service user's views on the service to help inform priorities • Identifying improvement opportunities for the Lower GI 28 day Fast Track Pathway • Supporting implementation of PDSA cycles for TURBT project and hospital acquired pressure injuries

Quality Improvement Team

The Royal Wolverhampton NHS Trust

Areas of Focus During Next Quarter

The team are currently supporting projects / work programmes across the organisation however key areas of focus over the next 3 months include:	
Division 2	• Continued input into Right Patient Right Place Programme • Provide QI support to the E-Consent project
Division 3	• Health Visitor team awayday May 2023 • Development of PIFU service in Foot healthcare • Continued support for Foot health DNA workstreams • Support Paediatrics with development of SDEC model

NHS delivery and continuous improvement review: recommendations

How can improvement-led delivery enhance the quality of outcomes for our patients, communities and our health and care workforce?

19 April 2023

Publishing ref: PRN2137

Contents

Foreword

Our health and care systems have navigated the impact of an unprecedented global pandemic, which has taken its toll on our workforce, our communities and the services we deliver. Current challenges across the NHS in its immediate aftermath have posed the question of how we use learning to effectively and systematically deliver real-time improvements at scale and at pace on our shared priorities, while developing the capacity and capability of the service to improve over time.

As a result, I was asked to lead the delivery and continuous improvement review in April 2022, to consider how the NHS can develop a culture for continuous improvement while focusing on its most pressing priorities.

NHS England understands that its role is to support and champion providers and systems in delivering for people (both those who deliver and use our services) and cannot do this in isolation. To this end, while NHS England has co-ordinated this review, its content has been co-designed by engagement with more than 1,000 patients, health and care leaders including clinicians and frontline staff, managers, improvement leads, senior executives across local government, the VCSE sector, NHS providers, ICSs, regional and national teams, and the Care Quality Commission.

We felt these partnerships were crucial in ensuring that recommendations were driven by those who deliver and receive NHS services, and that this document was relevant and reflective of your experiences.

The outcome of this review is 10 recommendations that have been consolidated into three actions, which collectively have the potential to provide immediate practical support to meet the short- and medium-term challenges outlined. This document is not intended to be static. In fact, it will be refined and iterated as we receive feedback from its users on how it has been used, and where it can be improved.

Over the last year, I have been overwhelmed by the interest in this work which I believe has the capacity to give not only hope, but real benefit to every layer of our health and care system, every staff member and every patient.

Together we can learn and embed process improvement, building clinical leadership for results and in doing so address the unwarranted variation in care.

We look forward to taking the next steps with you on this continuous improvement journey.

Anne Eden, Regional Director South East, NHS England

Review findings at a glance (1)

The delivery and continuous improvement (DCI) review considered how the NHS, working in partnership through integrated care systems (ICSs), delivers on its current priorities while continuously improving for the longer term. We know that focusing on improvement, as an essential component of quality, enables us to achieve more consistent, high-quality care. The review team explored how we 'improve with purpose', using all the assets at our disposal: data and evidence, digital transformation and the skills and experience of our health and care workforce.

Having assessed the current approach to delivery-led improvement both within NHS England and more widely, the review team made 10 recommendations which were endorsed by NHS England's Executive Group (outlined in this report). NHS England's Board has now consolidated these recommendations into three actions:

1. Describe a single, shared **NHS improvement approach**. NHS England will set an expectation that all NHS providers, working in partnership with their integrated care boards, will embed a quality improvement method aligned with the improvement approach to support increased productivity and enable improved health outcomes. This will require a commitment from NHS England itself to work differently, in line with the improvement approach and the new Operating Framework.

2. Co-design with our health and care partners a **leadership for improvement programme**, commissioned and supported by NHS England, enrolling all providers and systems (including primary care) in it to support a whole-system focus on improving healthcare outcomes with our workforce, patients and communities.

3. Establish a **national improvement board**, to agree the small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work, with national co-ordination and regional leadership. The new board will support more consistent, high-quality delivery of services to improve performance and reduce unwarranted variation.

Review findings at a glance (2)

NHS England's structures and governance

do not yet optimise our ability to focus on a small number of shared national priorities effectively. Creating the new NHS England gives us the opportunity to bring together specialist delivery and improvement resource in a centrally co-ordinated, regionally-led way, with delivery of improvements through systems

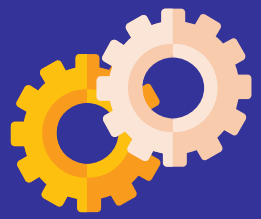
Effective improvement-led delivery of shared national priorities

requires NHS England to invest in a new approach to engaging with clinicians and operational managers at the point of care. We now need to develop a new model for how we tackle improvement challenges system-wide, sharing our learning and good practice more effectively.

A systematic approach to improvement

is embedded in many NHS organisations that deliver consistent, high-quality services with improved patient outcomes. All evidence-based quality improvement methodologies share common principles. We now need to support all leaders across providers and integrated care systems to embed those principles in practice.

Improvement methodology is important



to support a focus on improved quality and better patient outcomes. But it isn't enough. Our quality improvement efforts need to be focused on our most pressing operational and strategic challenges, within an overall focus on quality across planning, improvement and assurance.

There are further opportunities to support our most challenged organisations and systems

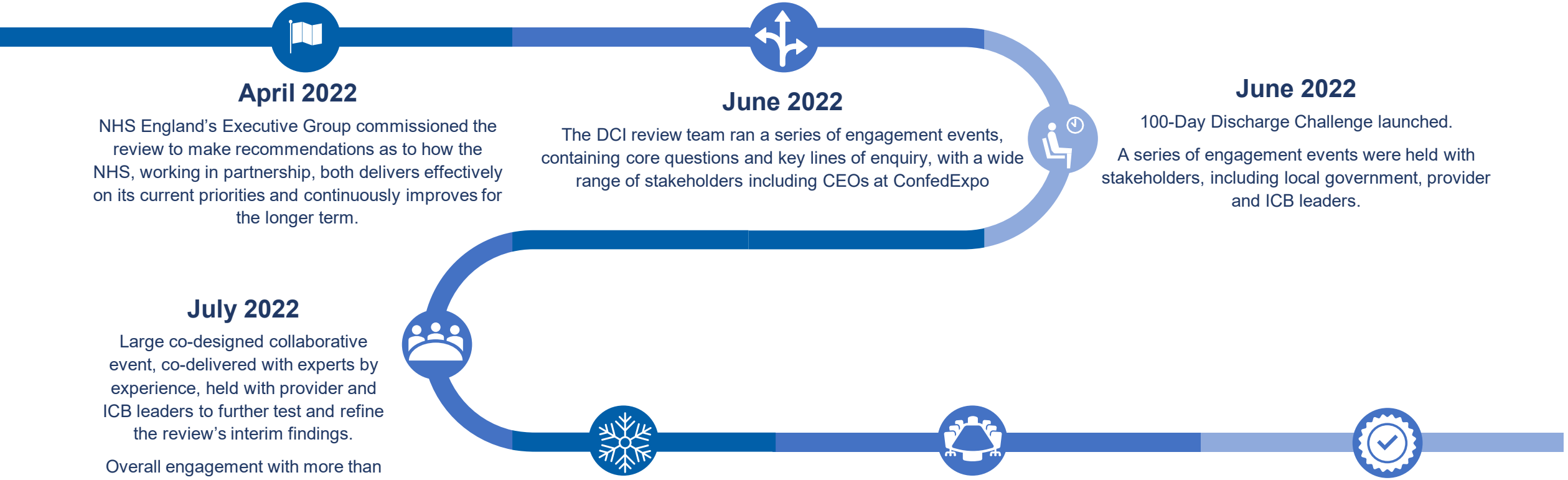
more consistently and effectively. During the DCI review, people told us that NHS England's recovery support programme works well and marks a positive shift from the previous special measures regime. We increasingly need to focus on earlier intervention for support and sustainable improvement.

NHS England can do more to provide credible and practical support for improvement-led delivery.

NHS England has a key role to incentivise a universal focus on embedding and sustaining improvement practice across our providers and integrated care systems. This includes regulatory incentives alongside clearer and more timely offers of support.

Background to the DCI review

In April 2022 Amanda Pritchard requested a review of the way in which the NHS, working in partnership, delivers effectively on its current priorities while developing the culture and capability for continuous improvement. Led by Anne Eden, NHS Regional Director South East, with a steering group chaired by Sir David Sloman, Chief Operating Officer, NHS England, the review team co-developed 10 recommendations with health and care leaders that have been consolidated into 3 actions.



April 2022

NHS England's Executive Group commissioned the review to make recommendations as to how the NHS, working in partnership, both delivers effectively on its current priorities and continuously improves for the longer term.

June 2022

The DCI review team ran a series of engagement events, containing core questions and key lines of enquiry, with a wide range of stakeholders including CEOs at ConfedExpo

June 2022

100-Day Discharge Challenge launched.

A series of engagement events were held with stakeholders, including local government, provider and ICB leaders.

July 2022

Large co-designed collaborative event, co-delivered with experts by experience, held with provider and ICB leaders to further test and refine the review's interim findings.

Overall engagement with more than 1,000 health and care leaders.

Endorsement of the review's final lines of enquiry by NHS England Executive Group.

September 2022

100-Day Discharge Challenge concluded.

Winter Collaborative launched.

October 2022

The review's findings were presented at the NHS England leadership event with ICB and provider chief executives. The review reported its findings and 10 recommendations to NHS England's Executive Group.

February 2023

NHS England's Board consolidated the 10 recommendations into three actions.

The three NHS England actions

Three actions formed from the consolidation of the DCI review's initial recommendations

	NHS improvement approach	Leadership for improvement programme	National improvement board
What is it?	Universal application of one shared high level 'NHS approach to improvement' to draw and build on the best approaches to organisational quality assurance, planning and improvement and to support increased productivity and enable improved health outcomes.	A leadership for improvement programme, commissioned and supported by NHS England, enrolling all providers and systems (including primary care) in it to support a whole-system focus on improving healthcare outcomes with our workforce, patients and communities.	A board that sets the direction for improvement-led delivery across the NHS, working with our partners. The scope and remit of the board will be informed by the new Operating Framework, with a focus on local delivery through system-working, with regional leadership and national co-ordination.
What does it mean?	All NHS providers, working in partnership with their integrated care systems, will embed an improvement method and culture aligned with the NHS improvement approach. This includes acute, community, mental health, primary care and ambulance providers.	It will create a more standardised approach to supporting providers and systems with shared priorities across England. It will help to support our most challenged organisations and systems more consistently and effectively by offering focused board level training.	It will agree a small number of shared national priorities and oversee the development and quality-assure the impact of the NHS improvement approach across all providers and systems.

NHS improvement approach

The NHS improvement approach

NHS England

NHS England will set an expectation that all NHS providers, working in partnership through integrated care systems, will embed a quality improvement method aligned with the NHS improvement approach. This will inform our ways of working across services at every level of place: primary care networks, local care networks, provider collaboratives and integrated care systems. It will require a commitment from NHS England itself to work differently, in line with the new NHS operating framework.

Drivers and enablers:

- Co-production with people and communities
- Clinical leadership
- Workforce, training and education
- Digital transformation (including federated data platform and model health system)
- Addressing health inequalities

Building a shared purpose and vision
Our workforce, trainees and learners understand the direction and strategy of the organisation/system, enabling an ongoing focus on quality, responsiveness and continued learning

Building improvement capability
All our people (workforce, trainees and learners) have access to improvement training and support, whether embedded within the organisation/system or via a partner collaboration

Developing leadership behaviours for improvement
A focus on instilling behaviours that enable improvement throughout organisations and systems, role-modelled consistently by our Boards and Executives

Investing in culture and people
Clear and supported ways of working, through which all staff are encouraged to lead improvements

Embedding a quality management system
Embedding approaches to assurance, improvement and planning that co-ordinate activities to meet patient, policy and regulatory requirements through improved operational excellence

Context: the evidence for improvement-led delivery

What is improvement-led delivery?

Improvement-led delivery involves a whole-system (or whole-organisation) focus on quality, using evidence-based quality improvement methods to increase productivity and deliver better health outcomes for patients and communities. It is underpinned by the use of data and measurement to achieve these outcomes.

Improvement-led delivery and people and communities

In organisations where improvement-led delivery has been embedded, the needs of people and communities have remained at the centre and resulted in the following:

- **Increased engagement:** People (patients and staff) have been involved in new improvement projects focused on organisational priorities, with outcomes informing the future of service provision. This has contributed to reduced health inequalities and PALS complaints and improved feedback.
- **Increased patient awareness:** Results of improvement initiatives are made visible to patients and in turn accelerates implementation.
- **Evaluation of improvement ideas:** Patients are able to support testing and evaluation of improvement ideas, before they are delivered more widely.

NHS University Hospitals Sussex NHS Foundation Trust

University Hospitals Sussex NHS FT fall reduction programme oversaw a 30% reduction in in-hospital falls.

NHS East London NHS Foundation Trust

Increase in accepted referrals for early intervention psychosis from 21% to 62% using improvement principles.

Improvement-led delivery and our health and care workforce

Our health and care workforce are tired, having supported people and communities through one of the toughest periods in the NHS's history. Organisations where improvement-led delivery has been embedded have noted the following:

- **Empowerment:** The workforce, including clinical leaders, have been engaged and equipped with the tools, routines and autonomy to drive improvements.
- **Purpose and direction:** The workforce is aligned in how their work feeds into the organisation and / or system's strategy, contributing to improved staff survey scores.
- **Improved staff morale:** They are encouraged to work on a small number of priorities that align with national and regional priorities.

NHS Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS FT finished in the top 5 and 3 nationally in the NHS Staff Survey for questions related to empowerment to make changes and improve.

NHS Surrey and Sussex Healthcare NHS Trust

SASH+ improvement work is embedded across the organisation with leaders ranging from AfC Band 4 to executives able to train and coach their own staff.

What is the evidence?

Improvement-led delivery is a long term approach to delivery that facilitates stronger organisational governance, productivity and positive cultural change over time. Many parts of the NHS have a long tradition of embedding approaches focused on quality improvement:

Alder Hey Children's NHS Foundation Trust

- Jumped from a baseline patient experience score of 59% at the beginning of the approach in 2020 to 92% in August 2022.
- 20% reduction in administration and prescribing errors for 2021-2022.
- HR time-to-hire fell from 68 to 28 days.

Surrey and Sussex Healthcare NHS Trust

- Consistently rated "Outstanding" by CQC since 2019.
- SASH+ improvement work is embedded across the organisation with leaders ranging from AfC Band 4 to executives able to train and coach their own staff.
- Collaborative quality improvement award in 2021 for their ICU clinic, increasing patient experience.

Berkshire Healthcare NHS Foundation Trust

- Rated "Outstanding" by the CQC since March 2020. CQC commented that 'staff across the trust felt valued and there was a real focus on doing what was best for staff, patients and carers'.
- NHS Staff Survey results were in the top 20 percent of scores.
- Reduced prone restraint use in adult acute and children settings by 61% in 15 months.

University Hospitals Sussex NHS Foundation Trust

- Transitioned from "Quality / Financial Special Measures" to "Outstanding" on all sites in all domains in 2019.
- The CQC noted exceedingly high 'buy in' from staff.
- Fall reduction programme oversaw a 30% reduction.
- Reduced 24 hour delayed discharges by as much as 75%.

East London NHS Foundation Trust

- Consistently rated "Outstanding" by CQC.
- A Total Quality Management System has been embedded. This applies across quality planning, assurance and improvement.
- Increase in accepted referrals for early intervention psychosis utilising improvement methods.

The Leeds Teaching Hospitals NHS Trust

- Rated "Good" by the CQC, improved from "requires improvement".
- Transitioned from a £100m deficit to a £19m surplus.
- 26% reduction in falls across the organisation - equating to approximately 65 falls per month and 780 falls per year.

Appendices

These DCI review's 10 recommendations were presented to NHS England's Executive Group in October 2022

Create a more standardised approach to shared priorities across England

1. NHS England's Executive Group will agree a small number of more consistently executed priority improvement initiatives, offering national co-ordination and regional leadership to support delivery.
2. NHS England will consolidate capability and expertise into a national priority improvement function, whose role is to co-ordinate action on a small number of pan-national improvement priorities on a rolling basis.
3. NHS England will test the model for the new priority improvement function through delivery of a winter collaborative. Action co-ordinated through the winter collaborative will be codified into more standardised approaches to delivery and improvement to support the spread and scale of learning.

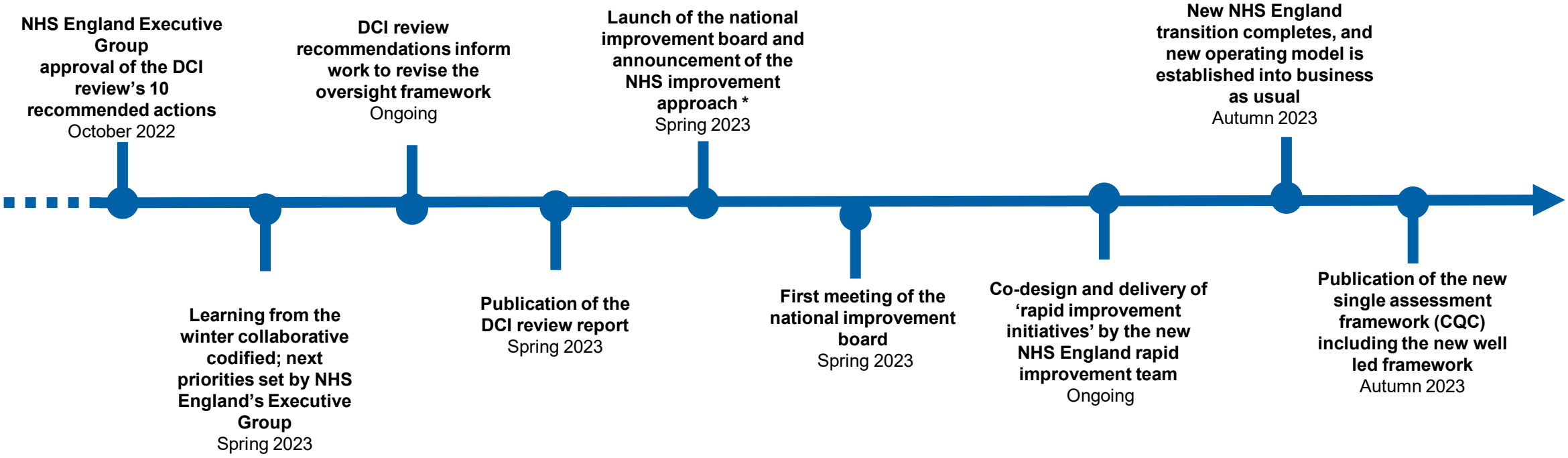
Embed continuous improvement-led delivery across all providers and integrated care systems

4. NHS England will set an expectation that all NHS providers, working in partnership with integrated care boards, will embed a quality improvement method aligned with the NHS improvement approach.
5. NHS England will collaborate with partners to co-develop leadership development products that support health and care boards, executives and the wider workforce to embed the NHS improvement approach in their organisations and systems.
6. NHS England will work with the CQC to align the revised CQC well-led with the improvement approach.
7. NHS England will critically review the NHS oversight framework, to incentivise providers and systems to embed improvement-led delivery.

Support our most challenged organisations and systems more consistently and effectively

8. NHS England's Support for Challenged Systems team will work with and through the regions to more consistently co-ordinate intensive support. This will include continued collaboration with other regulators and royal colleges to ensure consistent support and no duplication.
9. Further develop peer support between providers and systems, including through enhanced support for provider collaboratives programmes and pre-existing provider peer support networks.
10. NHS England will review the balance of national and regional resources between intensive support, pathway programmes and general capacity building. This will include an assessment of how national and regional teams more consistently support organisations in segment 3 and offer longer-term support to organisations exiting segment 4.

Proposed timeline for implementing the three actions



*** 19 April 2023: Publication of this Delivery and Continuous Improvement Review at NHS England's NHS leadership event with ICB and trust CEOs**

DCI review method and engagement process

The review team gathered evidence and insights directly from more than 1,000 people across the health and care system. Participants who have provided their insights and feedback include:

- Lived experience partners through NHS England's experience of care team
- ICB chief executives and non-executive directors (NEDs)
- Provider chief executives and NEDs
- Clinical leaders and people working at the point of care, such as nurses, GPs, consultants, and pharmacists
- Strategic roles including operational, improvement and transformation specialists
- ALB partners and collaborators, such as AQUA, CSUs and Health Data Research UK
- Networks, think tanks and academics, such as Q community, The King's Fund, and The Health Foundation.
- National bodies, such as CQC, local government representatives, and NHS Confederation
- Regional groups, such as local health and social care partnerships, and Academic Health Science Networks
- NHS England national and regional teams

Emerging insights were reported to the review's fortnightly steering group chaired by Sir David Sloman and Anne Eden.

During the course of the review, we provided inputs into several concurrent work programmes, seeking to align our emergent findings where appropriate. These included:

- The operating framework programme
- The Creating the new NHS England change programme
- Finance and productivity board
- NHS England business planning and guidance

The review team did not undertake original quantitative research or analysis. It focused on collating and considering existing research and evidence to inform our recommendations.

While we have set out implementation plans to sit alongside these recommendations, we recognise that:

- our recommendations are closely interdependent with the ongoing NHS England change programme, which will shape how NHS England's operating framework is realised.
- full implementation of our recommendations across the NHS (and, in time, health and care systems) will require ongoing co-design between national and regional teams with leaders in systems and providers as well as wider partners, using a collaborative approach centred on learning.

The Royal Wolverhampton NHS Trust

Trust Board		
Meeting Date:	6th June 2023	
Title of Report:	Safeguarding Children, Adults and Young People in Care Service Update Report: Q4 (January-March 2023)	
Action Requested:	The Safeguarding report is presented to the Group for information and assurance of progress.	
For the attention of the Board		
Assure	• During Q4, Midwifery safeguarding supervision compliance has improved significantly and now stands at 95% in comparison to 25% in Q3. • All outstanding actions for Safeguarding Adult Review 'Stan' are now complete. • Disclosure and Barring Service (DBS) compliance data demonstrates significant progress and now stands at 100% for new starters and 98.2% for existing staff.	
Advise	• Staffing shortages within the Health Visiting Service have impacted on safeguarding supervision. As a result, compliance has fallen from 94% in Q3 to 83% in Q4. • The children's electronic multiagency referral system was changed by the Local Authority in February 2023. This caused problems where referrals from RWT were not submitting to the Local Authority site. • A business case has been developed for the expansion of the Learning Disability (LD)Team following an external review by 'Changing Our Lives'. This reflects the recommendations for a safe and equitable service for people with learning disabilities and or autism. • There has been further escalation to the Local Authority and Integrated Care Board (ICB), around the current compliance for Initial Health Assessments (IHA), which demonstrate an average of 23% overall compliance and 31% compliance within provider control.	
Alert	A Trust wide audit of mental capacity assessments (MCA) has found that only 16% of assessments adhered to RWT Record Keeping Policy.	
Author and Responsible Director Contact Details:	**Authors** Clare Hope Tel: 01902 695163 Email: Clare.hope@nhs.net Fiona pickford Tel: 01902 695163 fiona.pickford@nhs.net **Responsible Director** Debra Hickman Director of Nursing Tel: 01902 307999 ext. 85961 debra.hickmn@nhs.net	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement
	Support our Colleagues	

	Improve the Healthcare of our Communities	a) Deliver improvements at PLACE in the health of our communities
	Effective Collaboration	a) Improve population health outcomes through provider collaborative. b) Implement technological solutions that improve patient experience. c) Progress joint working across Wolverhampton and Walsall
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	This report relates to adults and children and considers disability and the impact of abuse.	
Risks: BAF/ TRR	5388, Mental Capacity Assessment, score 15 (Red) - risk remains unchanged. 4812, Children and Young People in Care, score 9 (Amber) – risk remains unchanged	
Risk: Appetite		
Public or Private:	Public	
Other formal bodies involved:	ICB Matrons, Senior Nurses, Midwifes and Health Visitors Group Trust Safeguarding Group	
References	A variety of references apply to the topics outlined in this 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	

Brief/Executive Report Details	
Brief/Executive Summary Title:	Safeguarding Children, Adults and Young People in Care Service Update Report: Q4 (January-March 2023)
Item/paragraph 1.0	• Disclosure and Barring Service (DBS) compliance data demonstrates significant progress and now stands at 100% for new starters and 98.2% for existing staff (compliance December 2022 - 83% new staff, 92% existing staff). This improvement has been brought about by data cleansing and improvement in reporting processes. • All mandatory safeguarding training is in line with ICB compliance requirements. During Q4, MCA/Deprivation of Liberty Safeguards (DoLS), Prevent, Safeguarding Children and Safeguarding Adults level 1 and level 2 training has demonstrated compliance of 96% or above. • The number of DoLS applications submitted by RWT has increased by 26% in Q4 in comparison to Q3. This increase reflects March 2023 having the highest monthly total for the year 2022-23, when 53 DoLS were submitted (the monthly average for the 2022-23 year is 38). • During Q4 the Trust submitted 60 Safeguarding Adult referrals to the Local Authority, which demonstrated an increase of 20% in comparison to Q3 (where there were 50 SA1 referrals). However, 60 remains in line with the 2022-23 quarterly average of 58.

- A business case has been developed for the expansion of the Learning Disability (LD) Team following an external review by 'Changing Our Lives'. RWT currently employs three members of staff including 1 band 7 (1 WTE) and 2 band 6 (2 WTE), these posts are employed as LD specialist practitioners. There is an identified gap in service provision for autistic people of all ages. Therefore, the Trust is not meeting its legal requirements (Equality Act 2010, Autism Act 2009, Care Act 2014).
- The number of adult LD patients, who did not attend (DNA) or were not brought to outpatient appointments reduced throughout Q4. Urology patients have had a 0% DNA rate for 7 months in a row. This is attributed to the departments proactive approach and positive relationship with the Safeguarding LD team.
- During Q4, Midwifery safeguarding supervision compliance has improved significantly and now stands at 95% in comparison to 25% in Q3. This improvement is due to an increased number of supervisors and improved capacity within safeguarding and maternity services.
- Female Genital Mutilation (FGM) data disclosures in women booking with maternity services maintains an upward trend (Q1 – 26, Q2 – 33, Q3 – 41, Q4 – 37). As a result, a project to improve the availability of FGM information and resources to women with a FGM history at time of booking is being undertaken.
- Staffing shortages within the Health Visiting Service have impacted on the ability of staff to attend safeguarding supervision in a timely manner. As a result, compliance has fallen from 94% in Q3 to 83% in Q4. Supervision has now been provided and compliance will be updated in Q1 2023-2024.
- The children's electronic multiagency referral system was changed by the Local Authority in February 2023. This caused problems where referrals from RWT were not submitting to the Local Authority site. This issue was escalated to both the Local Authority and RWT services. A contingency plan was put in place for RWT staff to ring concerns directly through to the Multiagency Safeguarding Hub (MASH) and follow-up with an e-mail communication, until the issue is resolved. During Q1 progress has been made and the fault identified (generic email accounts). It is anticipated that a plan to resolve the issue will be in place by May 2023
- There has been further escalation to the Local Authority, Integrated Care Board (ICB), Clinical Quality Review Meeting and to Trust Board around the current compliance for Initial Health Assessments (IHA). Whilst action plans have been progressed, changes made to local processes and improvements noted in terms of the time taken to receive, process, clinic capacity and return the assessments, compliance remains poor. During Q3 compliance had improved to an average of 56% (overall) and 70% (within provider control) however during Q4 there was an average of 23% (overall) and 31% (within provider control). A meeting with the Director of Nursing, Children and Young People in Care (CYPiC) Team Lead, Named and Designated Doctors for CYPiC has been arranged for Q1, to review the current compliance, actions taken and plan to improve.

- A Trust wide audit of mental capacity assessments (MCA) completed by clinical staff across the Trust was undertaken in March 2023. The purpose of the audit was to review whether mental capacity assessments were completed in line with the Record Keeping Policy. The audit consisted of a sample size of one hundred patient records, across the three hospital sites. The findings suggest that only 16% of assessments adhered to the policy. Although there has been a successful drive to improve the overall compliance of mental capacity assessments, it is evident from the data that additional work is required to improve the quality of assessments completed. This work will be undertaken throughout 2023-2024.
- A Safeguarding Training Task and Finish Group has been convened to examine and review current training provision across both RWT and WHT. The aim of this group is to review current training packages, delivery methods and revisit the mapping of staff trust wide to ensure that all staff are completing the most appropriate level of safeguarding training. This will ensure that both organisations have a high quality and consistent approach to training (in keeping with the Intercollegiate documents 2018/19). It is hoped to launch the new training packages in summer 2023.
- RWT has attended all respective safeguarding case review groups across the region. This covers work aligned to Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Learning Disability Reviews (LeDeR) and Domestic Homicide Reviews (DHR).
- No Domestic Homicide Reviews, Child Practice Reviews or Safeguarding Adult Reviews have been published in Q4.
- Maternity duty advice call service activity increased in Q4, demonstrating the second highest amount of activity within the year (Q1 – 186, Q2 – 228, Q3 – 131, Q4 - 202). This may be linked to improved capacity within the Safeguarding Team and several complex cases requiring more direct advice.
- During Q4 there were 9 S42 Safeguards Against the Trust, all were in relation to neglect/acts of omission.
- The total number of MASH checks completed by the safeguarding adult team increased in Q4 by 7%. Concerns relating to financial abuse were identified in the largest number of cases, whilst domestic abuse and neglect accounted for the second and third largest categories.
- It is positive to note that 19 MARAC referrals were made by the Trust in Q4, which is an increase of 67% compared to previous Q3 data.
- In January 2023, RWT participated in a Mock Joint Targeted Annual Inspection (JTAI). Of the 6 cases discussed a multi-agency rating of ‘good’ was given to 4 cases and 2 were assessed as ‘Requiring Improvement’. A multi-agency action plan has been developed and will be shared across RWT in Q1 2023.
- Daily monitoring of 16–17-year-olds that are nursed on adult wards has continued, with 67 children being nursed on adult wards during Q4. This is in keeping with Q3 data, but an increase from Q2 data.

	• A reasonable adjustments tab has been developed on Clinical Web Portal; this tab is now live. The function of the tab is to allow all staff to record any reasonable adjustments that an individual patient may have. The tab has been designed to allow it to be used with all patients and can include a number of adjustments including a language barrier requiring an interpreter, to the patient requiring additional time for their appointment. • During Q4 there has been an increase noted in the number of CYPiC strategy meetings being held from 12 in Q3 to 18 in Q4 and a significant increase in care planning meetings totalling 32 in Q4 in comparison to 16 in Q3 • Adoption medicals examinations continue to be undertaken every 6 months for children under the age of 5 years of age. This continues to be managed within the medical and administration team and has identified no notable pressures on the service requiring escalation. • RWT have continued to submit the ICB dashboard on a monthly basis which provides assurance against the standards outlined in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) 2021-2022 (aligned to national and local safeguarding standards including the requirements from CQC, NHS Learning Disability Standards and Wolverhampton Safeguarding Together Partnership). This data has been presented to the Trust Safeguarding Group with exceptions discussed and escalated (as described within this report).

The Royal Wolverhampton NHS Trust

Trust Board		
Meeting Date:	6th June 2023	
Title of Report	Nursing Skill Mix Report	
Action Requested:	Receive and note	
For the attention of the Board		
Assure	• Trust has undertaken phase 2 (2022-2023) of the biannual skill mix review of: o adult inpatient wards o adult acute assessment units and o paediatric inpatient ward o emergency department utilising Safer Nursing Care Tool, an evidence-based acuity/dependency tool. The review also used the triangulation approach as recommended by NHSI Developing Workforce Safeguards document	
Advise	• This is Phase 2 of the biannual skill mix review and as such will be reviewed – to provide an annual overview of the last financial year. • This phase reflects recommendations for movements of funding within the Divisions to support establishment changes and will be processed through appropriate governance mechanisms. It also recommends movement of funding within the Emergency Department to support skill mix requirements and the requirement of a supporting business case to maintain operational delivery of the Ambulance Receiving Centre and additional ambulance offload spaces following cessation of Winter Funds • Compares against national benchmark data.	
Alert	• None	
Author and Responsible Director Contact Details:	Chrissla Davis- Head of Nursing Workforce Tel 01902 86974 Email chrissla.davis@nhs.net Debra Hickman, Director of Nursing	
Links to Trust Strategic Objectives	***Strategic Aim (SA)***	***Associated Strategic Objectives (SO)***
	Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement b) Safe and responsive urgent and emergency care c) Deliver the priorities within the National Elective Care Strategy d) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
	Support our Colleagues	a) Be in the top quartile for vacancy levels 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 Standards
	Improve the Healthcare of our Communities	a) Develop a health inequalities strategy b) Reduction in the carbon footprint of clinical services by 1 April 2025 c) Deliver improvements at PLACE in the health of our communities
	Effective Collaboration	a) Improve population health outcomes through provider collaborative b) Improve clinical service sustainability c) Progress joint working across Wolverhampton and Walsall d) Facilitate research that improves the quality of care

Resource Implications:	Workforce: Business case to support Paediatric requirement – to be completed separately. Funding Source: as above.
Report Data Caveats	This is a standard report using the January 2023 data. It may be subject to cleansing and revision.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**
Equality and Diversity Impact	NA
Risks: BAF/ TRR	None
Risk: Appetite	None
Public or Private:	Public
Other formal bodies involved:	None
References	If required/appropriate e.g. if addressing a national policy priority.
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:	Biannual Skill Mix Review – Phase 2
Item/paragraph 1.0	**Division 1: Phase 2 Skill Mix Review has identified:** No additional funding requirement, however, there is a requirement for alterations of budgeted establishments to be moved within the Division to align budget and establishment requirements. **Division 2: Phase 2 Skill Mix Review has identified:** No additional funding requirement, however, there is a requirement for alterations of budgeted establishments to be moved within the division to align budget and establishment requirements, supported predominantly by the reduction in establishment on C17. **Division 3: Phase 2 Skill Mix Review has identified:** The support of Paediatric business case to increase the required establishment. A21, Paediatric Assessment Unit (PAU) and A23 have been split to appropriately identify staffing requirements following review of service and changes since the Covid 19 pandemic with the need to provide separation of the elective surgical pathway on A23.

	A21 (Paediatric Inpatient Ward) requires support via business case/specialist commissioning to create and maintain Level 2 HDU facilities. **PAU (Paediatric Assessment Unit)** requires support via business case to provide additional Registered Nurses (RN) support to maintain patient safety. **A23 (Paediatric Elective Surgery)** requires support via business case to provide additional RN & Health Care Support Worker (HCSW) support to maintain patient safety. **Emergency Department** No additional funding is required, however there is a requirement for alterations within budgeted establishment to ensure clinical support associated with a junior skill mix. A business case is required to recurrently fund the Nursing establishment for the Ambulance Receiving Centre and offload areas.

THE ROYAL WOLVERHAMPTON NHS TRUST BIANNUAL SKILL MIX REVIEW

PHASE 2– January 2023

Chrissla Davis

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INTRODUCTION

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

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

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

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

This tool enables the measurement of both acuity and dependency which can be applied to patients whose care can be delivered within acute adult, paediatric or acute assessment settings (appendix 4). A multiplier for calculating establishments will suggest nursing Whole Time Equivalents (WTE) required to provide a safe and appropriate standard of care for each of the five levels of acuity and dependency identified by SNCT. Also measured are Nurse Sensitive Indicators (NSIs); these are quality indicators, which can be influenced by nursing establishments and skill mix (appendix 5).

Acuity and dependency data is collected twice a year for one month from:

- all adult inpatient wards (twenty nine currently open and all reviewed and compared)
- Three acute assessment wards/units (AMU, SAU and PAU) *
- Two paediatric inpatient wards (A21 and A23)

* Although these areas have been included in this review the assessment ward SNCT is being reviewed currently. The Shelford Group are in the process of piloting a different tool to ensure that more accurate data is captured and reflects these wards/areas. RWT is supporting the initial pilot phase of the new tool within our assessment wards/areas and continues to support with each year's progression.

This review has taken place during January 2023 with minimal covid-19 patients (37 covid patients in total), however this does not exclude that covid-19 patients were still being cared for within the inpatients wards and the green elective pathway remains in place on D7 Ward, Hilton Main, Appleby and Beynon Day Case units with Appleby and Beynon Day case not included in the review due to these not being overnight bed base areas.

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

Professional judgement considers:

- Ward layout/facilities: the configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments required. For example, wards with a high proportion of single rooms might make adequate surveillance of vulnerable patients more difficult. Elective surgical areas also support some enhanced levels of care within their footprint. This is particularly pertinent around covid with donning and doffing requirements and where isolation has reduced staff-patient visibility. Also inclusive of covid- 19 testing requirements.
- Escort duties: consideration needs to be given if this role is likely to affect the numbers of staff required. A local data collection and analysis exercise is undertaken to determine a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care needs if this is considered to have a significant impact on the ward activity.
- Shift patterns: the type of shift patterns (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These are monitored to understand the impact and effect on staff and patients.

The organisation has also recently received external oversight by Carol Stiles (Clinical Workforce Lead) NHSE/I that undertook a review of policies, procedures and overall skill mix/establishment review reporting and data collection. Feedback is awaited. In addition to this work Professional oversight has also been provided for Paediatrics, Cancer Services and Emergency Services by subject Matter experts.

RESULTS

OCCUPANCY, ACUITY AND DEPENDENCY

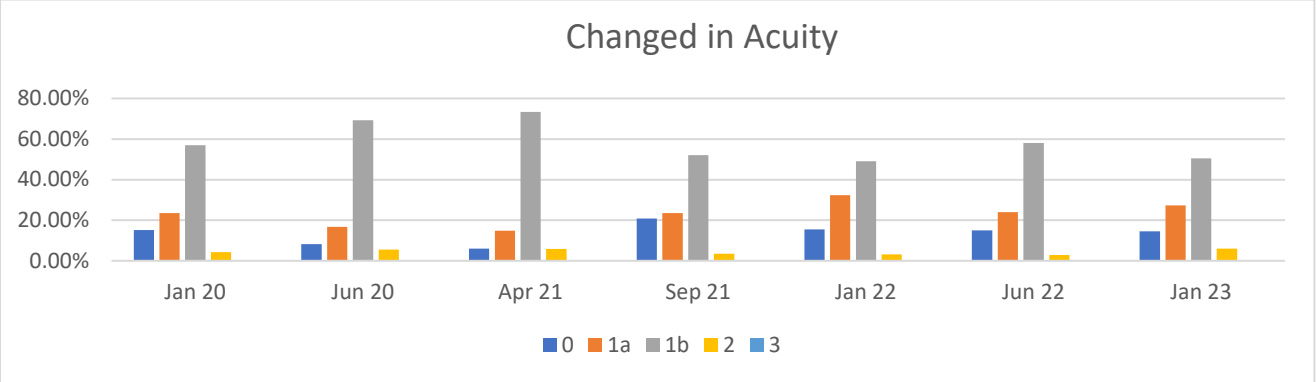
The data in Table 1 below summarises that 19707 acuity scores were collected daily throughout the census. 14.44% of patients were scored at level 0, 27.22% at 1a and 50.42% of patients were scored as level 1b (stable but have a higher dependency on nursing support). Level 2 7.93% and represent patients being provided with Non-Invasive Ventilation on respiratory wards/ Balloon Pump Cardiac Support in cardiology areas.

Table 1 (Acuity Scores collected by Level)

		Jan-20	Jul-20	Apr-21	Sep-21	Jan-22	Jun-22	Jan-23
No of Scores	Multiplier	**21332**	**16230**	**17576**	**15250**	**18250**	**19108**	**19707**
Level 0 (requires hospitalisation)	0.99	15.2%	8.2%	6.04%	20.8%	15.39%	14.99%	14.44%
Level 1a (acutely ill patients who unstable)	1.38	23.5%	16.7%	14.8%	23.55%	32.33%	23.98%	27.22%
Level 1b (stable patients who are heavily dependent on nursing care)	1.72	57%	69.3%	73.3%	52.08%	49.03%	58.11%	50.42%
Level 2 (require expertise provided in designated beds or Level 2 facility)	1.97	4.3%	5.6%	5.9%	3.53%	3.20%	2.86%	7.93%
Level 3 (require advanced respiratory support or therapeutic support of multiple organs).	5.96	0.0009 %	0.2%	0.0006 %	0.01%	0.02%	0.04%	0.03%

Graph 1 below shows a significant increase in the level 2 patients in the month of January 2023, this may be a result in the utilisation of the Acute Respiratory Unit (ARU) that accommodates patients that would previously have gone to ICCU to respiratory support.

Graph 1 – changes in acuity (last 6 SNCT reviews)



NURSE SENSITIVE INDICATORS (NSI) BY WARD

Table 2 captures the numbers of Falls, Pressure Ulcers, Medicine Incidents, Complaints, and Infections during January 2023 identifying those who have improved (↑) from the previous review, those that have decreased (↓) and those that have remained with no change (→), of which have been colour coded for visual representation of improved areas and those who have increased in NSI score.

Within Table 2 the wards which will be highlighted later in the paper as wards requiring establishment uplifts of greater than 10% are indicated with an asterisk* by ward name. There is no correlation between uplift request and NSI by ward. None of the wards show high NSI scores whilst also requiring significantly higher (10% or greater change) establishments.

	Table 2 Nurse Sensitive Indicators Jan 2023	FALLS per 1000 bed	PU	MED INCIDENTS *	COMPLAINTS	C-Diff	MRSA	SCORE (Jan 23)	Previous June 22 SCORE	Increase of decrease from previous review
Division 1	A9	3	0	2	0	0	1	6	6	→
	A12	2	0	0	1	0	0	3	5	↓
	A14	0	0	0	1	1	0	2	2	→
	B7	0	0	0	0	0	0	0	0	→
	A5	2	2	1	2	0	0	7	5	↑
	A6	1	5	1	2	0	0	9	1	↑
	HILTON MAIN	3	0	2	0	0	1	6	9	↓
	B8	1	3	0	0	0	1	5	5	→
	B14	7	0	2	0	0	1	10	5	↑
	D7	0	0	0	0	0	0	0	2	↓
Division 2	C18	0	3	0	0	0	0	3	11	↓
	C19	0	0	1	0	0	0	1	8	↓
	B11	0	1	4	0	0	0	5	5	→
	C15*	0	4	1	0	0	0	5	9	↓
	C16*	0	3	0	0	1	0	4	10	↓
	C14*	0	2	2	0	0	0	4	8	↓
	C26*	0	3	0	0	0	0	3	8	↓
	C21	0	4	0	0	1	1	6	11	↓
	C22	0	2	1	0	0	0	3	6	↓
	C24	0	2	1	0	0	0	3	6	↓
	C25	2	6	0	1	0	0	9	7	↑
	C35	0	1	0	0	0	0	1	8	↓
	A7 *	0	2	1	0	0	1	4	6	↓
	A8 *	0	2	0	0	1	0	3	7	↓
	C58	0	1	0	0	0	0	1	10	↓
	Ward 1	1	1	0	1	1	0	4	4	→
	Ward 2	0	0	0	0	0	0	0	6	↓
	Fairoak	0	0	1	0	1	0	2	3	↓
	C17*	1	3	1	1	0	0	6	6	→
	NRU	0	0	0	0	0	0	0	0	→
	BSSU (C39)	0	2	1	0	0	0	3	2	↑
Div 3	A21/PAU/A23*	0	0	4	0	0	0	4	1	↑
Totals		23	52	26	9	6	6	122	179	↓

Table 2 – Nurse Sensitive Indicators by Ward – January 2023 in comparison to June 2022 + RAG Rated by improved, declined or no change.

NOTE medication incidents are recording against the ward and does not differentiate between professional group (nursing/midwifery and medics/pharmacy/physio) responsible.

ESTABLISHMENTS

Applying the SNCT multipliers (described in Table 1) to the acuity data collected, the differential between funded establishments and required establishments are calculated inclusive of 20% uplift (to provide direct comparison).

The wards highlighted orange (in Table 3 over page) provided data that is suggestive of establishments requiring further analysis/review/consideration at skill mix review meetings (exceeded tolerance of 10% either above in required professional judgement establishment at Phase 1 or 2). These meetings took place between the Director of Nursing, Head of Nursing for Division and Head of Nursing Workforce.

Accuracy of Acuity – dip sampling of acuity data alongside professional confirm and challenge on ward acuity has outlined training is needed for new staff joining the Trust and blanket training is required for all registered nursing staff from Matron downwards to ensure staff understand the importance of accurate data entry and what the data is utilised for. The dip sampling has already identified the need for June 2023 review to revert back to manual data collection to ensure accuracy of the acuity data for each ward.

These are presented in tabular form over page in both WTE and percentage.

Note – the increase in required establishment will be supported through divisional budgets and for Paediatrics' this is supported by a business case.

Table 3 provides the full suite of data calculated. This is inclusive of the reflection that vacancies and sickness have on each area.

	No. of Beds	% Occupancy	Nurse Sensitive Indicators	CHPPD	Professional Judgement (WTE)	SNCT Tool Acuity (WTE)	Current Budget (WTE)	Required Budget (WTE)	Change in WTE	% based on current budgeted WTE	% change	Ratio Split (RN/HCSW)	Comments
A21	26				103	102.98	59.28	103	43.72	174	73.89	67/33	
PAU	16	113.2	4		34.9	37.34	17.81	34.9	15.1	196	95.95	70/30	
A23	8				21.4	26.36	5.88	21.3	15.4	362	262.24	62/38	
A9 (SAU)	37	86.4	6		69.5	44.94	68.3	69.5	1.2	102	1.76	63/37	
A12	25	96.65	3	6.65	34.9	34.99	35.23	34.9	-0.33	99	-0.94	63/37	
A14	25	96.26	2	6.65	34.9	33.32	35.23	34.9	-0.33	99	-0.94	63/47	
B7	16	82.86	0	11.12	40.04	13.98	40.27	40.04	-0.23	99	-0.57	68/32	Increase CHPPD due to Level 2 patients with Tracheostomies
A5	27	96.18	7	8.14	44.74	36.46	43.11	44.74	1.63	104	3.78	55/45	RN/UNREG split due to increase social requirement of patients
A6	27	93.43	9	8.14	44.74	36.65	43.73	44.74	1.01	102	2.31	55/45	RN/UNREG split due to increase social requirement of patients
Hilton main	32	85.74	6	6.84	49.23	33.52	46.7	49.23	2.53	105	5.42	56/44	
B8	31	80.65	5	7.59	52.91	34.23	43.34	43.69	0.35	101	0.81	76/24	
B14	43	93.32	1	7.59	72.75	51.84	69.62	71.29	1.67	102	2.40	75/25	
D7	32	78.63	0	7.51	53.98	41.45	40.62	40.62	0	100	0.00	58/42	
C18	23	98.7	3	7.23	37.2	28.32	36.8	37.2	0.4	101	1.09	59/41	
C19	23	69.42	1	7.23	37.2	32.73	37.8	37.2	-0.6	98	-1.59	59/41	
B11 CHU	26	82.18	5	7.56	43.8	23.13	41.7	43.8	2.1	105	5.04	67/33	Ward attenders not captured in in patient acuity
C15	21	96.03	5	6.83	32.3	29.11	26.9	32.3	5.4	120	20.07	60/40	
C16	28	60	4	5.94	37.2	39.69	33.53	37.2	3.67	111	10.95	59/41	
C14	27	77.56	4	7.42	43.2	35.37	40.1	43.2	3.1	108	7.73	54/46	Increased Tag bays requiring HCSW support over RN requirement
C26	27	96.42	3	9.49	55.2	36.5	46.41	55.2	8.79	119	18.94	63/37	Increased CHPPD due to national guideline for Level 2 patients (FICM?GPICS)
C21 ASU	39	95.45	6	7.06	61.6	91.83	62.69	61.6	-1.09	98	-1.74	58/42	
C22	20	97.5	3	6.6	29.6	27.28	27.1	29.6	2.5	109	9.23	54/46	
C24	28	95.48	3	5.9	36.9	37.73	34.54	36.9	2.36	107	6.83	57/43	
C25	28	94.05	9	5.82	36.5	33.81	34.54	36.5	1.96	106	5.67	58/42	
C35 Dean	17	98.82	1	7.76	29.5	16.27	29	29.5	0.5	102	1.72	56/44	
A7	28	94.59	4	6.35	40.3	30.48	33	40.3	7.3	122	22.12	61/39	Increase in beds from 22 to 28
A8	28	95.28	3	6.35	40.3	36.75	33	40.3	7.3	122	22.12	61/39	Increase in beds from 22 to 28
C58 (AMU)	49	96.73	1	8.13	89.2	57.33	89.29	89.2	-0.09	100	-0.10	62/38	
Ward 1	16	62.29	4	6.59	29.5	44.98	29.6	29.5	-0.1	100	-0.34	48/52	Rehab ward that requires more AHP input and doesn't fit into adult acute inpatient requirement
Ward 2	20	119.5	0	5.76	31	26.66	31.2	31	-0.2	99	-0.64	45/55	Rehab ward that requires more AHP input and doesn't fit into adult acute inpatient requirement
Fairoak	27	98.15	2	5.31	31	52.04	32	31	-1	97	-3.13	52/48	Rehab ward that requires more AHP input and doesn't fit into adult acute inpatient requirement
C17 (now diabetes	16	92.74	6	6.8	23.2	19.6	30.5	23.2	-7.3	76	-23.93	58/42	
NRU	10	99.67	0	10.56	23.6	13.82	21.8	23.6	1.8	108	8.26	49/51	Rehab ward that requires more AHP input and doesn't fit into adult acute inpatient requirement
BSSU (C39)	18	87.59	3	6.69	27.1	21.76	25.6	27.1	1.5	106	5.86	52/48	Step down, patients awaiting discharge reduced RN need

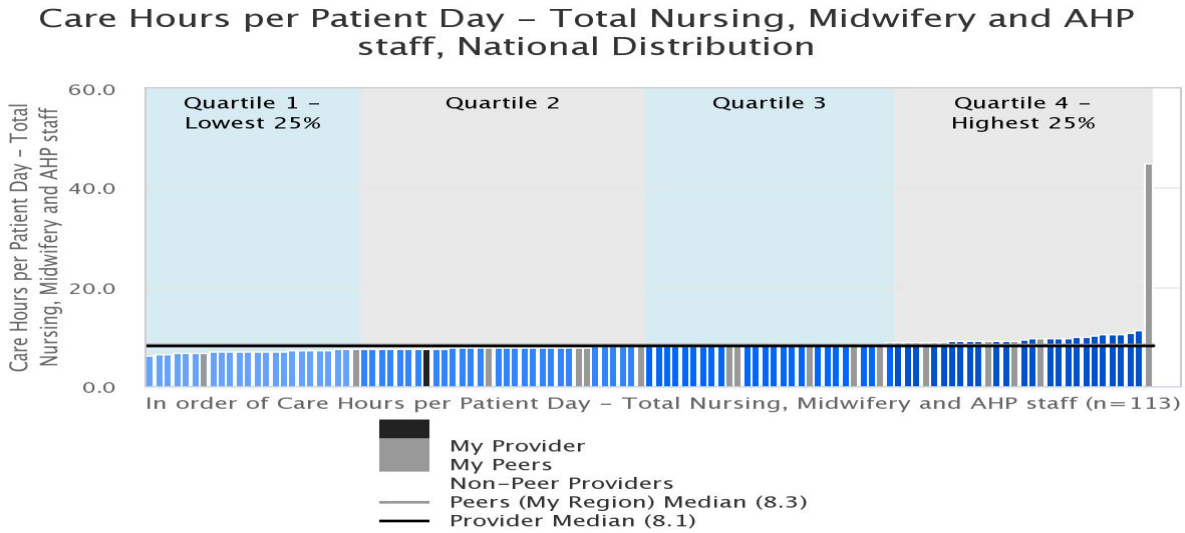
TRUST NURSE SENSITIVE INDICATORS AND CARE HOURS PER PATIENT DAY (CHPPD).

An additional part of the skill mix review has been to use data available on the Model hospital to benchmark the Trust position with Care Hours Per Patient Day (CHPPD) (graph 3) and nurse sensitive indicators (graph 4 and 5).

Note – Model Hospital updates the national value sporadically and this value was from November 2022, due to delays in national updates.

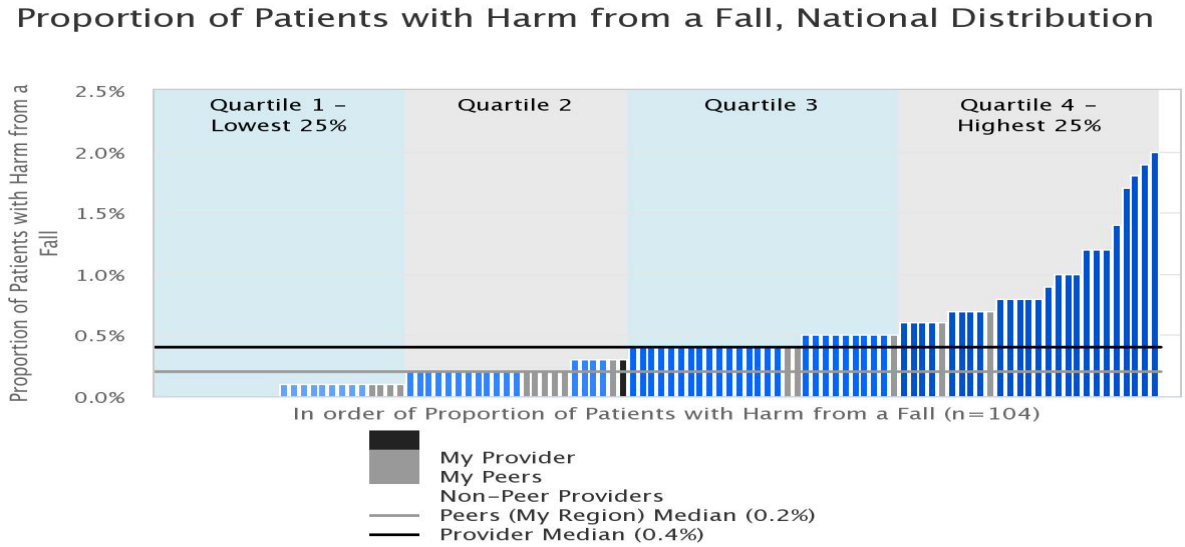
Graph 3 shows the position of the Trust CHPPD both nationally and with peers for the review period of January 2023, the Trust value is 7.5 (previous 7.3) against a national value of 8.1 or peer median of 8.1.

Graph 3 – Care Hours per Patient Day – Total Nursing/Midwifery and AHP staff



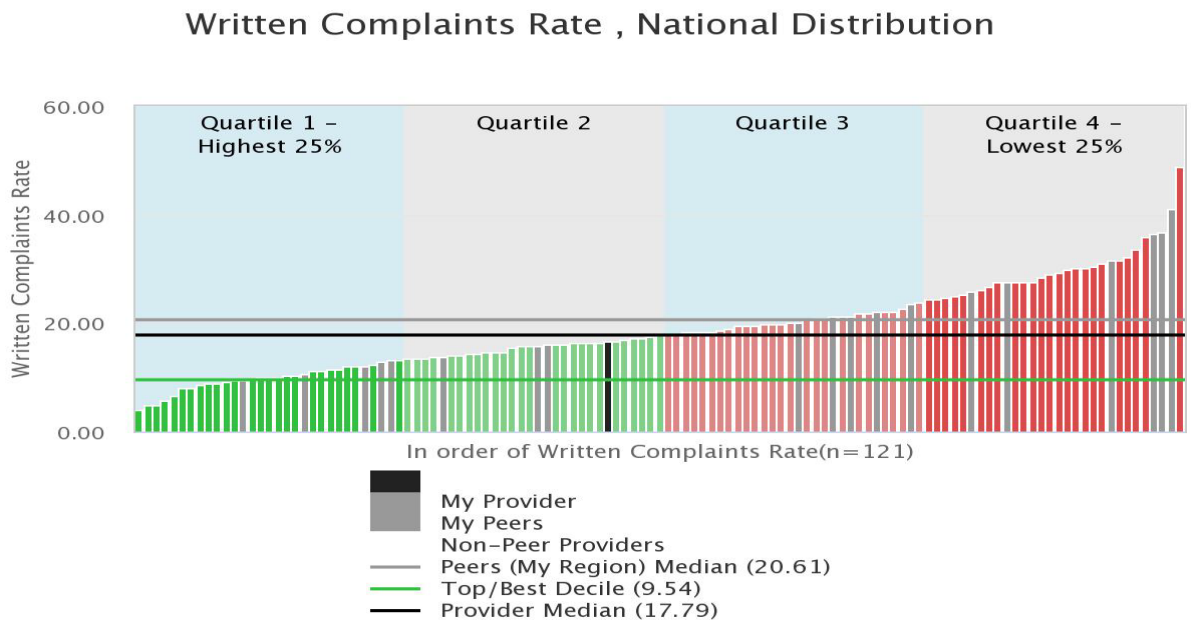
Graph 4 shows proportion of patients with harm from a fall, the Trust value is 0.3% (previous 0.3%) against a national median of 0.2% and peer median of 0.4%

Graph 4 – Proportion of Patients with Harm from a Fall



Graph 5 shows Complaints rate – The Trust Value of 16.65 against National Median 17.79 and Peer Median of 20.61 which outlines that we received 2.39 written complaints per 1000 staff in comparison to our peers.

Graph 5 - Written Complaint Rate – per 1000 staff (WTEs)



Although Graph 5 outlines the number of complaints, it should be noted this relates to Trust complaints as a whole and not just inpatient wards.

ANALYSIS

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

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

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

The skill mix review was concluded by the Executive Director for Nursing & Midwifery, Director of Nursing, Head of Nursing Workforce, appropriate Divisional Head of Nursing for each Division, Deputy Director of Finance and Head of Resourcing.

Division 1 – No change to Divisional budget – please note, that there is the requirement to move funding from some wards to support other wards within the Division.

Division 2 – No change to Divisional budget – please note, that there are the requirements to move funding from some wards to support other wards within the Division.

Division 3 (Paediatric Services) – Business case has been submitted for required budget increase and is supported by this skill mix/establishment review.

The confirm and challenge meetings reviewed the following wards which were outside of the 10% threshold between budgeted establishment and professional judgement during the review and will be supported in establishment change within the Divisions.

7 of the areas reviewed in Phase 1 (2023) were noted to be outside of 10% tolerance between Establishment and Professional Judgement.

Increase in establishment:

- C15
- C16
- C26
- A7 (increase in bed base from 22 – 28)
- A8 (increase in bed base from 22 – 28)
- A21/PAU/A23 (Business case in pipeline)

Decrease in establishment:

- C17

The Director of Nursing supports the changes to establishment required as a result of this census being either cost neutral, subject to either business case approval brought forward by Divisions to support the uplift or movement of funding within the Divisions.

APPENDIX 1 DIVISION 1

A9 SEU (Surgical Emergency Unit – New Cross)

A9 is a 37 bedded surgical assessment ward. The area has seen a recent introduction of a separate SDEC (Same Day Emergency Care) located on Appleby and staffed by Advanced Clinical Practitioners and other registered and unregistered staff. The new SDEC is open from the hours 08:00 – 20:00 (12 hours) across 7 days a week. This saw the separation of budget.

A12 Ward (Female General Surgery - New Cross

A12 is a general surgical ward for female patients admitted as emergencies. Previously this ward accommodated both elective and emergency patients, however due to the conversion of D7 to elective surgery, all elective patients are accommodated on D7, thus changing the patient profile for the area.

A14 Ward (Male General Surgery – New Cross)

A12 is a general surgical ward for male patients admitted as emergencies. Previously this ward accommodated both elective and emergency patients, however due to the conversion of D7 to elective surgery, all elective patients are accommodated on D7, thus changing the patient profile for the area.

B7 Ward (Head and Neck Surgery – New Cross)

SMALL REDUCTION OF 0.23 WTE TO SUPPORT OTHER AREAS IN DIVISIONS REQUIRING INCREASE

B7 is an emergency and elective head and neck ward that has increased its bed spaces to from 12 to 16.

A5 Ward (Trauma and Orthopaedics – New Cross)

Budget aligned with A6

A5 is a 27 bedded trauma and orthopaedic ward that accommodates both high risk elective patients and emergency trauma patients, both male and female.

A6 Ward (Trauma and Orthopaedics – New Cross)

Budget aligned with A5

A6 is a 27 bedded trauma and orthopaedic ward that accommodates both high risk elective patients and emergency trauma patients, both male and female.

Hilton Main (Elective Orthopaedics – Cannock Hospital)

Hilton Main is a 32 bedded elective orthopaedic ward with 4 level 2 SECU beds within existing bed base. The ward accommodates patients that attend for elective joint replacement surgeries. Review took place before final approval of a business case to increase theatres sessions and through put of elective surgical activity.

B8 Ward (Cardiothoracic Surgery Ward– New Cross)

B8 is a 31 bedded ward and includes 12 high care beds within the bed base of 31. The are accommodates both emergency and elective patients, along with critical care level 2 step down patients from ICCU requiring a nurse to patient ratio of 1:2.

B14 Ward (Cardiology Ward – New Cross)

B14 is a 43 bedded cardiology ward with 8 high care beds within the bed base of 43, the ward accommodates both elective and emergency patients. Moving forward the Director of Nursing agrees with plans to manually collect emergency assessment patient acuity and activity at June 2023 review to have the SNCT assessment multipliers utilised.

D7 Ward (Elective Pathway Surgery)

D7 is an elective surgical ward that is commissioned for 26 beds, however, is currently open to 32 beds. The Division are currently reviewing the current clinical utilisation of a 4 bedded SECU previously funded which may then require a reconciliation of bed numbers for the area.

APPENDIX 2 DIVISION 2

A7 & A8 Wards (Gastroenterology – New Cross)

Ward A7 and A8 are both 28 bedded wards with 4 side rooms and 4 bays. The bed base for both wards has increased since the previous (June-22) skill mix review from 22 to 28 initially to support Winter pressures, however the requirement for the increased beds remained during the skill mix review and funding from April 2023 is now recurrent, outlining a new budgeted establishment of 40.28 WTE for each ward.

C18 Ward (Older Person - New Cross)

Ward C18 is a 23 bedded ward that specialises in patients with dementia/delirium and psychiatric illnesses. A rising number of the patients being cared for in this ward demonstrate supported behaviours, requiring increased 1:1 supervision.

C19 Ward (Older Person – New Cross)

Ward C19 is a 23 bedded ward specialises in patients with dementia/delirium and psychiatric illnesses. A rising number of the patients being cared for in this ward demonstrate supported behaviours, requiring increased 1:1 supervision.

B11 Ward (Clinical Haematology Unit - New Cross)

Ward B11 is a 26 bedded ward specialising in clinical haematology. This inpatient ward also has day case ward attender elements which provides Systemic Anti-Cancer Therapy (SACT) and line care, these patients are recorded as ward attenders and are not captured as part of the inpatient environment and are added in separately in line with the SNCT. Acuity dip sampling and professional scrutiny has identified an additional training need with regards to acuity scoring. Noting that the SNCT tool does not capture the staffing/visibility issues within this area.

C15 Ward (Diabetes – New Cross)

Ward C15 is an acute medical ward specialising in diabetes with increased side rooms. The ward has a need to provide enhanced care to 2 bays, alongside challenges with visibility to ensure patient safety.

C16 Ward (Diabetes – New Cross)

Ward C16 is an acute medical ward, specialising in diabetes. The ward sees a high turnover of admissions and discharges.

C17 Ward (Diabetes - New Cross)

CHANGE TO SUPPORT C15/C16

Ward C17 is an acute medical ward, specialising in diabetes. The ward has a small bed base of 16 and is being used to resolve cost pressures due to previous skill mix reviews across the division.

C14 Ward (Respiratory – New Cross)

CHANGE IN ESTABLISHEMT – supported by ARC Business case.

Ward C14 is a 26 bedded ward specialising in respiratory medicine and is linked with C26.

The previous June 22 review took place before the final approval and budgeted establishment increase of Acute Respiratory Unit (ARU) business case. The Jan 23 review took place with the change in budgeted establishment.

C26 Ward (Respiratory – New Cross)

CHANGE IN ESTABLISHEMT – supported by Acute Respiratory Unit (ARU) Business case.

Ward C26 is a 26 bedded ward specialising in respiratory medicine and linked with C14.

C21 Ward (Acute Stroke Unit **-** New Cross)

Ward C21 is an acute stroke ward with 39 acute beds and has on average 4 admissions a day meaning 12 beds occupy patients within 72 hours of admission, 27 acute beds and a STAR room.

C22 Ward (Acute Renal – New Cross)

Ward C22 is an acute medical ward specialising in renal that is commissioned for acute dialysis patients and transfers from Walsall. The ward is currently open to 20 beds, however only established for a 17 bed base.

C24 Ward (Renal – New Cross)

Ward C24 is an acute medical ward, specialising in renal with 28 beds. The area also operates a procedure room, currently utilised twice a week at a minimum for outpatient visits for renal biopsies for both planned and emergency activity.

C25 Ward (Renal – New Cross)

Ward C24 is an acute medical ward, specialising in renal with 28 beds. The ward has seen an increase in the number of patients required tagging to ensure their safety and prevent falls.

C35 Deanesly

Deanesly ward is a 17 bedded ward that specialising in oncology and is required to adhere to neutropenic care guideline ratio's (1:2), they also care for patients with spinal cord compression. Out of hours the ward provides telephone triage calls for oncology patients, with some needing to attend if required. Reviewing the acuity data for this ward (Jan 23 = 16.29, June 22 = 22.54) shows a variance in comparison to the professional judgement of the current Matron and Senior Sister which requests 29.50 WTE. Noting that the SNCT tool does not capture the staffing/visibility issues within this area. Acuity dip sampling and professional scrutiny outlined further bespoke acuity training.

C58 Acute Medical Unit

Please note – We recognise that the inpatient SNCT does not fully support admission areas and have utilised the SNCT acute admission multipliers as they are reflective of the nuanced area.

Fairoak, Ward 1 and Ward 2 – These wards are rehabilitation wards and although they have been included in this review, the SNCT acute ward tool does not take into consideration the rehabilitation requirements of this patient group.

Neurology Rehabilitation Unit – West Park Hospital

INCREASE IN HCSW's

We recognise that for the rehabilitation areas that although we review the area using the adult in patient SNCT, it does not fully support the requirement of rehabilitation areas. There is currently no acuity tool available, thus the rationale for utilising the adult inpatient SNCT for this review. This will require a business case to support.

APPENDIX 3 DIVISION 3

The Paediatric inpatient and assessment areas has seen a complete separation of services, including A21 Ward, Paediatric Assessment Unit (PAU) and A23 (Elective Surgery). A business case has been completed to support the staffing requirements and this skill mix supports the business case request. The service has also recently had an external expert review that supports the business case.

Previous skill mix has not seen the separation of budget between the areas; thus, this is the first to support the separation.

A21 Ward – (Paediatric Inpatient)

26 bedded Paediatric area, 4 of the 26 beds are utilised for High Dependency (HDU) level 2 critical care children. In recent months, the area has been working at 110% capacity, seeing the requirement of increasing beds above 26. They have also seen up to 6 HDU critical care level 2 children within the department.

(In line with Royal College of Nursing (RCN) and Royal College of Paediatrics and Child Health (RCPCH) standards) and requires: -

- additional specialist commissioning funding for its Level 2 High Dependency Unit (HDU) - providing Continuous Positive Airway Pressure (CPAP) to respiratory compromised patients) to support 1:2 ratio nursing staff for 4 patients (24/7)
- additional Band 7 Senior Sister to support the professional development and management of the HDU facility.
- Children and Adolescent Mental Health Services (CAMHS) HCSW 24/7 to support the mental health patients routinely admitted to the ward.

Level 2 HDU activity is presently unfunded, and remains a cost pressure, The Directorate alongside the Division are currently in the process of pursuing level 2 status and the necessary requirements to achieve this.

PAU – (Paediatric Assessment Unit)

14 beds/trolleys, recently reviewed by an external senior paediatric nurse and requires: -

- Additional RN on duty 24/7 to bring roster up to 3 RN, allowing for 3 RNs per shift and mitigates the risk associated with layout and placement.
- Additional Band 7 to provide professional development and management of the PAU facility.

A23 Ward – (Paediatric Elective Surgery)

8 bedded Paediatric ward, for assurance and management of risk, maintaining an elective surgical pathway (away from A21), currently operated for 6 days and 5 nights.

- Facility needs to be open 24 hours, 6 days per week in order to support more complex surgery.
- Noted increasing paediatric waiting list needs addressing and this provides safe solution.

APPENDIX 4

Levels of acuity and dependency

Level 0: Patient requires hospitalisation. Needs met by provision of normal ward cares.

•Elective medical or surgical admission

•May have underlying medical condition requiring on-going treatment

•Patients awaiting discharge

•Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly

•Regular observations 2 - 4 hourly

•**Early Warning Score** is within normal threshold.

•ECG monitoring

•Fluid management

•Oxygen therapy less than 35%

•Patient controlled analgesia

•Nerve block

•Single chest drain

•Confused patients not at risk

•Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence

Level 1a: Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.

Increased level of observations and therapeutic interventions

•Early Warning Score - trigger point reached and requiring escalation.

•Post-operative care following complex surgery

•Emergency admissions requiring immediate therapeutic intervention.

•Instability requiring continual observation / invasive monitoring

•Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly

•Arterial blood gas analysis - intermittent

•Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains

•Severe infection or sepsis

Level 1b: Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.

•Complex wound management requiring more than one nurse or takes more than one hour to complete.

•VAC therapy where ward-based nurses undertake the treatment

•Patients with Spinal Instability / Spinal Cord Injury

•Mobility or repositioning difficulties requiring the assistance of two people

•Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care)

•Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome

•Patients on End of Life Care Pathway

•Confused patients who are at risk or requiring constant supervision

•Requires assistance with most or all activities of daily living

•Potential for self-harm and requires constant observation

•Facilitating a complex discharge where this is the responsibility of the ward-based nurse

Level 2: May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / •Deteriorating / compromised single organ system.

•Post-operative optimisation (pre-op invasive monitoring) / extended post-op care.

•Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure

•First 24 hours following tracheostomy insertion

•Requires a range of therapeutic interventions including:

•Greater than 50% oxygen continuously

•Continuous cardiac monitoring and invasive pressure monitoring

•Drug Infusions requiring more intensive monitoring e.g., vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium

•Pain management - intrathecal analgesia

•CNS depression of airway and protective reflexes

•Invasive neurological monitoring unit

Level 3: Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

•Monitoring and supportive therapy for compromised / collapse of two or more organ / systems

•Respiratory or CNS depression / compromise requires mechanical / invasive ventilation

•Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection.

APPENDIX 5

Nurse Sensitive Indicators

Formal complaints

Registered complaints about nursing/midwifery care/staff in the following three areas:

- Communication
- Clinical care
- Attitude

Medication Errors

Actual medication errors where nursing was the primary cause.

Infection

Incidence rates of MRSA bacteraemia and Clostridium Difficile

Slips, trips and falls

Number of slips, trips and falls

Pressure Ulcers

Prevalence of pressure ulcers developed in hospital.

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THE ROYAL WOLVERHAMPTON EMERGENCY DEPARMTNET SAFER NURSING CARE TOOL (ED SNCT) SKILL MIX REVIEW

PHASE 2– JANUARY 2023 data

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V6.2-Report completed- May 2023

INTRODUCTION

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

To demonstrate the Trust's commitment to the above requirement a twice-yearly assessment of the Emergency Department will take place to align staffing establishment to patient numbers and acuity.

The Royal Wolverhampton NHS Trust (RWT) uses the Emergency Department Safer Nursing Care Tool (ED SNCT) which is a safer staffing decision support tool that uses the principles and framework of the Safer Nursing Care Tool for Adult Inpatients in Acute Hospitals. It has been developed to help NHS hospital managers/clinicians in England measure patient acuity and/or dependency to inform evidence-based decision making on setting nursing establishments for the emergency department.

A previous review of the department using the SNCT took place in June 2022, since this review, the department has seen an extension of its footprint with the opening of the Ambulance Receiving Centre (ARC) in November 2022, this has provided an additional 17 cubicles spaces solely for the purpose of off-loading ambulance patients in a safe and timely manner. The ARC is a separate entity to the original Emergency Department footprint requiring careful allocation of staff to ensure patient safety. This additional area poses added challenges due to transferring patients to and from the main building to receive investigations such as x-rays or CT scans and ultimately transfer into a cubicle within the main department. It is recognised by the directorate that the Emergency Department has already received significant investment into the ED nurse staffing budgeted establishment. However, this was based upon hour-by-hour attendances and not patient acuity. It is acknowledged that the ED workforce is the most crucial factor for providing safe, effective, high quality emergency care in a timely manner. In accordance with RCEM Nursing Workforce Standards for Type 1 Emergency Departments (2020) nurse staffing ratios for medium and high acuity patients should be based upon 1:3 ratio, currently the ED workforce is based upon a 1:4 ratio.

The Tool will also offer nurses a reliable method of delivering evidence-based workforce plans to support existing services or the development of new services. The emergency departments involved in this project included large acute trusts, as well as those with major trauma centres, and district general hospitals caring for adults only or adults and children. It is therefore suitable for determining nurse staffing establishments for all emergency departments.

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

It is recognised that no national workforce tool can incorporate all the factors that may influence the nursing workload locally, e.g.,

- Staff capacity and capability, seniority and confidence
- Organisational factors - support roles, department layout, co-location of supporting services
- Senior Sister/Charge Nurse supervisory time and leadership capability and combining methods (triangulation) using the ED SNCT together with professional judgement and other qualitative measures is recommended to arrive at optimal staffing levels.

Acuity and dependency data was collected in June 2022 and again in January 2023. Data is collected twice a year for one month to allow a review of the summer and winter periods from:

- All patients within the Emergency Department
- All patients within the Same Day Emergency Care (SDEC) Department

This review has taken place during January 2023 whilst within winter pressures. It is recognised that during the data collection period the department experienced 2 ambulance strikes that took place on 21/01/2023 and 28/01/2023, it's impossible to determine if these strikes had any impact on the number of attendances.

Overview of the Tool

The ED Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care, DH 2000). These classifications have been adapted to support measurement across the emergency department.

Figure 1

Levels of Care
Level 0 Walk-in attendee / minor injuries Needs met by provision of routine interventions.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.
Level 1c Patients who are in a physiologically STABLE condition but are requiring additional intervention to mitigate risk and maintain safety.
Level 2 May be managed within clearly identified, designated beds, resources with the required expertise and staffing level.
Level 3 Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Nurse Sensitive Quality Indicators

These are the indicators linked to nursing care in the department and as identified by the National Quality Board (2018) focuses on patient outcome measures, process measures, patient and staff experience and staffing metrics.

The organisation has also recently received external oversight by Carol Stiles (Clinical Workforce Lead) NHSE/I that undertook a review of policies, procedures and overall skill mix/establishment review reporting and data collection. Feedback is awaited. In addition to this work Professional oversight has also been provided for Paediatrics, Cancer Services and Emergency Services by subject Matter experts.

RESULTS

OCCUPANCY, ACUITY AND DEPENDENCY

The Emergency Department (ED) at RWT has a local average of 153,092 attendance annually, with 132 (daily average of 11 patients) of those attend with symptoms of covid-19, to which the staff need to allocate additional time to don and doff appropriate PPE.

Table 1 Shows the number of attendances to the department from Jan 2022 – Dec 2022, to allow to review of numbers dependant on the month/season.

Date	Attendance Numbers
Jan-22	11,605
Feb-22	11,399
Mar-22	13,474
Apr-22	12,571
May-22	13,463
Jun-22	13,349
Jul-22	12,930
Aug-22	12,569
Sep – 22	12,399
Oct-22	13,134
Nov-22	13,154
Dec-22	13,045
Total 12 months	153,092

The data in Table 2 below summarises both ED and SDEC. ED shows that 2618 acuity scores were collected using the ED SNCT in January 2023. 68.9% (average 289) of patients were scored at level 0, 4.8% (average 20) at 1a, 6.9% (average 29) of patients were scored as level 1b and 17.6% (average 74) at a level 1c (physically stable but requires additional interventions). Level 2 totalled 1.6% (average 7) and 0.2% (average 1) scored at Level 3, outlining a representation of the patients within the department.

SDEC shows that 742 acuity scores were collected using the ED SNCT in January 2023. 96.9% (daily average 184) of patients were scored at level 0, 0.7% (average 1) at 1a, 0.7% (average 1) of patients were scored as level 1b and 1.8% (average 3) at a level 1c (physically stable but requires additional interventions). There were no level 2 and 3 patients, and it would not be expected that these level patients would be cared for within SDEC.

Day:		*1*	*1*	*2*	*2*	*3*	*3*	*4*	*4*	*5*	*5*	*6*	*6*	*7*	*7*	*8*	*8*	*9*	*9*	*10*	*10*	*11*	*11*	*12*	*12*	*Proportion*	*Patients*
Care level (précised - see Decision Matrix tab for full definitions)		**1200**	**0000**	**1300**	**0100**	**1400**	**0200**	**1500**	**0300**	**1600**	**0400**	**1700**	**0500**	**1800**	**0600**	**1900**	**0700**	**2000**	**0800**	**2100**	**0900**	**2200**	**1000**	**2300**	**1100**	*Average*	*Daily Average*
Level 0: Walk-in patient.	**ED**	103	83	77	58	75	72	74	70	67	60	89	68	101	56	88	44	115	61	78	53	77	45	109	81	68.9%	289
	SDEC	39	33	39	36	35	32	27	29	32	15	39	27	35	22	49	20	39	23	32	29	25	33	15	14	96.9%	184
Level 1a: Acutely ill, unstable, likely to deteriorate.	**ED**	0	5	3	7	7	5	12	6	7	5	4	4	9	7	6	1	5	5	1	4	10	3	7	2	4.8%	20
	SDEC	0	0	1	0	0	0	0	0	0	0	1	0	0	1	0	2	0	0	0	0	0	0	0	0	0.7%	1
Level 1b: Stable but dependent on support for basic needs.	**ED**	0	0	4	12	4	0	11	13	10	18	0	0	1	28	3	2	9	16	13	6	9	7	7	8	6.9%	29
	SDEC	0	0	2	1	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0.7%	1
Level 1c: Patients who are in a physiologically STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	**ED**	27	31	27	16	17	24	11	17	12	12	24	19	21	0	24	24	12	25	17	19	15	14	32	21	17.6%	74
	SDEC	1	2	0	0	4	4	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1.8%	3
Level 2: Requires therapeutic support in HDU settings.	**ED**	0	0	1	1	1	2	4	2	5	1	0	0	0	0	0	2	6	3	2	0	4	5	0	3	1.6%	7
	SDEC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%	0
Level 3: Requires therapeutic support in ITU settings.	**ED**	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	1	0	0.2%	1
	SDEC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%	0
Totals ED	**ED**	130	119	112	94	104	103	113	108	102	96	117	91	133	91	121	74	147	110	111	82	115	74	156	115	109	419
Totals SDEC	**SDEC**	40	35	42	37	39	36	27	29	32	15	43	28	35	23	49	22	39	23	32	29	25	33	15	14	31	189

Table 3 below shows the variation in care levels using the daily average for ED & SDEC from June 2022 (Phase 1 – Summer - Blue) and January 2023 ED (Phase 2 – Winter - Green), SDEC (Phase 2 – Winter – Grey).

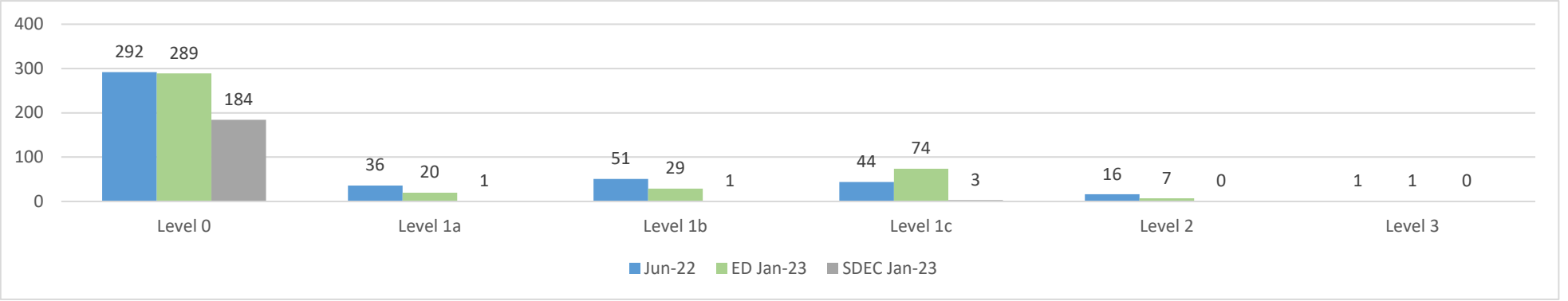
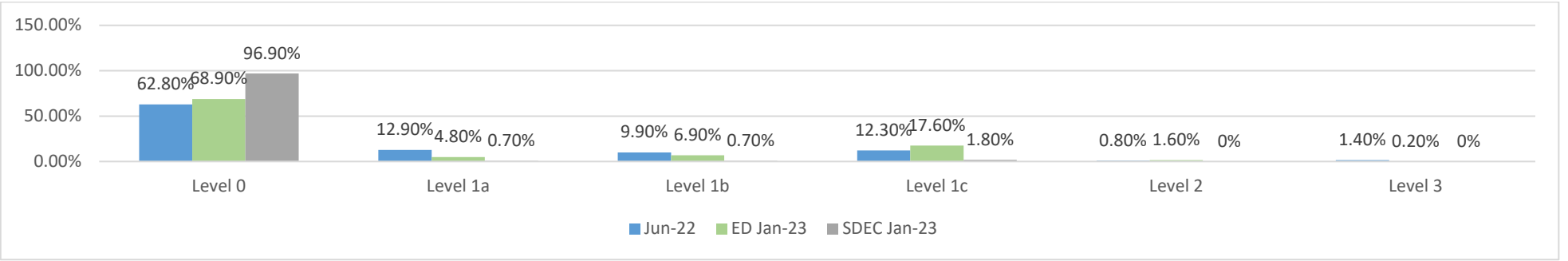


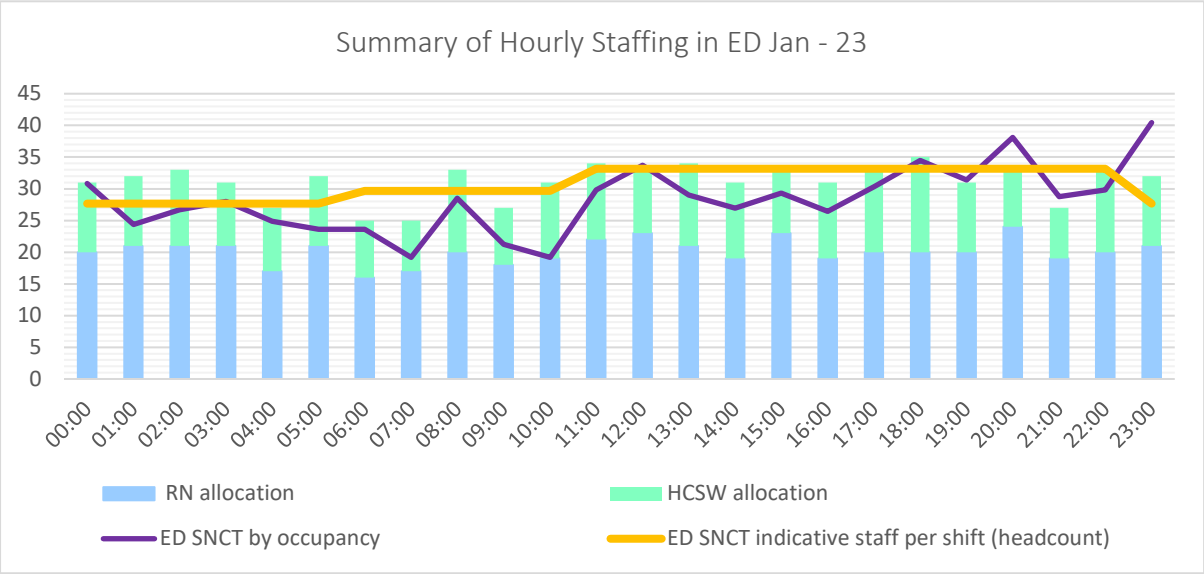
Table 4 below shows the variation in care levels using percentages for ED & SDEC from June 2022 (Phase 1 – Summer - Blue) and January 2023 ED (Phase 2 – Winter - Green), SDEC (Phase 2 – Winter – Grey).



Footnote: Phase 1 – June 2022 included ED and SDEC, the above variance for Phase 2 – January 2023 separates ED and SDEC as this has been separated in phase 2.

Table 5 below outlines a visual summary of the above data in Table 2. There appears to be a significant increase in patients within the department after midday and increases through the night depicted by the purple line (patient headcount). The blue column outlines registered nurses allocated and the green healthcare support workers allocated. The orange line Illustrates the staffing numbers required for a 24 hour period within the Emergency Department when utilising the SNCT.

Table 5



Footnote - The blue bar's represent RN's and the green bars represent HCSW's, purple lines represent the patient headcount number and the orange is the ED SNCT staff requirement.

Table 6 illustrates the comparison from Phase 1 (June 2022, Summer – includes SDEC) and Phase 2 (January 2023, Winter – excludes SDEC, includes ARC). Recognising that phase 1 in June included SDEC and the ARC was not completed. Phase 2 January excludes SDEC as this is separate and includes the new ARC.

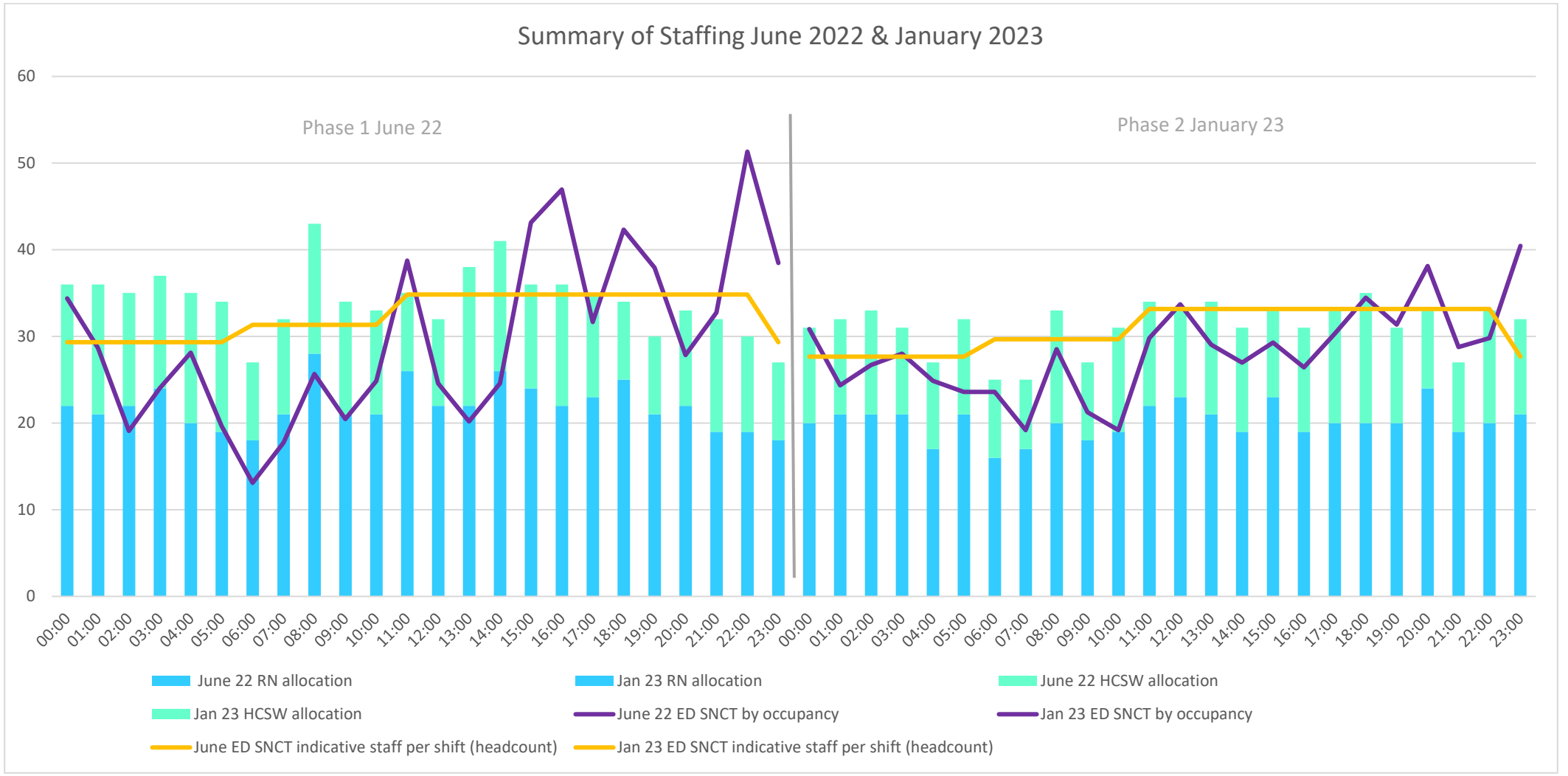


Table 7 below outlines the attendance numbers and transfers with escort, which is an additional 163.46 hours or 4.36 WTE registered nurses to support safe transfer/escort of patients.

Day	Paeds		AMU		Stroke		SAU		ITU / Cardiology		Other		Total Admissions / day	
	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23	Jun-22	Jan-23
1	3	6	42	26	1	1	10	0	3	1	9	**34**	**69**	**68**
2	7	13	27	44	2	4	15	0	2	4	9	**32**	**64**	**97**
3	7	10	42	24	3	1	11	2	2	2	7	**34**	**75**	**73**
4	7	5	39	33	1	2	10	0	3	6	6	**17**	**70**	**63**
5	8	11	30	32	2	2	12	0	3	2	5	**22**	**65**	**69**
6	6	12	38	34	3	1	8	1	1	2	7	**26**	**69**	**76**
7	4	8	43	20	0	2	13	0	5	4	6	**16**	**78**	**50**
8	8	9	41	26	3	1	16	0	1	2	3	**40**	**80**	**78**
9	8	7	39	30	1	3	7	0	2	2	10	**22**	**76**	**64**
10	2	9	35	35	1	2	9	0	3	2	16	**27**	**76**	**75**
11	8	9	51	33	2	1	9	0	0	2	14	**41**	**95**	**86**
12	4	11	32	38	1	1	10	0	0	0	14	**30**	**73**	**80**
Total	72	110	459	375	20	21	130	3	25	29	106	**341**	**890**	**879**

All PAU, AMU, ITU & Cardiology transfer have an escort.
SEU will depend upon treatments in progress, i.e., fluids

Professional Judgement Daily Staffing Number requirements

To ensure that the department is safely staffed and in accordance with managing patient acuity and volume according to average number of patients in the department by time of the day the total nurse staffing is staggered. The following staffing roster numbers is required:

Main ED + Paed's ED

Daily Staffing (Professional Judgement)						
	Adults (Main ED)			Paediatrics (Triage, Cubicles, and high care)		
	Long Day 07:15-19:30	**Twilight** 10-10 or 12-12	**Long Night** 19:15-07:30	**Long Day** 07:15-19:30	**Twilight** 10-10 or 12-12	**Long Night** 19:15-07:30
RN	21	3	20	3	1	4
HCA	11	1	10		1	
Staffing Totals Adults	Day 24+12			Night 24+12		

Paediatrics	Day 4+1	Night 4+0
Indicative Staff per Shift (SNCT)		**Headcount SNCT**
0600-1100		31.2
1100-2300		34.7
2300-0600		29.2

SDEC

Indicative Staff per Shift	**Headcount SNCT**	**Headcount (Professional Judgment)**
0600-1100	2.9	**8** (RN 5 + 3 HCSW)
1100-2300	6.4	
2300-0600	0.9	**6** (RN 4 + 2 HCSW)

Shifts in SDEC cover Long Days (07:30 – 20:00) and Long Nights (19:30 – 08:00) SNCT tool separates these into 3 equal parts across a shifts pattern. The SNCT does not include the SNI's and layout of an area. It also doesn't look at national guidelines for specific areas.

Table 9 below demonstrates Budgeted Establishments from January 2023, against the SNCT and then the SNCT against the Professional Judgements. The SNCT numbers are inclusive of ARC and additional AOA spaces as these were utilised during the data collection period and would require the development of a business case to support funding these. The Professional Judgement is for the current Main ED and Paediatric ED only and does not include ARC and additional AOA spaces.

Budgeted Establishment and Required Establishment	January Budget Establishment		SNCT only Establishment Requirement		SNCT and Professional Judgment Requirement		Banding Variance January 23 budget to SNCT Professional Judgment	
	ED	**SDEC**	**ED**	**SDEC**	**ED**	**SDEC**	**ED**	**SDEC**
Band 7	16.45	1	10.48	1	14.3	1	-2.15	0
Band 6	43.79	5.15	31.43	5.27	41.22	5.19	-2.57	0.04
Band 5	70.04	18.03	115.34	11.53	79.61	18.18	9.57	0.15
Band 4	0	0	0	0	0	0	0	0
Band 3	6	0	0	0	5.15	0	-0.85	0
Band 2	32.64	12.24	25.7	12.88	32.64	12.99	0	0.75
Total budgeted WTE	**168.92**	**36.42**	**182.95**	**30.68**	**172.92**	**37.37**	**Variance 4**	**Variance 0.94**
Variance (WTE)	N/A	N/A	**14.03**	**-5.74**	**4**	**0.94 WTE**		
Difference from current to required (%)	N/A	N/A	8.30%	-15.76%	25.89%	2.60%		

Footnote: SNCT only does not take into consideration the layout of the department, along with other qualitative measures, which is recommended to arrive at optimal staffing levels for each area.

Table 10 – Nurse Sensitive Indicators January 2023

Jan - 22	Falls	Pressure Ulcers	Medication Errors	Complaints	C- Diff	MRSA	Total
ED	**5**	**0**	**1**	**2**	**0**	**0**	**8**

Total of 8 (Previous June 2022 was 20, which sees an overall reduction, however this was taken during a time of additional supported funding for ARC and additional AOA spaces).

* It's also important to outline that during the period of review there were 10 patients detailed under the mental health act, 1 Self-harming patient and 1 Deprivation of Liberty patient.

ANALYSIS AND SUMMARY OF REQUEST

Reviewing the acuity data for January 2023 suggests a requirement for budgeted establishment to be altered to accommodate safer staffing within the main ED and Paediatric ED. This establishment change outlines a decrease in Band 7 (-2.15WTE), a decrease in Band 6 (-2.57WTE) to support and increase in band 5 RN (9.57WTE) as the band 5 workforce develop skills set within the ED setting. This establishment change does not require any additional funding.

Nurse Sensitive Indicators – Falls 5, Pressure Ulcer 0, Medication Incidents 1, Complaints 2 and no HCAI, a total of 8.

The Director of Nursing supports the request and appropriateness of the above changes in budgeted establishment and supports continued rostering efficiency supporting activity movement throughout the 24hr care period.

There is a requirement to develop a business case to support staffing for the Ambulance receiving centre and additional ambulance off load areas that remain open for periods to assist in timely ambulance turnaround times at peak periods. Note original Winter funding for ARC support has since ceased.

APPENDIX 1

Levels of acuity and dependency

Level 0: Patient requires hospitalisation. Needs met by provision of normal ward cares.

- Elective medical or surgical admission
- May have underlying medical condition requiring on-going treatment
- Patients awaiting discharge
- Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly
- Regular observations 2 - 4 hourly
- **Early Warning Score** is within normal threshold.
- ECG monitoring
- Fluid management
- Oxygen therapy less than 35%
- Patient controlled analgesia
- Nerve block
- Single chest drain
- Confused patients not at risk
- Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence

Level 1a: Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.

Increased level of observations and therapeutic interventions

- Early Warning Score - trigger point reached and requiring escalation.

•Post-operative care following complex surgery

•Emergency admissions requiring immediate therapeutic intervention.

•Instability requiring continual observation / invasive monitoring

•Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly

•Arterial blood gas analysis - intermittent

•Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains

•Severe infection or sepsis

Level 1b: Patients who are in a STABLE condition but are dependent on nursing care to meet most or all the activities of daily living.

•Complex wound management requiring more than one nurse or takes more than one hour to complete.

•VAC therapy where ward-based nurses undertake the treatment

•Patients with Spinal Instability / Spinal Cord Injury

•Mobility or repositioning difficulties requiring the assistance of two people

•Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care)

•Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome

•Patients on End-of-Life Care Pathway

•Confused patients who are at risk or requiring constant supervision

•Requires assistance with most or all activities of daily living

•Potential for self-harm and requires constant observation

•Facilitating a complex discharge where this is the responsibility of the ward-based nurse

Level 2: May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / •Deteriorating / compromised single organ system.

•Post-operative optimisation (pre-op invasive monitoring) / extended post-op care.

•Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure

•First 24 hours following tracheostomy insertion

•Requires a range of therapeutic interventions including:

•Greater than 50% oxygen continuously

•Continuous cardiac monitoring and invasive pressure monitoring

•Drug Infusions requiring more intensive monitoring e.g., vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium

•Pain management - intrathecal analgesia

•CNS depression of airway and protective reflexes

•Invasive neurological monitoring unit

Level 3: Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

•Monitoring and supportive therapy for compromised / collapse of two or more organ / systems

•Respiratory or CNS depression / compromise requires mechanical / invasive ventilation

•Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection.

APPENDIX 2 EMERGENCY DEPARTMENT LAYOUT

Ambulance These spaces are utilised to support the WMAS transfers and off loads. At times of peak activity, they may also need to be flexed for acutely ill patients presenting at the front door via triage when there is no available cubicle space

Majors/A 31 cubicles in total with a ratio of 1:4 Qualified nurses 24/7. Average of 104 patients through area per day with each nurse looking after 13.4 patients in a 24hour period. Average priority is 2-3

Children's Excluding triage, 3x qualified paediatric nurses required 24/7. 1x Paediatric qualified nurse required 12hrs per day.

Average of 83pts per day with varying acuity. Average of 3 through High care area per day.

Resus

Average of 14 patients per day with average 7hr LOS in department. Priority 1 patients with acuity level 2-3.

4x Qualified Nurses 24/7 based on acuity of patients. The 4th nurse can be flexed within the department as an urgent treatment /sepsis nurse to achieve associated targets

NB: this does not account for the use of Resus 7 negative pressure room.

Triage

Average total patients through front door triage is 360 in a 24hour period. this equates to 75% of total department attendances. Staffing 2 x Triage competent Nurses 24/7. 2x triage competent Nurses 12hrs per day.

Average of 4 patients per hour per nurse during peak times in attendance. This will allow for eradication of breach to 15-minute target time.

Average of 41 patients per day that present with chest pain requiring initial assessment and ECG upon arrival which is supported by the HCAs working within Triage.

Key

- Helicopter Role Band 7
- Nurse In Charge Band 6/7
- Sister Band 6
- Staff Nurse Band 5
- Health Care Assistant Band 2/3

APPENDIX 3 ARC LAYOUT

Ambulance Receiving Centre

The ARC is a newly built 17 cubicle space receiving centre for all West Midlands Ambulance Conveyances. The area is co-ordinated by either a Band 7 or Band 6 triage nurse and is nursed on a 1-4 ratio by staff nurses with HCA support. This ensures that all patients are assessed and initial first line treatments are commenced. Average ambulances per day are 136

Key

Triage Nurse Band 6/7

Staff Nurse Band 5

Healthcare Assistant Band 2

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Care Closer to Home

Community NHS services update

The Community structure

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Community Intermediate Care
- Integrated nursing and therapy service
- Short term rehab goals
- Therapy provision for admission avoidance
- Realigned to AHP Acute and Community Group

Virtual Ward
- Multiple pathways
- Integrated Hospital at Home function

Community Supportive Care
- Care Co-ordination Hub 24/7
- MDT Co-ordinators
- PEF's

Community Ambulatory Care
- Anti-Coagulation
- Phlebotomy
- Ambulatory Clinics

Community Urgent Care
- Admission Avoidance 24/7
- Rapid Access to Social Care

Community Planned Care
- District Nursing Service 8am – 8pm (Centralised City-wide service)

Accessing community services

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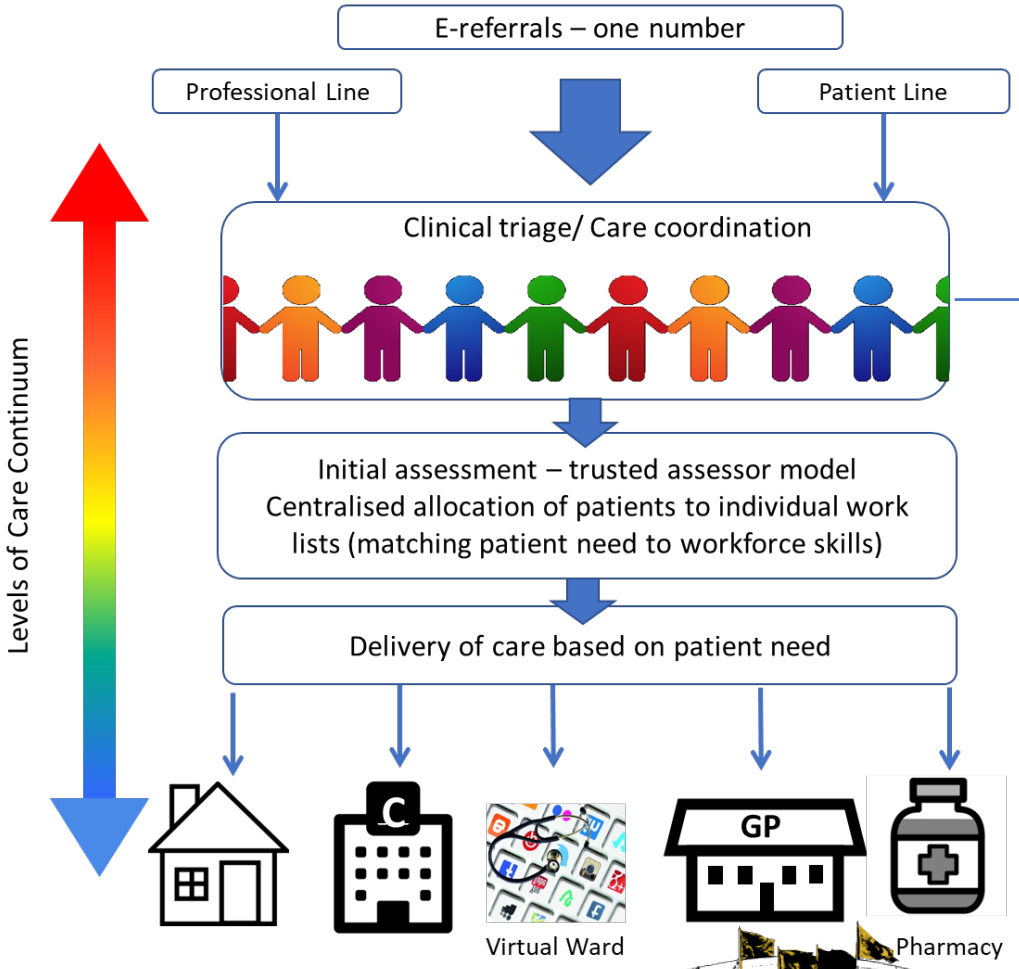

Care Co-ordination

The gateway to alternatives to hospital

- MDT Coordinators
- Routine Clinical Triage
- Rapid Clinical Triage
- Pharmacy
- See and Treat
- Hospital In-Reach
- Therapy Face to Face
- IoT & Docobo
- CAD links with WMAS

Care co-ordination for WMAS

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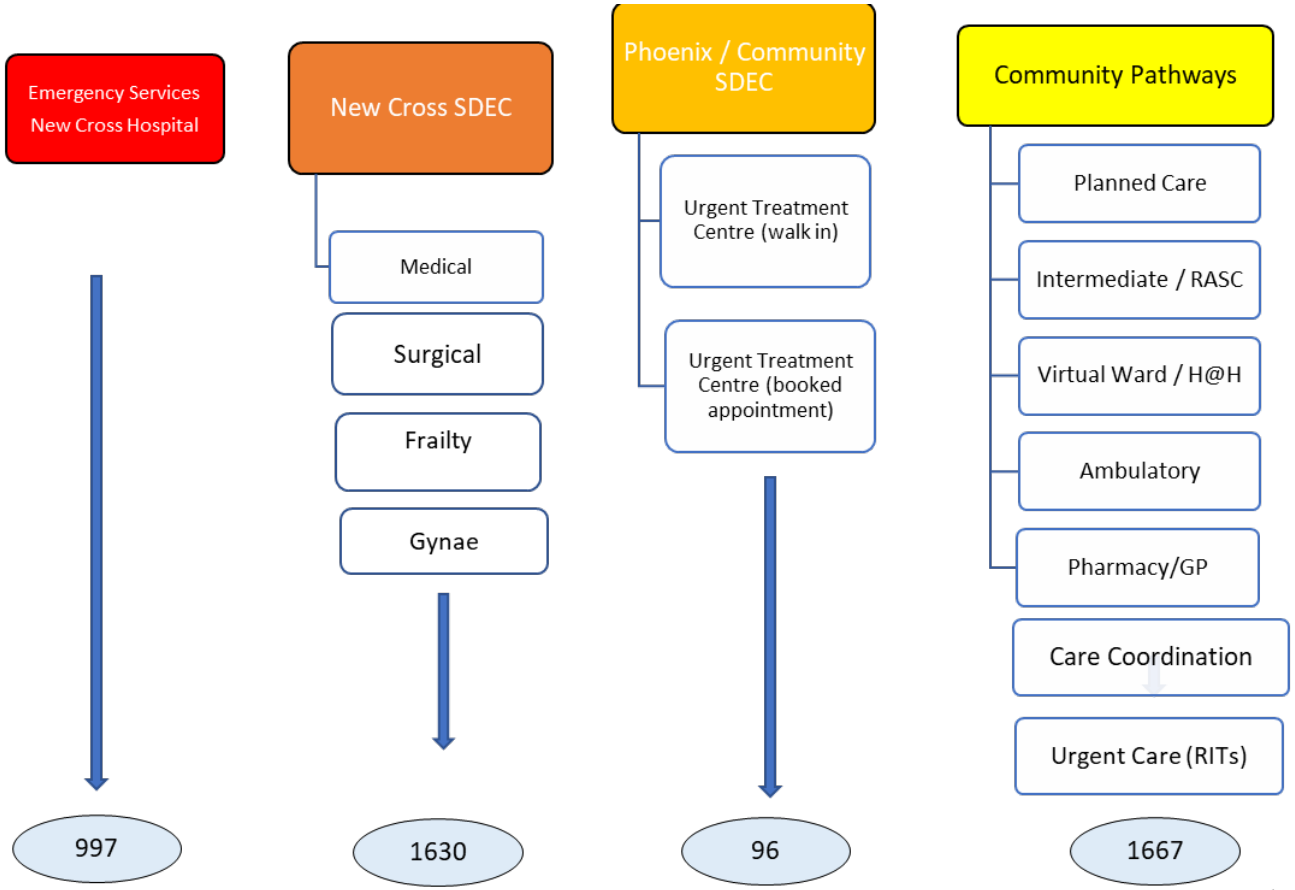

Since July 2021 Care Co have taken 4532 calls from WMAS and triaged almost 3500 patients to alternative pathways to ED.

Care co review all calls after 72 hours to review if they made the right decision re. pathway disposition.

2 hour Urgent Community Response

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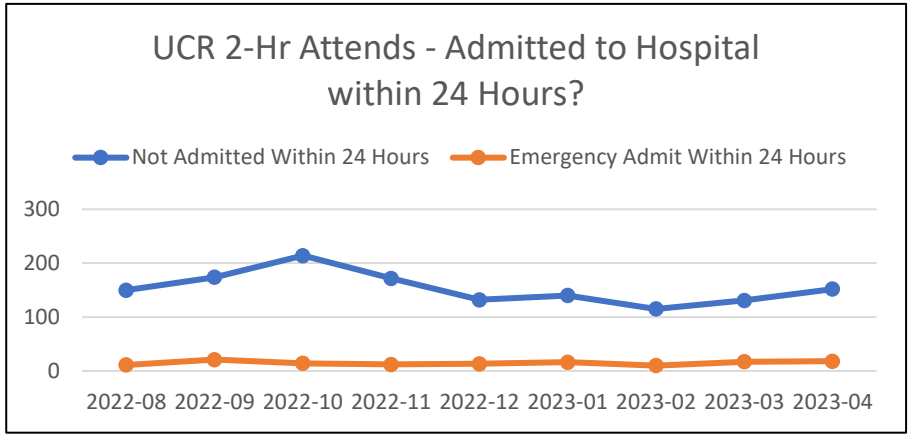
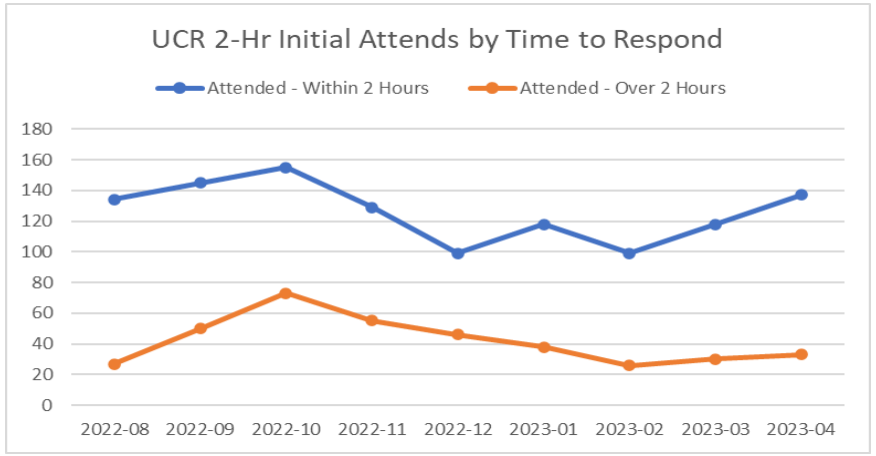
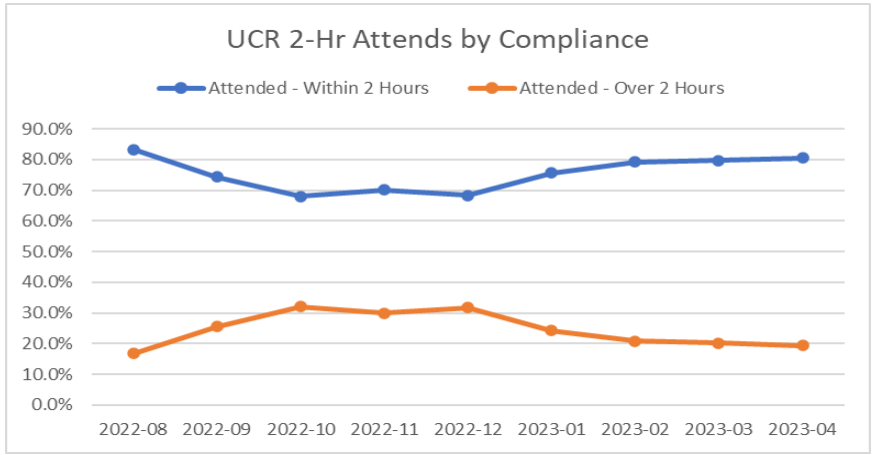
- Compliant with 7/9 key clinical conditions
- Falls pick up response and pathway due to go live 22nd May 2023
- Diabetes, first urinary catheterisation, sepsis and additional IV therapy pathways in development
- POCT pilot planned







Urgent Community Response – RASC

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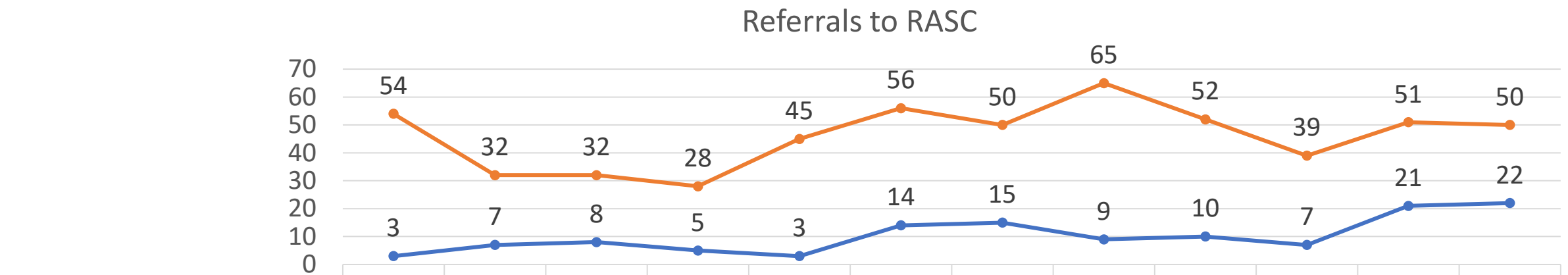
Rapid Access to Community Care – providing bridging at hospital discharge for those awaiting a start date for a package of care or short term crisis response for those who's needs have escalated due to physical illness.



	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04
Step-Down	3	7	8	5	3	14	15	9	10	7	21	22
Step-Up	54	32	32	28	45	56	50	65	52	39	51	50

Virtual ward

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Service Model

- Nurse led service seven days a week from 08:00 – 22:00
- Consultant oversight /medical governance – weekly MDTs
- 15-20 patients: 1 RN
- Prescribing Pharmacist and Pharmacy ATO role in acute to expedite discharges
- Monitoring frequency according to clinical need
- Condition specific pathways
- Knowing patients' 'normal'

Onboarding Process

- Referral or proactive onboarding (depending on pathway)
- F2F to supply kit / education
- Virtual monitoring and F2F if required

Clinicians and Nursing

Digital Platforms

System Working

Collaborative Working

MDT/ Consultant Led

Escalation Pathways 24/7

Care Home Monitoring

- Docobo enabled monitoring
- Live within majority of care/ residential settings (10 homes)
- Development to merge pathways
- Is my patient unwell escalation

Adult virtual ward pathways

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WHO	WHEN	HOW	OUTCOME
COVID / COPD	Higher acuity / complexity patients	Emergency hospital patients and early intervention	Virtual Delivery of Care Remote Monitoring Hospital @ Home Integrated Services Collaborative / Supervised Treatment MDT Approach
Asthma	Higher acuity / complexity patients	Proactive monitoring to prevent or reduce episodes of illness	
Supportive / Palliative Care	Gold Standards Framework – Green Patients	Monitoring for hospital avoidance, early discharge & detect deterioration	
General Medicine	Medical patients needing extended observation – BP/ Temp/Oxygen saturation/ Rpt Bloods/ Wound output	Proactive monitoring to prevent or reduce episodes of illness	
O2 Weaning/ Covid Step down	Higher acuity / complexity patients and/or with comorbidities	To safely monitor O2 management and levelling off O2	
Diagnostics / Awaiting Discharge to Scan	Patients fit for discharge awaiting diagnostics/scan	Monitor patients at home while they await a scan to avoid occupying a bed	
ARI / Pneumonia	CURB65 Score 2 or lower	Managing low / mild symptoms out of hospital	
Frailty	Frailty SDEC, Step Down Beds, ED Reattendances	Proactive CGA, management of care to prevent or reduce episodes of illness	

- Early Supported Discharge
- Safe Admission Avoidance
- Patient Centric Care at Home
- Improved Patient Experience / Journey
- Ensuring Patients Receive the Right Care at the Right Time by the Right Service
- Early Detection of Deterioration

Paediatric virtual ward pathways

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WHO	WHEN	HOW	OUTCOME
Respiratory	SP02 >92%/ PEWS 1-3/ Wheeze/ Asthmatic	Monitoring for hospital avoidance, early discharge & detect deterioration	Virtual Delivery of Care
Extended Observation	PEWS 1-3/ clinically stable – consultant approval	Monitoring for hospital avoidance, early discharge & detect deterioration	Remote Monitoring
IV Antibiotics (IVAB)	PEWS 1-3/ OD or BD IVAB between 8am – 7pm)/ clinically stable	Monitoring for hospital avoidance, early discharge & detect deterioration	Hospital @ Home
Bronchiolitis	SP02 90-92% self ventilating/ PEWs 1-3/ Diagnosed bronchiolitis RSV +/-	Monitoring for hospital avoidance, early discharge & detect deterioration	Integrated Services
Awaiting Diagnostics	Pt awaiting scan MRI or USS/ PEWS 2 or below/ clinically stable	Monitoring for hospital avoidance, early discharge & detect deterioration	Collaborative / Supervised Treatment
Henoch Schönlein Purpura (HSP)	Step Down Beds, ED Reattendances	Proactive CGA, management of care to prevent or reduce episodes of illness	MDT Approach

Virtual ward impact

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- Total number of referrals to VW in the last 12 months (May 22 – Apr 23) has been 1494.
- 71% of the total number of patients were not re-admitted to hospital whilst on the caseload therefore enabling hospital avoidance.
- Virtual Ward team have enabled early facilitated discharge in the following referring specialties
  - Paediatrics (41%)
  - A&E (23%)
  - Respiratory Medicine (11%)
  - General Medicine (8%)
  - Diabetic Medicine (4%)
  - Older Adults (3%)
- Referrals have significantly increased month on month,
  - Jan 21 ~50 per month
  - April 23 ~120 per month.
- Decreasing acute LoS for patients admitted to VW
  - May 22 AvLoS prior to VW admission 7.8 days
  - April 23 AvLoS prior to VW admission 5.2
- Seeing an almost even split between step-up (preventing the admission in the first place) and step-down (facilitating an earlier discharge)

Digitally enabled community care

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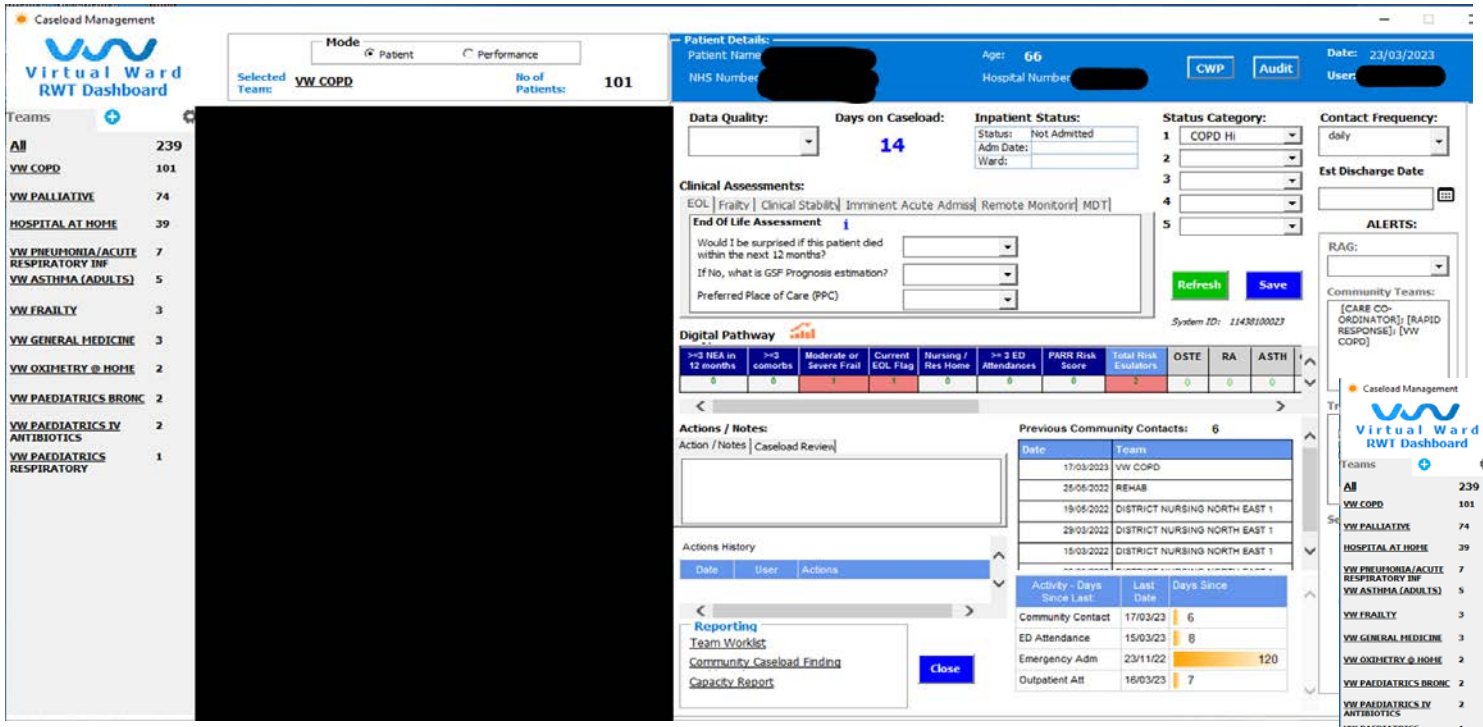
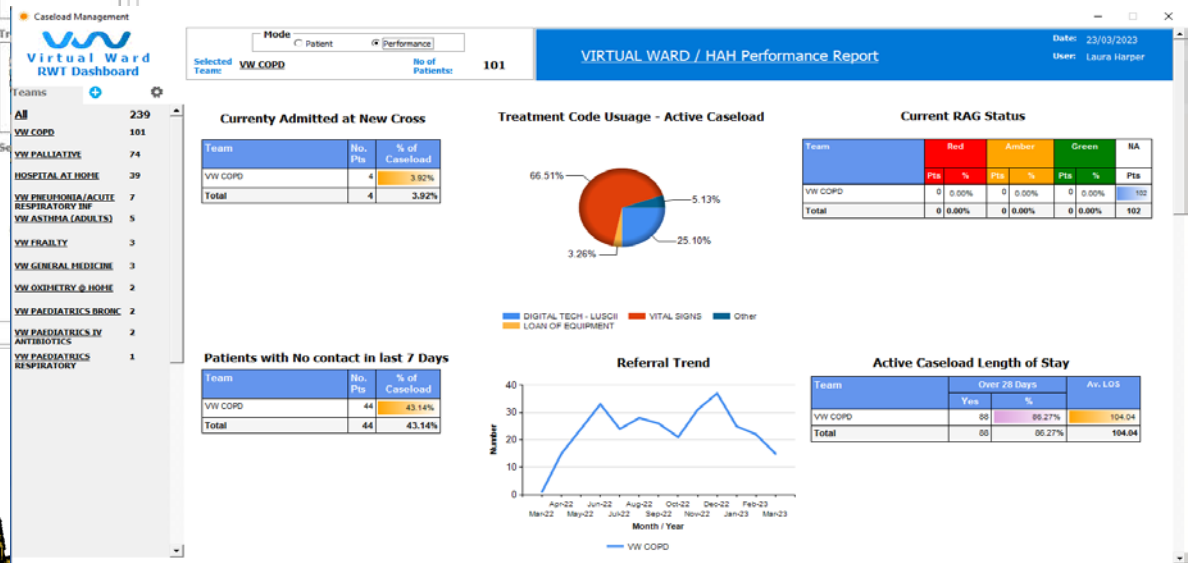


Live date - handover support tool



Tactical performance tools

Reviewing our progress

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Successes:

- Remote monitoring has proven to reach more people proactively whilst **supporting continuity of care** in an alternative way.
- If observations are submitted regularly, the data provides an **individualised snapshot of the patient's health** over a course of time, any peaks or abnormalities triggers / alerts staff to make contact with the patient. This has enabled for **early detection of deterioration**.
- Patients have felt reassured to have **direct access to the same team** / contact via remote monitoring as opposed to going through a Secretary or Switchboard.
- Remote monitoring has **improved the patient journey** as travel time, waiting time and clinic time is reduces dramatically.
- Feedback has shown patients feel empowered by **taking control** of their healthcare monitoring

Challenges:

- × Some cohorts of patients have been found to be digitally unaware or not trust the app / platform – communication & language
- × Digital exclusion for patients due to personal circumstances
- × Restrictions down to the technology on certain providers, there is the need for a proxy (family / carer) to submit readings into the app – the proxy may not always be available.
- × Clinical engagement – being able to engage the acute clinical teams to enable seamless pathways
- × Data reporting – the ask on data reporting and conforming to an acute way of reporting (square peg/round hole)

Patient experience

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"The app was great and within minutes a staff member called me when my heart rate was high, giving advice and reassurance."

"Liked using the App which was easy to use. I did not feel alone, very helpful."

Patient said she felt happy and comfortable with the service knowing she had the support she needs.

"Staff always relaxed me and gave me peace of mind. Feeling safe and cared for at home – a great idea!"

"The app is very easy to use. Supportive service in the community. Reassuring to have the service."

"A very big thank you for all your care, support, advice and monitoring me over the last few weeks. I felt safe at home knowing I had the support – much appreciated."

The Royal Wolverhampton NHS Trust

Trust Board Meeting held in Public	
Meeting Date:	06 June 2023
Title of Report:	Covid – 19 National Inquiry
Action Requested:	Update
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	• That 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. • That the Preliminary Hearing was held on 28th February 2023 • That there has been a Webinar update, a precis of which is in the body of this report
Author and Responsible Director Contact Details:	Stephanie Poulter – Governance Team Support Kevin Bostock – Director of Assurance Tel 07989275283 Email stephanie.poulter@nhs.net
Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	a) Embed a culture of learning and continuous improvement. b) We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	a) Improve overall staff engagement.
Improve the Healthcare of our Communities	a) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	a) Improve population health outcomes through provider collaborative. b) Implement technological solutions that improve patient experience. c) Progress joint working across Wolverhampton and Walsall d) Facilitate research that improves the quality of care
Resource Implications:	Resources will be met from current staff and technology within teams.
Report Data Caveats	None
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:
Equality and Diversity Impact	There are no equality & diversity implications associated with this paper.
Risks: BAF/ TRR	No
Risk: Appetite	Low
Public or Private:	Public
Other formal bodies involved:	None
References	

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
Item/paragraph 1.0	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 Royal Wolverhampton NHS Trust (RWT) involvement in the Covid-19 National Inquiry which opened in June 2022. It is also to inform the Trust Board of relevant updates on next steps and likely expectations on the Trust regarding its input to the Inquiry.

The Royal Wolverhampton NHS Trust

COVID-19 NATIONAL INQUIRY UPDATE

1. PURPOSE OF REPORT

The purpose of this report is to inform the Trust Board and its associated committees that all appropriate and necessary steps have been taken in preparation for Royal Wolverhampton NHS Trusts (RWT) involvement in the Covid-19 National Inquiry which opened in June 2022.

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 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.

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.

3. Update following Webinar on 19th April 2023

The Inquiry held its first preliminary hearing for Module 3 '*looking at the impact of the pandemic on healthcare'*, on Tuesday 28 February 2023.

Following this the UK Covid-19 Inquiry Team facilitated a Webinar on 19th April 2023 with key speakers from Browne Jacobson; Capsticks and Hempsons Solicitor's each offering a perspective from different aspects of the hearing.

The following are key aspects covered by this Webinar including what progress has been made to date and what the expectation is likely to be on NHS Trusts going forward:

- Evidence gathering exercise and Rule 9 requests now received for the Preliminary Hearing
- Module 3 Full Hearing to take place in 2024, no date set as yet.
- There is a lot of overlap and inter-relationship with the other 2 modules and of particular concern to the Core Participants are the links to Module 1 (resilience and preparedness of the United Kingdom for a Coronavirus pandemic) and the preparedness of the NHS immediately prior to the pandemic.
- The published scope largely remains the same with the Chair of the Inquiry resistant to formal expansion of the scope as published although note has been made of Mental Health and Inequalities issues raised by Core Participants.
- 36 Core participants took part in Module 3 representing particular interest groups.
    - 19 made written submissions to the preliminary hearing.
    - 18 attended to present to the hearing in person.
- NHSE are a Core Participant but have stated that they cannot and will not be speaking for NHS bodies or their actions.

- The Inquiry is keen to hear the voice of the NHS Workforce and how they were supported by their employing bodies. 'Every Story Matters' along with targeted face to face listening sessions will facilitate this as part of Module 3.
    - Staff should be encouraged to take part at:
        - https://share.covid19.public-inquiry.uk/share-your-experience/
    - Note these methods are to seek experiences of the workforce from a generic and thematic (not individual experiences) perspective, including impact on certain groupings.
    - If organisations receive a Rule 9 request specifically about staff experiences the advice is to tell the story of how our workforce was impacted by the pandemic
        - Talk about your workforce general structure.
        - Key decision makers
        - Staffing levels
        - Challenges to the workforce
        - Impact on the workforce e.g., childcare, transport etc
        - Impact on certain group members e.g. ethnicity, disadvantaged etc
    - It is not the story or perception of the Senior Management Team that is of interest to the Inquiry.
    - Go back over concerns raised via FTSU, Datix, HR and reflect the workforce issues as a collective.
- Learning from Rule 9 Requests received to date:
    - Questions were extensive and wider in scope that expected.
    - It is imperative to get together the right team of people to respond.
    - They needed dedicated resource to collate the response and respond in the given timeframe.
    - It is advisable to seek legal advice.
    - Timeframes are short ranging from 28 days to 6 weeks maximum.
    - It is advisable to engage with the Inquiry Legal Team
    - They want to see compassionate leadership and a response that reflects the workforce experience.
    - Consider external support for your submission.
    - Involve a well-being guardian throughout.
    - Show how you have continually signposted to information and support.
    - Show how you prepared for increased sickness absence.
    - Reinforce the positives.
- It was asked at the Webinar how likely the panel feel it is that the Inquiry will be contacting individual Trusts for Rule 9 requests?
    - The decision has been made that all Ambulance Trusts are contacted (this has happened already). The list of documents they have been asked to produce is extensive.
    - Therefore, it is thought by the panel to be unlikely that other Trusts will be asked to respond but if yours is the exception, preparation is key, and guidance provided is good.

4. RECOMMENDATIONS

Trust Board members are requested to note the content of the report.